



Goldsboro Spine Center, PLLC

Goldsboro Spinal Care & Rehabilitation

605 Spence Avenue, Goldsboro, NC 27534
(919) 751.0555 • Fax (919) 751.3001
www.goldsborospinecenter.com



CONSENT FOR USE OR DISCLOSURE OF HEALTH INFORMATION SERVICE AGREEMENT AND ACKNOWLEDGMENT

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have and always will, respect the privacy of your health information. There are several circumstances in which we may have to use or disclose your health care information.

1. We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you for the diagnosis, assessment, or treatment of your health condition.
2. We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
3. We may need to use your health information within our practice for quality control or other operational purposes.

You have the right to request that we do not disclose your health care information to specific individuals, companies or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. You may revoke your consent to us at any time; however, your revocation must be in writing. We will not be able to honor your request if we have already released your health information before we receive your request. If you were required to give your authorization of a condition while obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

I authorize you to use or disclose my health information in the manner described above. I have read your consent policy and agree to the terms. I am also acknowledging that, if I request, I can receive a copy of this consent and authorization form.

Initial _____

I acknowledge that any gift certificate that I may present in this office is not redeemable for cash. I also acknowledge that if I wish to receive any additional services that are not described on the gift card, I am responsible for payment for those services. Any discounted or free services described on the gift certificate are only applicable on the day that the gift certificate is presented.

Printed Name _____ date _____

Signature _____
(Or signature of guardian representative)

**KIDS SPINAL HEALTH
GOLDSBORO SPINE CENTER, PLLC**

Name of Child _____ Age _____ Date of Birth _____
 Parent/Guardian Name _____
 Child's Social Security Number _____
 Address _____ City _____ State _____ Zip _____
 Home Phone _____ Previous Doctor: _____

Name of Insurance company: _____
 Card Holder Name: _____ D.O.B. _____ SS# _____
 Relationship to cardholder: _____ Cardholder's Place of Employment: _____

1. Does your child experience any of these health problems?

<input type="checkbox"/> Headaches	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Scoliosis	<input type="checkbox"/> Stomach/Digestive Trouble
<input type="checkbox"/> Sinus Pain/Allergies	<input type="checkbox"/> Irritability	<input type="checkbox"/> Rashes	<input type="checkbox"/> Learning Disorders
<input type="checkbox"/> Ear Infections/Problems	<input type="checkbox"/> Hyperactivity	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Bed-Wetting
<input type="checkbox"/> Sleeping Problems	<input type="checkbox"/> Underactive	<input type="checkbox"/> Constipation	<input type="checkbox"/> Poor Diet
<input type="checkbox"/> Breathing Problems	<input type="checkbox"/> Frequent Colds/Flu	<input type="checkbox"/> Colic	<input type="checkbox"/> Asthma

Current Health Problems: _____ Currently taking medications yes no

2. Regarding your child today:

Is your child "accident prone"? yes no
 Has your child had any falls down steps? yes no
 -ever been involved in a motor vehicle accident yes no
 -ever been hospitalized or had surgery? yes no
 -ever had any broken bones or sprain injuries? yes no

3. How does this affect your child's life?

Restricted in daily activities
 Excessive appetite or thirst
 Hindering ability to exercise or to participate in sports or activities
 Poor posture during reading, watching TV, working on computer

4. How long has your child been living this way? Weeks(#) _____ Months(#) _____ Years(#) _____

5. Would you like to find the cause of your child's problem(s)? yes no maybe

6. If found, what results would you want for your child? _____

7. What has prevented you from finding out your child's problem(s)? money time other

REGARDING YOUR CHILD

Were there any complications in your pregnancy or delivery?	Y	N
Was your child born by C-Section?	Y	N
Did the doctor use forceps or other device for delivery?	Y	N
Did your child have any spills or falls that concerned you?	Y	N
Does your child complain of headaches, neck pain, or back pain?	Y	N
Does your child have difficulty concentrating?	Y	N
Does your child have frequent temper tantrums?	Y	N
Are there any other health problems that concern you?	Y	N
When was the last time your child's posture was examined?		Date: _____

REGARDING YOUR RELATIONSHIP WITH YOUR CHILD

Do you miss work often due to your child's illnesses?	Y	N
Do you miss sleep often due to your child's illnesses?	Y	N
Do you worry often about your child's health?	Y	N
Do you have health problems that affect your family?	Y	N
Are aches and pains preventing you from taking part in family activities?	Y	N

Parent/Guardian signature _____ Date _____

How did you hear about our office? _____

Patient Name _____

GOLDSBORO SPINE CENTER, PLLC

FAMILY HEALTH HISTORY

Please take a few moments to complete the following... the better you fill it out, the better it will help us to treat your condition. Thank you for your cooperation.

Place an **X** in the boxes that apply

	SELF	SPOUSE	CHILD	OTHER FAMILY
Back Pain				
Neck Pain				
Headaches				
Auto Accident				
Work Accident				
Pinched Nerve				
Allergies				
Scoliosis				
Arthritis				
Asthma				
Carpal Tunnel				
Fatigue				
Diabetes				
Cancer				
Stroke				
Kidney Disease				
Heart Disease				

Signature _____

Date _____

Goldsboro Spine Center, PLLC Office Policies

- We advise that you follow treatment recommendations given by the doctor.
- Please give 24 hour notice if you are going to miss an appointment.
- We reserve the right to charge a \$25 fee for any missed appointments.
- Payment is expected at the time of service, unless prior arrangements have been made.
- Finances can not and will not be discussed over the telephone, if you should have a question you may address it at your next scheduled appointment.
- There are multiple providers in the office.
- Additional letters or forms requested by the patient will be subject to a \$35 administration fee. Copies of records will be assessed at a fee of:
 - .75 pg 1-25
 - .50 pg 26-100
 - .25 100+
- Copies of records requested will be assessed a fee of:
- If there are any questions regarding treatment, treatment recommendation, or insurance please feel free to contact our office immediately to set up a consultation.
- Congratulations on choosing to improve your health!!

(initials)

Informed Consent for Chiropractic Care

Chiropractic care, like all forms of health care, while offering considerable benefit may also provide some level of risk. This level is most often very minimal, yet in rare cases injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include; sprain/ strain injuries, irritation of a disc condition , and rarely fractures. One of the rarest complications associated with chiropractic care, occurring at a rate between one instance per one million to one per two million cervical spine (neck) adjustments may be a vertebral artery injury that could lead to stroke. Prior to receiving chiropractic care in this chiropractic office, a health history and physical examination will be completed. These procedures are performed to assess your specific condition, your overall health and, in particular, your spine health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations, or studies are needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan prior to beginning care. I understand and accept that there are risks associated with chiropractic care and give my consent to the examinations that the doctor deems necessary, and to the chiropractic care including spinal adjustments, as reported following my assessment.

Patient Name (printed)

Patient or Legal Guardian Signature

Date