Spine & Neuromuscular Associates of S.E.I., P.S.C. # _____

First Name _____ Middle Initial _____ Last Name _____

_____

Home Address City State Zip code

Email address _____ S.S.# _____

Date of Birth _____ Age _____ Male or Female _____

Please circle one: Single Married Divorced Widowed

Home phone # _____ Cell phone # _____ Work phone # _____

Medical Doctor Name _____ Phone # _____

Preferred Pharmacy Name _____ Phone # _____

Employer _____ Occupation _____ Employer Address: _____

In case of emergency contact _____ phone # _____

Nearest relative not living with you _____

Home # _____ Cell # _____

Please name the person who referred you here _____

You will receive a statement once a month until your bill is paid in full

We will not bill third party insurance (office policy)

I authorize the use of this information for insurance billing, the release of information to the insurance company, I am responsible for my charges for services, and authorize payment to Spine & Neuromuscular Assoc. of S.E.I., P.S.C., and permit a copy of this authorization to be used in place of the original. Your insurance policy is between you and your insurance company. We will file your claims as a courtesy to you however; you are ultimately responsible for all bills and may be responsible for out of network charges and deductibles. Co-payments are due at the time of service. We accept cash, personal checks, Visa, Master Card, and American Express. The fee for returned checks is $25 cancellation of less than 24 hr. notice or "NO SHOWS" WILL BE BILLED an office visit charge of $75 that is not covered by insurance and must be paid before further services are provided by our practice subject to the discretion of the practice.

INSURANCE AUTHORIZATION, ASSIGNMENT OF BENEFITS AND HIPAA NOTICICATION

I authorize payment of medical benefits directly to the provider(s) who have treated me or rendered services or materials. My signature below also serves as my consent to treatment and verifies that I have received a copy of this practice's HIPAA policy and Required Disclosure for Medicare Conditions of Coverage for any physician owned entity where this practice delivers care and that any questions that I may have concerning these documents have been adequately answered.

Signed _____ Date _____

Patient Name _____ File # _____

NATURE OF ACCIDENT

Date of accident _____Time of accident _____State of accident _____

Explain accident details in full _____

_____

_____

List the type of vehicle you were in: Year _____Make _____Model _____

What is the estimated cost of damage to your vehicle? _____

List the type of vehicle other driver was in: Year _____Make _____Model _____

Was your car stopped at time of impact? _____

On what part of the automobile did your following body parts hit?

Head hit the _____Chest hit the _____

Right/Left shoulder hit the _____Right/Left arm hit the _____

Right/Left hip hit the _____Right/Left leg hit the _____

Right/Left knee hit the _____Other_____

What bruises did you sustain during this accident? _____

Did you lose consciousness upon impact? _____ Were you wearing a seat belt? _____

Did the police come to the scene of accident? _____Was a report made? _____

Did you go to a hospital? _____If yes, name of hospital_____

How did you get to the hospital? _____

What areas of your body were x-rayed? _____

How long did you stay at the hospital? _____

Besides ER/Hospital care have you seen any other health care providers for your injuries? _____

Who & when _____

Have you missed any work because of your accident? _____

Have any diagnostic tests been ordered since your accident? _____
examples: MRI, EMG, CT Scan, If so where? _____

File#_____

Before the accident were you having any similar symptoms? _____**If yes,**

please list similar symptoms _____

Please list any other past conditions or injuries we should be aware of: _____

_____

_____

Case History

Please list your Chief Complaints:

- _____
- _____
- _____

Do you feel your symptoms are mild, moderate, or severe? _____

What worsens your symptoms? _____

What makes your symptoms better? _____

Are your symptoms: **Constant** **Progressive** **Intermittent**

Have you had the *same or similar symptoms* in the past? Y / N If so please explain

_____

Have you had any prior treatment or testing regarding this problem? _____

_____

Have you had <u>any past injuries</u> we should know about? _____ **Please list**

the year and type of injury _____

Do your symptoms interfere with daily living? Y or N, with your sleep? Y or N

Do your symptoms interfere with your lifestyle? Y or N, with your work? Y or N

Please list *all medications* you are currently taking _____

_____

Please list *all surgeries* you've ever had (including breast implants) _____

_____

File # _____

Have you had any past illnesses you feel are significant? _____

_____

Family history of illness? Example: Dad-diabetic, Mom-high B/P, Sister-scoliosis

_____

_____

Father's age _____or Cause & age at death_____

Mother's age _____or Cause of age at death_____

Are you single, married, divorced? _____ Number of children? _____

Alcohol use: none rarely social drinker abuses recovering alcoholic_____

Tobacco use: none cigarettes cigars pipe chew dip Quit _____

Do you exercise? None—occasional—regularly—type of exercise_____

Circle the highest level of education completed: High School College Post Graduate

<u>Please circle the condition that describe your work environment</u>

Loud—Lung Pollutant—Extreme Hot/Cold—Constant Sitting—Constant Standing

Requires Lifting—Heavy Data Entry—Stressful No Problems

Have you experienced any recent traumas such as divorce, death of family or friend,

job loss, change in residence? _____

_____

Please circle your race: Asian Black Hispanic White Other_____

Have you been treated by a chiropractor before? _____ Dr._____

Were your results satisfactory? _____

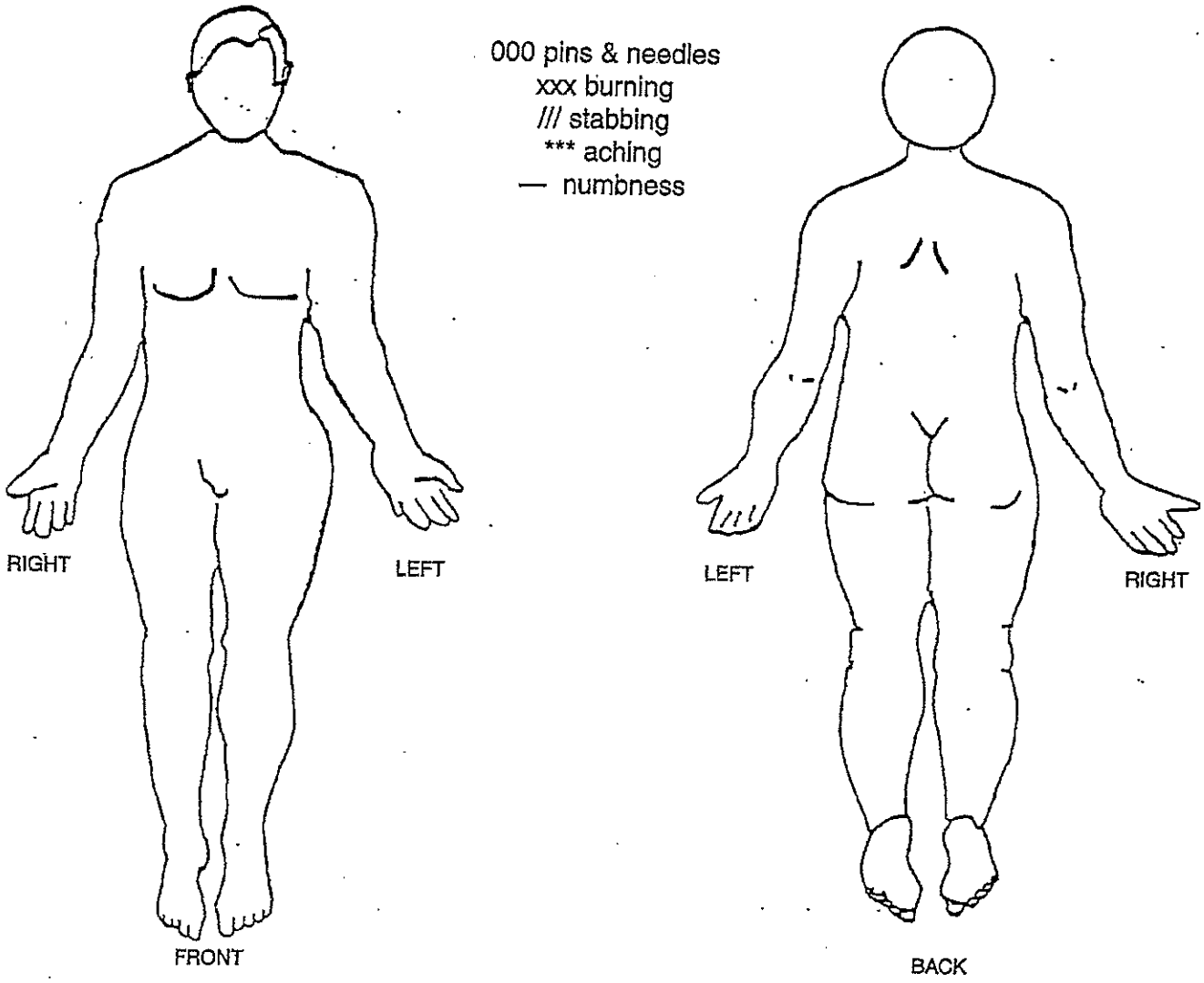
Women Only - Is there any chance you are currently pregnant? _____

I have read the above information and answered to the best of my ability.

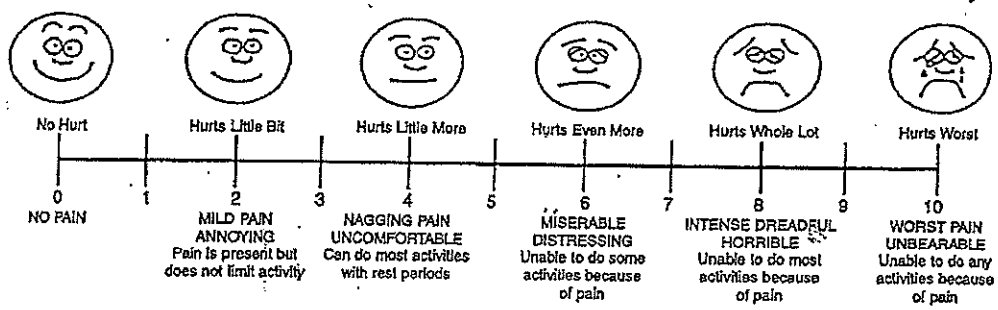
Date _____ Signature _____

BODY SHEET

PATIENT INSTRUCTIONS: PLEASE INDICATE THE LOCATION, TYPE AND INTENSITY OF YOUR PAIN. USING SYMBOLS BELOW, SHOW WHICH AREA OF BODY THAT SYMBOLS EXIST.



2. On the 0 - 10 pain scale and the Faces scale below, circle the number which best describes your pain.



ND-001

SIGNATURE DATE

Consent Form/Description

HIPAA Consent Form

Preliminary Draft Subject to Change
[This form does not constitute legal advice and is for educational purposes only. This form is based on current federal law and subject to change based on changes in federal law or subsequent interpretative guidance. This form is based on federal law and must be modified to reflect state law where that state law is more stringent than the federal law or other state law exceptions apply.]

Consent for Purposes of Treatment, Payment and Healthcare Operations

I consent to the use or disclosure of my protected health information by Spine & Neuromuscular Associates of S.E.I., P.S.C. for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Spine & Neuromuscular Associates of S.E.I., P.S.C. I understand that diagnosis or treatment of me by The Doctors of The Chiropractic Associates PSC may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Spine & Neuromuscular Associates of S.E.I., P.S.C. is not required to agree to the restrictions that I may request. However, if Spine & Neuromuscular Associates of S.E.I., P.S.C. agrees to a restriction that I request, the restriction is binding on Spine & Neuromuscular Associates of S.E.I., P.S.C. and The Doctors of the Spine & Neuromuscular Associates S.E.I., P.S.C.

I have the right to revoke this consent, in writing, at any time, except to the extent that the Doctors of the Spine & Neuromuscular Associates of S.E.I., P.S.C. or the Spine & Neuromuscular Associates of S.E.I., P.S.C. has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review Spine & Neuromuscular Associates S.E.I., P.S.C.'s Notice of Privacy Practices prior to signing this document. The Spine & Neuromuscular Associates of S.E.I., P.S.C.'s Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the Spine & Neuromuscular Associates of S.E.I., P.S.C. The Notice of Privacy Practices for Spine & Neuromuscular Associates of S.E.I., P.S.C. is also provided at 120 Industrial Dr, Lawrenceburg, IN 47025. This Notice of Privacy Practices also describes my rights and the Spine & Neuromuscular Associates of S.E.I., P.S.C.'s duties with respect to my protected health information.

Spine & Neuromuscular Associates S.E.I., P.S.C. reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by accessing the Spine & Neuromuscular Associates S.E.I., P.S.C., calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____
Signature of Patient or Personal Representative

Name of Patient or Personal Representative

Description of Personal Representative Authority

_____
Date

Patient Acknowledgment of Privacy Notice

To Be **Maintained with Patient's Chart**

This is to acknowledge that I (print name) _____ have been given the opportunity to review The Spine & Neuromuscular Associates of S.E.I., P.S.C., **Notice of Privacy Practices**.

I understand that I have the right to request a personal copy of this office's **Notice of Privacy Practices**.

_____
Signature of Patient or Personal Representative

_____
Date

_____
Name of Patient or Personal Representative

_____
Description of Personal Representative's Authority