Goldsboro Spine Center

605 N Spence Ave Goldsboro NC 27534

Phone: 919-751-0555 Fax: 919-751-3001
www.goldsborospinecenter.com

DATE ☐☐☐☐

First Name:	Last Name:	Date Of Birth:
Home Phone:	Mobile Phone:	Work Phone:
@ E-Mail:	Preferred Communication: (Circle) H M W E@	
Street Address:	Apt/Suite :	
City:	ZipCode:	State:

SSN:	Gender: ☐ ♀ Female ☐ ♂ Male	Preferred Language: ☐ English ☐ Other _____
Race & Ethnicity: ☐ American Indian or Alaska Native ☐ Hispanic or Latino ☐ Asian ☐ Native Hawaiian or Other Pacific Islander ☐ Black or African American ☐ White ☐ Other		Marital Status: ☐ Single ☐ Married ☐ Other ☐ Divorced ☐ Widowed ☐ Separated
Emergency Contact Name:	Phone:	Relationship:

Primary Care Provider Name:	Phone:	
Street Address:	Apt/Suite #:	
City:	ZipCode:	State:

Employer/Company Name:	Phone:	
Street Address:	Apt/Suite #:	
City: ZipCode:	State:	
Job Title/Position:	Currently Working: ☐ Yes ☐ No ➪ Date Stopped Working:	

Insurance Detail

Primary Insurance Coverage

Insurance Company	Policyholder Name:	
Insurance ID #:	Group Number:	
Plan Name:	Phone Number:	
Street Address:	Suite/Unit #:	
City:	ZipCode:	State:
(Office Use) Policy Effective Date(s):	Payer ID:	
Co-Pay $:	Co-Insurance %:	Deductible:

Secondary Insurance Coverage

Insurance Company Name:	Policyholder Name:	
Insurance ID #:	Group Number:	
Plan Name:	Phone Number:	
Street Address:	Suite/Unit #:	
City:	ZipCode:	State:
(Office Use) Policy Effective Date(s):	Payer ID:	
Co-Pay $:	Co-Insurance %:	Deductible:

Financially Responsible Party

☐ Self ☐ Other (If Other Please Complete Section Below)		
First Name:	Last Name:	Date Of Birth:
Home Phone:	Mobile Phone:	Work Phone:
@ E-Mail:	Relationship With Patient:	
Street Address:	Apt/Suite #:	
City:	ZipCode:	State:

Medical Detail

Reason For Your Visit

☐ Wellness & Health Maintenance			
☐ Injury, Pain Complaint, or Ailment		Date Of Injury (When Did Your Pain Start?)	
☐ Accident ☐ Automobile Related Accident ☐ Other Type Of Accident		Date Of Accident:	State: Where Accident Occurred
Please Provide Brief Details Of Your Injuries & Pain:			

Referring Provider

☐ I Was Referred By My Primary Care Physician (Same Doctor Listed On First Page)

☐ I Was Referred By Another Doctor (Please Fill Out Doctor Info Below)

Referring Provider Name:		Phone:
Street Address:	Apt/Suite #:	@ E-Mail:
City:	ZipCode:	State:

Representative Details (If You Are Being Represented By An Attorney For An Accident Please Provide Info)

Referring Provider Name:		Phone:
Street Address:	Apt/Suite #:	@ E-Mail:
City:	ZipCode:	ZipCode:

Medical History

Lifestyle

DATE | | | | |

Are You A Smoker?	☐ Yes	☐ No	If Yes ➪How Often? _____ / Day / Week
Do You Drink Alcohol?	☐ Yes	☐ No	If Yes ➪How Often? _____ / Day / Week
Do You Exercise?	☐ Yes	☐ No	If Yes ➪How Often? _____ / Day / Week

Have You Ever Been Hospitalized? ☐ Yes ☐ No	Have You Had Any Surgeries? ☐ Yes ☐ No
If Yes, Please List Dates/Details:	

Do You Have Any Allergies? ☐ Yes ☐ No ➪ Do You Require Medical Treatment For Your Allergies? ☐ Yes ☐ No

If Yes, Please Provide Details:

Do You Take Any Medications? ☐ Yes ☐ No

Please List All Medications & Dosage (How Much & How Often?)

Please Provide Any Other Medical Information You Feel The Doctor Needs To Know About

Patient Signature _____ Date _____

Patient Name _____ Date _____

Spouse

First Name _____ Middle Initial _____ Last Name _____

Home Phone (_____) _____-_____ Work Phone (_____) _____- _____

Date of Birth _____/_____/_____

Emergency Contact

Contact Name _____ Relationship to Patient _____

Home Phone (_____) _____ - _____ Cell Phone (_____) _____- _____

How did you hear about our office?

_____

Medical Conditions: (Check all that apply to you)

☐ Arthritis	☐ Cancer	☐ Diabetes	☐ Heart Disease
☐ Hypertension	☐ Psychiatric Illness	☐ Skin Disorder	☐ Stroke
☐ Other _____	☐ Fibromyalgia	☐ Asthma	☐ Osteoporosis

Surgeries: (Check all that apply to you)

☐ Appendectomy	☐ Cardiovascular procedure	☐ Cervical spine	☐ Hysterectomy
☐ Joint Replacement	☐ Prostate	☐ Lumbar spine	☐ Gall Bladder
☐ Brain	☐ Shoulder	☐ Thoracic spine	☐ Knee
☐ Carpal Tunnel	☐ Gastro-intestinal	☐ Uro-genital Hernia	☐ Breast Augmentation
☐ Other _____			

Allergies: (Check all that apply to you)

☐ Mold	☐ Seasonal	☐ Milk or Lactose Animal	☐ Chemical _____
☐ Sulfites	☐ Wheat/Glutens Other		

Social History: (Check all that apply to you)

Caffeine use:	☐ occasional	☐ often	☐ never
Drink Water:	☐ <64 oz/day	☐ >64 oz/day	☐ never
Sleep:	☐ <8 hours/night	☐ >=8 hours/night	☐ Insomnia

Family History: (Check all that apply)

Arthritis:	☐ Parent	☐ Sibling Cancer:	☐ Parent	☐ Sibling
Diabetes:	☐ Parent	☐ Sibling Heart Disease	☐ Parent	☐ Sibling
Hypertension	☐ Parent	☐ Sibling Stroke	☐ Parent	☐ Sibling
Thyroid	☐ Parent	☐ Sibling	Other _____	

Occupational Activities: (Check one that best describes your job description)

☐ Administration	☐ Business Owner	☐ Clerical/Secretary	
☐ Computer User	☐ Heavy Equipment operator	☐ Daycare/Childcare	
☐ Construction	☐ Health Care	☐ Food Service Industry	
☐ Medium Manual Labor	☐ Manufacturing Home Services		☐ Heavy Manual Labor
☐ Other _____			
☐ Light Manual Labor	☐ Executive/Legal	☐ Housekeeper	

_____ _____

Signature of patient or responsible party Date

I acknowledge that any gift certificates/cards 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.

Review of Systems – (Check box if you have had trouble with any of the following)

Cardiovascular	Past	Present	No	**Respiratory**	Past	Present	No	**Allergic/Immunologic**	Past	Present	No
Poor Circulation	☐	☐	☐	Asthma	☐	☐	☐	Hives	☐	☐	☐
Hypertension	☐	☐	☐	Tuberculosis	☐	☐	☐	Immune Disorder	☐	☐	☐
Aortic Aneurism	☐	☐	☐	Short Breath	☐	☐	☐	HIV/AIDS	☐	☐	☐
Heart Disease	☐	☐	☐	Emphysema	☐	☐	☐	Allergy Shots	☐	☐	☐
Heart Attack	☐	☐	☐	Cold/Flu	☐	☐	☐	Cortisone Use	☐	☐	☐
Chest Pain	☐	☐	☐	Cough	☐	☐	☐		☐	☐	☐
High Cholesterol	☐	☐	☐	Wheezing	☐	☐	☐		☐	☐	☐
Pace Maker	☐	☐	☐		☐	☐	☐	**Ear, Nose and Throat**	Past	Present	No
Jaw Pain	☐	☐	☐	**Eyes**	Past	Present	No	Difficulty Swallowing	☐	☐	☐
Irregular Heartbeat	☐	☐	☐		☐	☐	☐	Dizziness	☐	☐	☐
Swelling of legs	☐	☐	☐	Glaucoma	☐	☐	☐	Hearing Loss	☐	☐	☐
	☐	☐	☐	Double Vision	☐	☐	☐	Sore Throat	☐	☐	☐
Genitourinary	Past	Present	No	Blurred Vision	☐	☐	☐	Nosebleeds	☐	☐	☐
Kidney Disease	☐	☐	☐	**Psychiatric**	Past	Present	No	Sinus Infections	☐	☐	☐
Burning Urination	☐	☐	☐		☐	☐	☐	Bleeding Gums	☐	☐	☐
Frequent Urination	☐	☐	☐	Depression	☐	☐	☐		☐	☐	☐
Blood in Urine	☐	☐	☐	Anxiety	☐	☐	☐	**Gastrointestinal**	Past	Present	No
Kidney Stones	☐	☐	☐	Stress	☐	☐	☐		☐	☐	☐
Lower Side Pain	☐	☐	☐		☐	☐	☐	Gall Bladder Problems	☐	☐	☐
	☐	☐	☐	**Endocrine**	Past	Present	No	Bowel Problems	☐	☐	☐
Neurologic	Past	Present	No		☐	☐	☐	Constipation	☐	☐	☐
Stroke	☐	☐	☐	Thyroid	☐	☐	☐	Liver Problems	☐	☐	☐
Seizures	☐	☐	☐	Diabetes	☐	☐	☐	Ulcers	☐	☐	☐
Head Injury	☐	☐	☐	Hair Loss	☐	☐	☐	Diarrhea	☐	☐	☐
Brain Aneurysm	☐	☐	☐	Menopausal	☐	☐	☐	Nausea/Vomiting	☐	☐	☐
Numbness	☐	☐	☐	PMS	☐	☐	☐	Bloody Stools	☐	☐	☐
Severe Headaches	☐	☐	☐		☐	☐	☐	Poor Appetite	☐	☐	☐
Pinched Nerves	☐	☐	☐	**Hematologic**	Past	Present	No		☐	☐	☐
Parkinson's	☐	☐	☐		☐	☐	☐	**Musculoskeletal**	Past	Present	No
Carpal Tunnel	☐	☐	☐	Hepatitis	☐	☐	☐	Gout	☐	☐	☐
Vertigo	☐	☐	☐	Blood Clots	☐	☐	☐	Arthritis	☐	☐	☐
	☐	☐	☐	Cancer	☐	☐	☐	Joint Stiffness	☐	☐	☐
Constitutional	☐	☐	☐	Bruising	☐	☐	☐	Muscle Weakness	☐	☐	☐
	Past	Present	No	Bleeding	☐	☐	☐	Osteoporosis	☐	☐	☐
	☐	☐	☐	Fever, Chills	☐	☐	☐	Broken Bones	☐	☐	☐
Weight Loss/Gain	☐	☐	☐	Sweating	☐	☐	☐	Joints Replaced	☐	☐	☐
Low Energy Level	☐	☐	☐	Varicose Vein	☐	☐	☐	Neck Pain	☐	☐	☐
Difficulty Sleeping	☐	☐	☐		☐	☐	☐	Low Back Pain	☐	☐	☐
	☐	☐	☐		☐	☐	☐	Upper Back Pain	☐	☐	☐

Signature of patient or responsible party Date

How are your symptoms changing? Getting better Not changing Getting worse

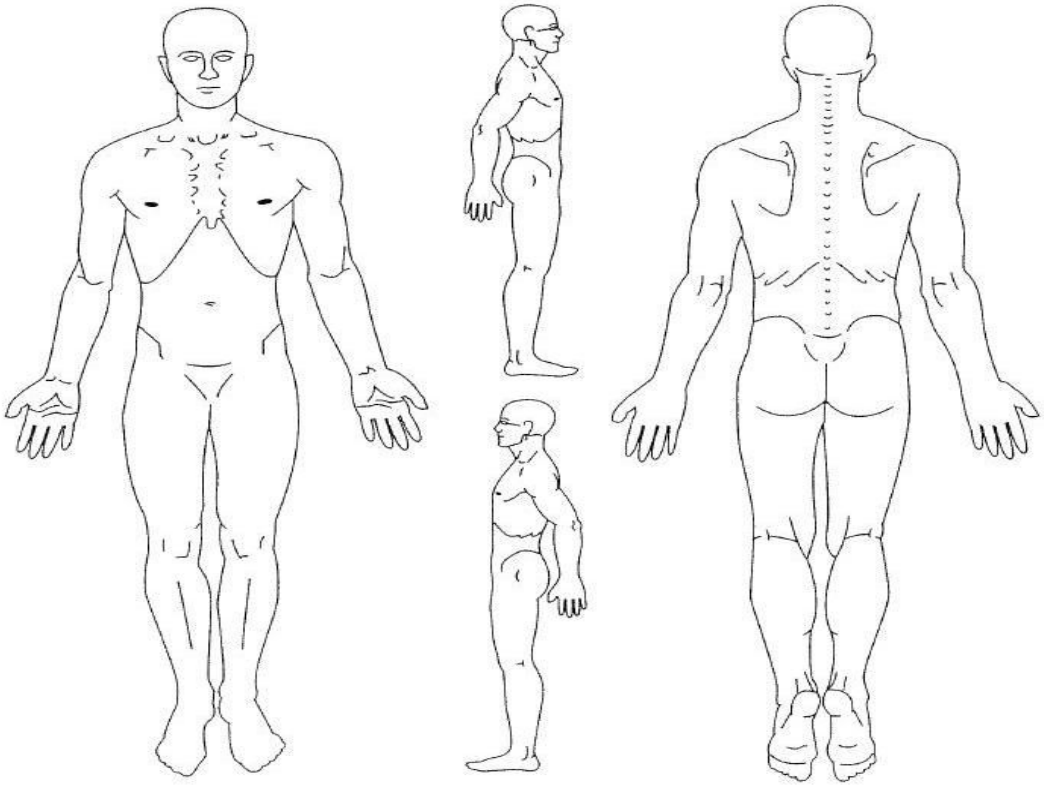
Are You Pregnant? (Check) ☐ Yes ☐ No

At this time, to the best of my knowledge, I am not pregnant, and I consent to radiographic pictures if necessary.

By using the key below, indicate on the body diagram where you are experiencing the following symptoms:

N=Numbness B=Burning S=Sharp T=Tingling

A=Dull Ache



Average Pain Intensity:

Last 24 hours: no pain 0 1 2 3 4 5 6 7 8 9 10 worst pain

Past week: no pain 0 1 2 3 4 5 6 7 8 9 10 worst pain

Does anything improve your pain? Yes No

If Yes, please list: _____

When did your symptoms begin? _____

Are your symptoms a result of: Motor Vehicle Accident Work related Accident Other _____

How did your symptoms begin? _____

_____

How often do you experience your symptoms?

Constantly ☐ (76-100% of the day) Frequently ☐ (51-75% of the day) Occasionally ☐ (26-50% of the day) Intermittently ☐ (0-25% of the day)

What describes the nature of your symptoms?

Sharp ☐ Ache ☐ Numb ☐ Shooting ☐

Burning ☐ Tingling ☐ Throbbing ☐

Other _____

_____ _____

Signature of patient or responsible party Date

How often do you experience your symptoms?

☐ Constantly (76-100% of the day) ☐ Frequently (51-75% of the day) ☐ Occasionally (26-50% of the day) ☐ Intermittently (0-25% of the day)

How long have you had this condition? _____ years _____ months _____ days

Have you had this condition in the past? _____

Is this condition interfering with your ☐ work ☐ sleep ☐ daily routine

☐ Other: Please describe: _____

Since your last visit, have you had any:

☐ Injuries (Falls, Accidents)

☐ Activities (Pain Caused by too much Gardening)

☐ Conditions (New Medications, New Diagnosis, New Health Problems)

Please describe: _____

Have you have any: ☐ Surgeries ☐ Chiropractic Care ☐ Medical Care ☐ Physical Therapy Please list name of provider and condition: _____

_____

_____

For Women Only: To your knowledge, are you pregnant? ☐ Yes ☐ No

Stressors:

Because accumulation of stress affects our health and ability to heal, please list your top three stresses (you have ever had) in each category:

1. Physical stress (falls, accidents, work postures, etc.)
   a. _____
   b. _____
   c. _____
2. Bio-chemical Stress (smoke, unhealthy foods, missed meals, don't drink enough water, drugs, alcohol, etc.)
   a. _____
   b. _____
   c. _____
3. Psychological or mental/emotional stress (work, relationships, finances, self esteem, etc.)
   a. _____
   b. _____
   c. _____

On a scale of 1-10, please grade your present levels of stress:

Work: _____ Home: _____ Play: _____

On a scale of 1-10, please describe your: (1 being very poor and 10 being excellent)

Eating Habits: _____ Exercise Habits: _____ Sleep: _____

General Health: _____ Mind set: _____

Medication List: Please list Dosage:

Prescriptions	Over the Counter (Tylenol)

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowledgement*

I, _____, have received and had the opportunity to review a copy of Goldsboro Spine Center's Notice of Privacy Practices. I understand that the Notice describes the uses and disclosures of my protected health information and informs me of my rights with respect to my protected health information.

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify) :

_____

_____

Signature: _____

Date: _____

Patient Name _____Date_____

PAYMENT POLICY

Thank you for choosing Goldsboro Spine Center as your chiropractic provider. We are committed to providing you with quality and affordable health care. Due to some of the questions our patients have regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask any questions you may have, and sign in the space provided below. A copy will be provided to you upon request.

1. INSURANCE. We participate in most insurance plans, including Medicare. If you are not insured by a plan we participate with, payment in full is expected at each visit. If you are insured by a plan we do participate with, but do not have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility, please contact your insurance company with any questions you may have regarding your coverage. If your insurance company requires a referral it is your responsibility to provide us with a referral dated the day of your first visit from your primary care physician prior to your first visit. We are only able to provide a summary of your chiropractic benefits.

2. CO-PAYMENT AND DEDUCTIBLES. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help is in upholding the law by paying your co-payment at each visit.

3. PROOF OF INSURANCE. All patients must complete out patient information form before seeing the provider. We must obtain a copy of your most current insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

4. CLAIM SUBMISSION. We will submit your claims and assist you in any way we reasonably can to help get your claim paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance pays your claim. Your insurance benefits are a contract between you and your insurance company; we are not party to that contract.

5. COVERAGE CHANGES. If your insurance coverage changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 90 days, the balance will automatically be billed to you.

6. MISSED APPOINTMENT. Our policy is to charge $25.00 after one missed appointment not cancelled 24 hours in advance. The charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regular scheduled appointment.

7. RETURNED CHECK. There will be a $25.00 returned fee for any returned checks.

8. X-RAYS. X-rays remain property of this office and cannot be released.

9. REACTIVATION FEE. There will be a $35.00 fee for any established patient who has been inactive (has not visited the office for 3 months).

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.

I have read and understood the payment policy and agree to abide by its guidelines. In order to maximize your treatment at Goldsboro Spine Center, 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 the information under HIPAA guidelines. A signature will also authorize 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, and gives us limited power of attorney to endorse any check made out to you for services rendered by our office to you on your behalf.

Patient Name _____Date_____

ASSIGNMENT OF BENEFITS / ERISA AUTHORIZED REPRESENTATIVE FORM

FINANCIAL RESPONSIBILITY

I have requested professional services from Goldsboro Spine Center, 605 N. Spence Avenue Goldsboro, NC 27534 ("Provider") on behalf of myself and/or my dependents, and understand that by making this request, I am responsible for all charges incurred during the course of said services. I understand that all fees for said services are due and payable on the date services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement unless other arrangements have been made in advance.

Assignment of Insurance Benefits

I hereby assign all applicable health insurance benefits to which I and/or my dependents are entitled to Provider. I certify that the health insurance information that I provided to Provider is accurate as of the date set forth below and that I am responsible for keeping it updated.

I hereby authorize Provider to submit claims, on my and/or my dependent's behalf, to the benefit plan (or its administrator) listed on the current insurance card I provided to Provider, in good faith. I also hereby instruct my benefit plan (or its administrator) to pay Provider directly for services rendered to me or my dependents. To the extent that my current policy prohibits direct payment to Provider, I hereby instruct and direct my benefit plan (or its administrator) to provide documentation stating such non- assignment to myself and Provider upon request. Upon proof of such non-assignment, I instruct my benefit plan (or its administrator) to make out the check to me and mail it directly to Provider. I am fully aware that having health insurance does not absolve me of my responsibility to ensure that my bills for professional services from Provider are paid in full. I also understand that I am responsible for all amounts not covered by my health insurance, including co-payments, co-insurance, and deductibles. Authorization to Release Information

I hereby authorize Provider to: (1) release any information necessary to my health benefit plan (or its administrator) regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims. This order will remain in effect until revoked by me in writing.

ERISA Authorization

I hereby designate, authorize, and convey to Provider to the full extent permissible under law and under any applicable insurance policy and/or employee health care benefit plan, as my Authorized Representative: (1) the right and ability to act on my behalf in connection with any claim, right, or cause in action that I may have under such insurance policy and/or benefit plan; and (2) the right and ability to act on my behalf to pursue such claim, right, or cause of action in connection with said insurance policy and/or benefit plan (including but not limited to, the right to act on my behalf in respect to a benefit plan governed by the provisions of ERISA as provided in 29 C.F.R. §2560.5031(b)(4)) with respect to any healthcare expense incurred as a result of the services I received from Provider and, to the extent permissible under the law, to claim on my behalf, such benefits, claims, or reimbursement, and any other applicable remedy, including fines.

A photocopy of this Assignment/Authorization shall be as effective and valid as the original.

_____ _____

Signature of patient or responsible party Date

Patient Name _____Date_____

NOTICE OF PRIVACY PRACTICES

Purpose: This form, Notice of Privacy Practices, presents the information that federal law requires us to give our patients regarding our privacy practices.

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you. Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations.

Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient

Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. Record charges are as follows: $.75 pages 1-25, $.50 pages 26-100, $.25 pages 100+. If you request an alternative format, we will charge a cost- based fee for providing your health information in that format. If you prefer, we will prepare a summary

or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before September 12, 2016. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.
Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.
If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.
We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Dr. Wayne Wagner
Telephone: (919)751-0555
Fax: (919)751-3001
Email: DrWagner@goldsborospinecenter.com
Address: 605 N. Spence Avenue Goldsboro, NC 27534

INFORMED CONSENT TO TREATMENT

I hereby request and consent to the performance of chiropractic treatments (also known as chiropractic adjustments or chiropractic manipulative treatments) and any other associated procedures: physical therapy by Dr. Wayne Wagner and/or other assistants and/or licensed practitioners.

I understand, as with any health care procedures, that there are certain complications, which may arise during chiropractic treatments. Those complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, Horners' syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to complications including stroke.

I do not expect the doctor to be able to anticipate all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure(s) which the doctor feels at the time, based upon the facts then known, that are in my best interest.

I have had an opportunity to discuss with the doctor(s) named above and/or with office personnel the nature, purpose and risks of chiropractic treatments and other recommended procedures. I have had my questions answered to my satisfaction. I also understand that specific results are not guaranteed.

I have read (or have had read to me) the above explanation of the chiropractic treatments.

By signing below, I state that I have been informed and weighed the risks involved in chiropractic treatment at this health care office. I have decided that it is in my best interest to receive chiropractic treatment. I hereby give my consent to that treatment. I intend for this consent to cover the entire course of treatment for my present condition(s) and for any future conditions(s) for which I seek treatment.

PATIENT FINANCIAL RESPONSIBILITY FORM

Thank you for choosing Goldsboro Spine Center as your healthcare provider. We are committed to providing you with the highest quality healthcare. We ask that you read and sign this form to acknowledge your understanding of our patient financial policies.

Patient Financial Responsibilities:

The patient (or patient's guardian, if minor) is ultimately responsible for the payment for treatment and care. We will bill your insurance for you, however the patient is required to provide the most correct and updated information regarding insurance. Patients are responsible for payment of copays, coinsurance, deductibles and all other procedures or treatment not covered or approved by their insurance plan. Copays are due at the time of service. Coinsurance, deductibles and non-covered items are due 30 days from receipt of billing.

_____ _____

Signature of patient or responsible party Date

HIPAA COMPLIANT AUTHORIZATION FOR THE RELEASE OF PATIENT INFORMATION PURSUANT TO 45 CFR 164.508

TO: Goldsboro Spine Center
Name of Healthcare Provider/Physician/Facility/Medicare Contractor

605 N Spence Avenue
Street Address

Goldsboro, NC 27534
City, State and Zip Code

RE: Patient Name: _____

Date of Birth:_____ Social Security Number: _____

I authorize and request the disclosure of all protected information for the purpose of review and evaluation in connection with a legal claim. I expressly request that the designated record custodian of all covered entities under HIPAA identified above disclose full and complete protected medical information including the following:

☐ All medical records, meaning every page in my record, including but not limited to: office notes, face sheets, history and physical, consultation notes, inpatient, outpatient and emergency room treatment, all clinical charts, r ports, order sheets, progress notes, nurse's notes, social worker records, clinic records, treatment plans, admission records, discharge summaries, requests for and reports of consultations, documents, correspondence, test results, statements, questionnaires/histories, correspondence, photographs, videotapes, telephone messages, and records received by other medical providers.

☐ All physical, occupational and rehab requests, consultations and progress notes.

☐ All disability, Medicaid or Medicare records including claim forms and record of denial of benefits.

☐ All billing records including all statements, insurance claim forms, itemized bills, and records of billing to third party payers and payment or denial of benefits for the period _____ to _____.

I understand the information to be released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), and alcohol and drug abuse. I authorize the release or disclosure of this type of information.

This protected health information is disclosed for the following purposes (Why do they need this letter?): _____

_____

This authorization is given in compliance with the federal consent requirements for release of alcohol or substance abuse records of 42 CFR 2.31, the restrictions of which have been specifically considered and expressly waived.
You are authorized to release the above records to the following representatives of defendants in the above-entitled matter who have agreed to pay reasonable charges made by you to supply copies of such records (Who is the office that this is going to?):

_____
Name of Representative

_____
Representative Capacity (e.g. attorney, records requestor, agent, etc.)

_____
Street Address

_____
City, State and Zip Code

I understand the following: See CFR §164.508(c)(2)(i-iii)

a. I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization.
b. The information released in response to this authorization may be re-disclosed to other parties.
c. My treatment or payment for my treatment cannot be conditioned on the signing of this authorization.

Any facsimile, copy or photocopy of the authorization shall authorize you to release the records requested herein. This authorization shall be in force and effect until two years from date of execution at which time this authorization expires.

Records Deposit: _____
Payment Method: _____
Staff Initial: _____

It is the patient's responsibility to pay this fee before letter/information is released. Records Fee: 75 cents each page for the first 25 pages, 50 cents each page for pages 26 to 100, 25 cents each page for pages 101 and more.

At least 72 hours are needed to prepare these requests for you.

_____ _____
Signature of Patient or Legally Authorized Representative (See 45CFR § 164.508(c)(1)(vi)) Date

_____
Name and Relationship of Legally Authorized Representative to Patient
(See 45CFR §164.508(c)(1)(iv))

_____ _____
Witness Signature Date

NORTH CAROLINA INDUSTRIAL COMMISSION

OFFICE OF THE EXECUTIVE SECRETARY

REQUEST FOR CHANGE OF PHYSICIAN

Claimant _____ Date of Injury _____

Claimant's Telephone # _____ Insurance Carrier _____

Employer _____ Insurance claim # _____

WC# (if applicable) _____

I am requesting a change of authorized treating physician/facility from _____ (name of current physician/medical facility) to Goldsboro Spine Center, 605 N Spence Ave Goldsboro, NC 27534.
Phone: 919-751-0555; Fax: 919-751-3001

Reason for Requested Change: change is necessary to cure the injury, reduce pain and/or help the employee return to work.

Please fax a copy of the ruling to Goldsboro Spine Center at 919-751-3001.
Send this document to: forms@ic.nc.gov EXECSEC@IC.NC.GOV FAX: (919) 715-0282
MAIL: NCIC-EXECUTIVE SECRETARY
4336 MAIL SERVICE CENTER RALEIGH, NC 27699-4336
HELPLINE: (800) 688-8349 WEBSITE: HTTP://WWW.IC.NC.GOV

Employee Signature: _____
Signature

RESPONSE TO REQUEST (Check one box and return to claimant)
The request to change physicians is:

☐ **GRANTED:** If approval is granted, write the name of the new physician/facility on the line below: Goldsboro Spine Center.

☐ **DENIED**

CERTIFICATE OF SERVICE: Copies of this document were placed in the U.S. mail, hand-delivered, faxed or emailed to the claimant this ____ (Day) day of _____ (Month), _____ (Year).

List the name(s) and mailing address(es), fax number(s) or email address(es) of all person(s) copied:

Claimant or Claimant's Attorney: _____

_____

_____

By: _____
Signature

North Carolina Industrial Commission

NOTICE OF ACCIDENT TO EMPLOYER AND CLAIM OF EMPLOYEE, REPRESENTATIVE, OR DEPENDENT (G.S. §§97-22 THROUGH 24)

IC File #_____

Emp. Code #_____

Carrier Code #_____

Employer FEIN_____

The I.C. File # is the unique identifier for this injury. It will be provided by return letter and is to be referenced in all future correspondence.

The Use of This Form Is Required Under the Provisions of the Workers' Compensation Act

Employee's Name

Address

City State Zip

( ) -
Home Telephone

- - ☐ M ☐ F / /
Social Security Number Sex Date of Birth

Employer's Name ( ) -
Telephone Number

Employer's Address City State Zip

Insurance Carrier Policy Number

Carrier's Address City State Zip

( ) - ( ) -
Carrier's Telephone Number Carrier's Fax Number

EMPLOYEE – This form must be filed with the Industrial Commission within two years of the date of injury or occupational disease or your claim may be barred. Notice shall be given to the employer immediately after the accident or as soon as practicable and within 30 days. (This form should also be used for occupational disease claims; however, for asbestosis, silicosis and byssinosis, Form 18B is to be used.)

Notice is hereby given, as required by law, that the above-named employee sustained an injury or contracted an occupational disease, described as follows: _____ (Time of Injury) on ____/__/____ (Date (required)) at _____ (City and County). Describe the injury or occupational disease, including the specific body part involved (e.g., right hand, left hand) _____

Describe how the injury or occupational disease occurred: _____

Occupation when injured: _____ Nature of employer's business: _____

Number of days out of work due to injury:

Medical treatment received? ☐Yes ☐No

Weekly wage: $_____ Number of hours worked per day: _____ Days worked per week: _____

NOTE: If employee is unable to sign this form, another may sign for him. This form should be typed or printed by hand in black ink, if possible. Employee should retain one signed copy of this notice, mail one signed copy to the Industrial Commission at the address below, and provide one signed copy to employer.

Signature of (Check One) ☐ Employee, ☐ Attorney, ☐ Representative, or ☐ Dependent

( ) -
Telephone Number

Address City State Zip

/ /
Date Completed

EMPLOYER: This notice is being sent to you in compliance with requirements of the North Carolina Workers' Compensation Act, in order that the medical services prescribed by the Act may be obtained; and, if disability extends beyond 7 days duration, or if death ensues, compensation may be paid according to law.

FOR IC USE ONLY

RESEARCHER: _____
CC: _____
EC: _____
DATA ENTRY: _____

FORM 18

FORM 18
02/2017
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ATTORNEYS: FILE WITH AN **IC FILE NUMBER** VIA **EDFP**
HTTP://WWW.IC.NC.GOV/DOCFILING.HTML OR
IF NO IC FILE NUMBER, FOLLOW EMPLOYEE FILING OPTIONS.
EMPLOYEES: E-MAIL TO: **FORMS@IC.NC.GOV**
OR MAIL TO: **NCIC - CLAIMS SECTION**
4335 MAIL SERVICE CENTER
RALEIGH, NC 27699-4335
MAIN TELEPHONE**: (919) 807-2500** HELPLINE: **(800) 688-8349**
WEBSITE: **HTTP://WWW.IC.NC.GOV/**