GOLDSBORO SPINE CENTER, PA

Name: ______________________ **Date of Birth:** ____________

Address: ______________________ **City:** ____________ **Zip:** ________

Social Security No. : ______________ **Where Employed:** ______________

Home Phone: ____________ **Work Phone:** __________ **Cell Phone:** __________

Married ________ **Single** _______ **Widower** _________ **Separated** ________ **Divorced** _______

Name of insurance company? ______________________________

Card Holder Name: ______________ **D.O.B.** __________ **SS#** __________

Relationship to cardholder: __________ **Cardholder's Place of Employment:** __________

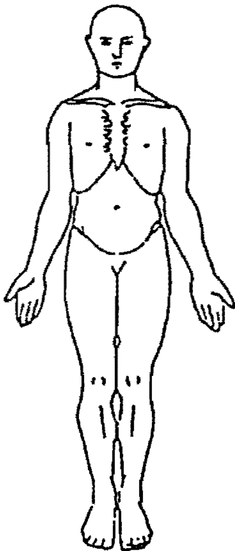
Present Health Problems - In order of importance, please list the complaints in which you are seeing the Doctor:

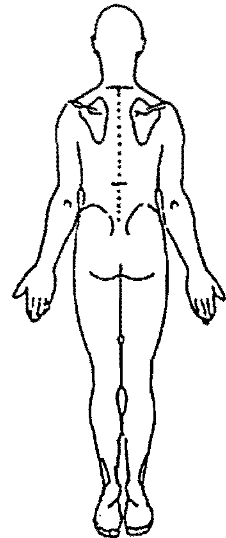
1. ______________________________ **How long?** __________

2. ______________________________ **How long?** __________

3. ______________________________ **How long?** __________

Please mark the areas of your complaint on the illustration below:
P = Pain N = Numbness T = Tenderness S = Spasm





Please answer the following questions: (circle and write in blanks)

Is this pain due to an accident? **Y or N**

If so: ****please let the receptionist know immediately**** Date of Accident: __________

Patient initials __________ Date ________

Patient Name____

Please answer the following questions (circle and write in blanks)

Have you ever had any pain like this before? **Y** or **N**

If so: When?____

Does it radiate anywhere (up, down, left, or right?)___________________________________

Have you seen any other Drs. for this pain? **Y** or **N**

If so: whom did you see?____________________ How long ago did you see him/her?_________

What was the Progress: **Better** **Worse** **Same**

What is the pain on a scale of 1 - 10 ***when the pain is at its worst***: (with 10 being the worst)?_______

Describe the pain please: **(throbbing, stabbing, burning, numb, dull ache.)**__________________

Does anything make it feel better? **(Ice, Heat, Massage, Tylenol, Ibuprofen, Excedrin, Aleve, or others)**

If so: what have you tried?____

Does anything make it feel worse **(specific movements, sleeping or work posture, activities, etc)**___

____

When does the pain bother you? (Please Circle) Night Day Constant Occasionally Daily Weekly

Has your pain caused you to miss any work or school? Y or N

If so: how much?____

Are you taking any medications?____

If so: how much and how often?____

Have you ever been hospitalized? Y or N

If so: when and why?____

Have you had any surgeries? Y or N

If so: when and what surgeries?____

Personal Habits: Smoker? Y or N If so: how much, how often?_____________________

Alcohol? Y or N If so: how much, how often?_____________________

Vitamins? Y or N If so: how much and what kind?___________________

Exercise? Y or N If so: how much and what kind?___________________

Date of last menstrual cycle_________________________**Are you currently pregnant Y or N**

****If you are pregnant please notify the Doctors and staff immediately****

*Following today's consultation, if the doctor feels you can benefit from chiropractic care, he/she will make specific recommendations for examination procedures in order you fully understand your condition. At the completion of your examination, you will be scheduled for a separate appointment for the doctor to review these findings with you and make recommendations for you care. We are committed to providing you with the best chiropractic care possible in a caring environment, and have financial policies consistent with the goal, You are expected to pay for your chiropractic care at the time service is rendered unless other arrangements are made in advance. Details of available investment options will be discussed with you when the doctor goes over your specific recommendation for care during your report of findings, which will typically be scheduled on our next business day. You are responsible for any and all expenses incurred in the collection of any overdue account. There will be a $25.00 returned fee for any returned checks. We reserve the right to charge our typical adjustment fee for missed appointments without prior notification. X-rays remain property of this office and cannot be released.

**In order to maximize your treatment at the Goldsboro Spine Center, PA, group therapy is required as part of the treatment process. Disclosure of Private Health Information is required in order to carry out this procedure. A signature below states that you release the use of that information under HIPPA guidelines. A signature will also authorize your consent to release your health information to your insurance company, which allows them to make any contributions to your care directly to Goldsboro Spine Center PA, and gives us limited power of attorney to endorse any check make out to you for services rendered by our office to you or on your behalf.

Signature of Patient:____________________________ **Date:**_______________

How did you hear of our office?____

Patient Name__________________________________

GOLDSBORO SPINE CENTER, PA

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, PA

Goldsboro Spinal Care & Rehabilitation

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www.goldsborospinecenter.com

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

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 or 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 is 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)

Goldsboro Spine Center, PA 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 th 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

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Office policies for Personal Injury patients

This office will accept you as a new patient based on our clinical examination and belief that chiropractic care will be effective for the treatment of your injuries. Your responsibility to this office will be to follow the doctor's recommendations and to provide the appropriate financial information so that payment for services can be received.

Patients need to bring the following:

1 - Copy of police report and/or a copy of the exchange slip.

2 - Copy of personal automobile policy
This is to verify Medical Payments covered by your Automobile Insurance.

3 - Name of individual and insurance company of party that's liable. Please include policy number.

4 - Name and telephone number of attorney if an attorney has been retained.

You are asked to give 24 hour notice if you need to reschedule an appointment. All appointments that have been missed without notice may be billed to your account.

Following the completion of your treatment in this office, your bill will be forwarded to the responsible party. Please note that this account is still your responsibility.

Signature_______________________________________ Date_______________

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Election to Pursue Liability Claim and NOT Health Insurance Claim

To Whom It May Concern:

The staff of Goldsboro Spine Center, PA has advised me that cost of my treatment for injuries sustained in an automobile accident that occurred on__________________ may be covered in whole or part by both my own health insurance and by the liability insurance of the party at fault.

The clinic staff has informed me that if I file on my own health insurance, I will be responsible for paying deductibles and co-payments and that any such payments will be due as treatment is received. The staff has also informed me that if my health insurance makes any payments towards the cost of treatment and I successfully pursue a claim against the liable party, I may be required to reimburse my health insurer for any sums it has paid either to me or to my treating physicians.

I have decided that **I do not wish to file any claim on my health insurance.** I hereby direct and authorize the clinic to send bills and treatment records only to my attorney, or to the liability insurance carrier, or to my own automobile insurer for the purpose of receiving payment under my Medical Payments, Uninsured or Under-Insured Motorist coverage, if applicable.

I understand that the clinic will rely on my decision and render treatment based on the assumption that payment will be received from sources other than my health insurance. I will not be expected to pay deductibles and co-payments and third party payers will be billed at the clinic's usual rates rather than at discounted rates that may apply to in-network providers.

I understand that if for any reason, my liability claim is ultimately denied, compromised or litigated unsuccessfully, I will remain personally liable for the reasonable value of the treatment rendered to me by the clinic.

Today's date is:______________________________

____
Patient

____
Witness

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To any insurance company with coverage applicable to my claim(s) and to any attorney representing me:

ASSIGNMENT OF BENEFITS

IN CONSIDERATION of the willingness of Goldsboro Spine Center, PA to treat me on credit without demand for payment at the time services are rendered, I hereby agree and stipulate as follows:

I irrevocably assign to Goldsboro Spine Center, PA any proceeds or compensation that I am or may become entitled to receive as a result of injuries that occurred on____________________to the extent of the chiropractic services rendered. I make this agreement without prejudice to any rights I may have to prosecute legal claims against any party who may be liable for my injuries, but I hereby authorize and instruct you to pay directly to Goldsboro Spine PA, from any disability benefits, medical payments benefits, liability benefits, health and accident benefits, workers compensation benefits, judgments, or proceeds of any kind that would otherwise be payable to me, such as are due or may become due to Goldsboro Spine Center, PA for its services rendered.

I appoint Goldsboro Spine Center, PA as my attorney in fact to affix my name as an endorsement upon the reverse of any check or draft upon which I am a named payee and to deposit said check or draft and apply the proceeds to any unpaid balance I may have with Goldsboro Spine Center, PA.

I authorize Goldsboro Spine Center, PA to release to any insurer with applicable coverage or to my attorney or successor attorney any information regarding my injuries, prior medical history, or treatment as may be necessary to facilitate collection of proceeds under this assignment.

I acknowledge that I remain personally liable for the total amount due to Goldsboro Spine Center, PA for services rendered, including balance remaining after the application of insurance payments and settlement or judgment proceeds. If Goldsboro Spine Center, PA is required to take legal action against me to recover any unpaid balance on my account, I agree to reimburse Goldsboro Spine Center, PA for its costs of recovery, including reasonable attorney's fees.

____
Patient

____
Date

____
Witness

NOTICE OF LIEN

Pursuant to N.C.G.S. 44-49 and 44-50, Goldsboro Spine Center, PA hereby asserts and gives notice of a lien upon any sums recovered in damages for personal injury in any civil action and also upon all funds paid to the above-named patient in compensation for or settlement of injuries sustained, whether in litigation or otherwise.

Goldsboro Spine Center, PA hereby requests that if its claim is not paid in full from the foregoing proceeds, a full disclosure and accounting of proceeds be provided in conformity with N.C.G.S. 44-50.1. Goldsboro Spine Center, PA agrees to be bound by any confidentiality agreements regarding the contents of the accounting.

GOLDSBORO SPINE CENTER, PA
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Goldsboro, NC 27534

By:______________________________

Doctor, Member/Manager