

CHIROPRACTIC SPINE & SPORTS REHAB CENTER

PATIENT INFORMATION

Date: _____ SS #: _____
 Patient Title: (Circle One) Mr. Mrs. Ms. Miss Dr. Prof. Rev.
 Full Name: _____
 Nickname/Preferred Name: _____
 Address: _____
 City: _____
 State: _____ Zip: _____
 E-mail: _____
 Birthdate: _____ Age: _____ Sex: M F
 Marital Status: Married Single Divorced
 Separated Widowed
 Occupation: _____
 Employer/School: _____
 Spouse's Name: _____
 Spouse's Employer: _____
 Who referred you to us? _____

PHONE NUMBERS

Cell Phone: _____
 Home Phone: _____
 Work Phone: _____
 Best time and place to reach you: _____

INSURANCE INFORMATION

Who is responsible for this account? _____
 Relationship to Patient: _____
 Insurance Co: _____
 Group #: _____ ID#: _____
 Is patient covered by additional insurance? Yes No
 Subscriber's Name: _____
 Birthdate: _____ SS#: _____
 Relationship to Patient: _____
 Insurance Co: _____
 Group #: _____ ID#: _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Dr. Corbin/Dr. Hymel all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor(s) may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

 Signature of Patient, Parent, Guardian or Personal Representative

 Please print name of Patient, Parent, Guardian or Personal Rep.

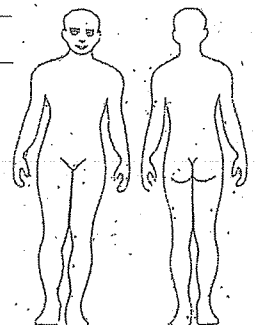
 Date

 Relationship to Patient

- Race:** White Black/African American Hispanic American Indian/Alaskan Native
 Asian Asian Indian Chinese Filipino
 Japanese Korean Vietnamese Native Hawaiian/ Pacific Island
 Samoan Guamanian/Chamorro Other _____ I choose not to specify
- Multi-Racial:** Yes No Unknown I choose not to specify
- Ethnicity:** Hispanic or Latino Not Hispanic or Latino I choose not to specify
- Preferred Language:** English Spanish American Sign Language Chinese French
 German Vietnamese Italian Korean Russian Polish
 Arabic Portuguese Greek Hindi Persian Urdu
 Armenian Japanese Gujarati French Creole I choose not to specify

PATIENT CONDITION

Reason for visit: _____
 When did your symptoms appear? _____
 Is this condition: Improved Unchanged Getting Worse
 Mark an X on the picture where you continue to have pain, numbness, or tingling.
 Type of Pain: Sharp Dull Throbbing Numbness Aching Shooting
 Burning Cramps Tingling Stiffness Swelling Other
 Does it interfere with: Work Sleep Recreation Daily Routine
 Activities that are painful to perform: Sitting Standing Walking Bending Lying Down



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HEALTH HISTORY

What treatment have you already received for this condition? Medications Surgery Physical Therapy
 Chiropractic Services None Other _____

Other doctor(s) who have treated this condition for you: _____

Date of Last: Physical Exam _____ Spinal X-Ray _____ Spinal Exam _____
 Chest X-Ray _____ MRI/CT-Scan/Bone Scan _____

Please circle "Yes" or "No" if you have had any of the following:

AIDS/HIV	Yes	No	Diabetes	Yes	No	Liver Disease	Yes	No	Rheumatoid Arthritis	Yes	No
Alcoholism	Yes	No	Emphysema	Yes	No	Measles	Yes	No	Rheumatic Fever	Yes	No
Allergy Shots	Yes	No	Epilepsy	Yes	No	Migraines	Yes	No	Scarlet Fever	Yes	No
Anemia	Yes	No	Fractures	Yes	No	Miscarriage	Yes	No	STDs	Yes	No
Anorexia	Yes	No	Glaucoma	Yes	No	Mononucleosis	Yes	No	Stroke	Yes	No
Appendicitis	Yes	No	Goiter	Yes	No	Multiple Sclerosis	Yes	No	Suicide Attempt	Yes	No
Arthritis	Yes	No	Gonorrhea	Yes	No	Mumps	Yes	No	Thyroid Problems	Yes	No
Asthma	Yes	No	Gout	Yes	No	Osteoporosis	Yes	No	Tonsillitis	Yes	No
Bleeding Disorder	Yes	No	Heart Disease	Yes	No	Pacemaker	Yes	No	Tuberculosis	Yes	No
Breast Lump	Yes	No	Hepatitis	Yes	No	Parkinson's Disease	Yes	No	Tumors/Growths	Yes	No
Bronchitis	Yes	No	Hernia	Yes	No	Pinched Nerve	Yes	No	Typhoid Fever	Yes	No
Bulimia	Yes	No	Herniated Disk	Yes	No	Pneumonia	Yes	No	Ulcers	Yes	No
Cancer	Yes	No	Herpes	Yes	No	Polio	Yes	No	Other: _____		
Cataracts	Yes	No	High Blood Pressure	Yes	No	Prostate Problem	Yes	No	_____		
Chemical Dependency	Yes	No	High Cholesterol	Yes	No	Prosthesis	Yes	No	_____		
Chicken Pox	Yes	No	Kidney Disease	Yes	No	Psychiatric Care	Yes	No	_____		

Injuries/Surgeries: _____ Description: _____ Date: _____

Falls _____

Broken Bones: _____

Surgeries: _____

If not taking medication/vitamins/herbs/minerals and/or have no allergies, PLEASE specify NONE.

MEDICATIONS / DOSAGE/ FREQUENCY: _____

DRUG ALLERGIES: _____

VITAMINS/ HERBS/ MINERALS: _____

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ACCIDENT INFORMATION

Is this condition do to an accident? Yes No If Yes, Date of Accident: _____

Type of Accident: Auto Work Home Other _____

To whom have you made a report of your accident? Auto Insurance Employer Worker's Comp. Other _____

Attorney Name/Phone (if applicable) _____

FAMILY HISTORY

Relative	Age If Living	Age At Death	Cause Of Death	State Of Health	Illnesses
FATHER	_____	_____	_____	_____	_____
MOTHER	_____	_____	_____	_____	_____
BROTHER(S)	_____	_____	_____	_____	_____
SISTER(S)	_____	_____	_____	_____	_____
MATERNAL G-FATHER	_____	_____	_____	_____	_____
MATERNAL G-MOTHER	_____	_____	_____	_____	_____
PATERNAL G-FATHER	_____	_____	_____	_____	_____
PATERNAL G-MOTHER	_____	_____	_____	_____	_____

SOCIAL HISTORY

<p style="text-align: center;"><u>EXERCISE</u></p> <p><input type="checkbox"/> None</p> <p><input type="checkbox"/> Weekly</p> <p><input type="checkbox"/> Daily</p> <p><input type="checkbox"/> Runs <input type="checkbox"/> Walks <input type="checkbox"/> Swims</p>	<p style="text-align: center;"><u>HABITS</u></p> <p>Smoking: <input type="checkbox"/> Current Everyday <input type="checkbox"/> Current Sometimes <input type="checkbox"/> Previous <input type="checkbox"/> Never</p> <p>If current smoker, what is your level of interest in quitting on scale of 1-10: _____</p> <p>Alcohol: <input type="checkbox"/> None <input type="checkbox"/> Casual <input type="checkbox"/> Moderate <input type="checkbox"/> Heavy <input type="checkbox"/> Wine <input type="checkbox"/> Beer</p> <p>Caffeine: <input type="checkbox"/> < 3 drinks/day <input type="checkbox"/> 3-6 drinks/day <input type="checkbox"/> >6 drinks/day</p>
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Current Weight: _____ Have you recently lost or gained weight? _____ Height: _____

Are you pregnant? _____ Date of Last Menstrual Period: _____

Patient/Guardian Signature: _____ Date: _____

Print Name: _____ Relationship to Patient: _____

Informed Consent for Examination and Treatment

I (we) hereby consent to the performance of examination and treatment on me or on _____, by the licensed doctors of chiropractic, medical doctors, and/or licensed physical therapists who may be employed by or engaged in practice in this clinic.

I have had an opportunity to discuss with the doctor(s) or other clinic personnel the nature and purpose of the different physical therapy procedures and chiropractic treatment (manipulation/adjustment). I understand that neither chiropractic nor medical treatment is an exact science and that my care may involve judgments based upon facts and information known to the doctor. The doctor uses this judgment to attempt to anticipate or explain risks and complications and an undesirable result does not necessarily indicate an error in judgment. No guarantee for results can be made or expected but rather I wish to rely on the doctor to choose and recommend a best course of treatment based upon facts known that is in my best interests.

I further understand that there are certain degrees of risk associated with chiropractic health care and physical therapy, which includes rarely, but not limited to fractures, disc injuries, strokes, and strain/sprains and am therefore willing to accept and consent to the risk associated with the care that I am about to receive.

I have read, or the above information has been explained regarding consent. I have had an opportunity to ask questions about my examination and treatment. By signing below, I agree and intend this consent form to cover the procedures prescribed for my condition and for any future conditions for which I seek treatment.

Female Patients: By my signature on this form I do hereby state that to the best of my knowledge, I am not pregnant, nor is pregnancy suspected or confirmed at this particular time. Date of last menstrual period _____.

Patient's Name (Print)

Patient's Signature

Date

Relationship or authority if not signed
By patient

Witness

INFORMED CONSENT TO PARTICIPATE IN ACTIVE REHABILITATION

THE GOALS OF THE REHABILITATION PROGRAM INCLUDE:

1. Determining the cause and extent of your problem.
2. Providing a therapeutic exercise program to strengthen you, increase your cardiovascular endurance, range of motion and flexibility, and decrease your pain.
3. Return you to full-duty, non-restricted work status and lifestyle.

THE EQUIPMENT USED TO TEST YOU AND THE PROCESS WE WILL BE USING WILL BE EXPLAINED TO YOU.

Your participation in the rehabilitation program is voluntary. You can stop at any point in the program. Should you stop your program, we are obligated to notify your doctor, insurance company, attorney, and DVR manager, if it is applicable.

If at any point during the evaluation or rehabilitation process you have any questions, we will answer them to the best of our ability or refer you to someone more qualified. Please be advised that there are no guarantees that your personal goals and/or those listed above will be met to your satisfaction. The success of any rehabilitation process lies in the combined efforts of you and your provider. The "team" approach has the best chance of attaining your goals, so please ask as many questions as necessary for you to gain the maximum benefit from your rehabilitation program.

Since the process of strengthening and conditioning are a form of "controlled strain", there is a chance of aggravation or injury. It is therefore imperative that you communicate to your provider any aggravation or injury that you may observe during the rehabilitation process. For example, the *best* exercise for you, if performed too early in your condition, may be your *worst* enemy if performed too soon. Communication with your provider will help put into perspective problems that may occur. Failure to discuss problems may only foster additional problems down the road.

I HAVE READ THE ABOVE AND UNDERSTAND THE RISKS AND BENEFITS OF THE REHABILITATION PROGRAM. I AGREE TO PARTICIPATE AND HAVE MY REHABILITATION INFORMATION RELEASED TO MY DOCTOR, INSURANCE CARRIER, ATTORNEY, OR DVR PERSONNEL IF REQUESTED.

SIGNATURE OF PARTICIPANT

DATE _____

SIGNATURE OF WITNESS

DATE _____

RESEARCH CONCERNING THE REHABILITATION PROGRAM AND RESULTS MAY BE CONDUCTED. DATA WILL BE USED FROM THE PARTICIPANT'S EVALUATIONS AND EXERCISE PROGRAM. NO NAMES WILL BE USED AND ALL INFORMATION IS STRICTLY CONFIDENTIAL. PLEASE INITIAL BELOW.

_____ I AGREE TO PARTICIPATE

_____ I DO NOT WISH TO PARTICIPATE

CHIROPRACTIC
Spine & Sports
REHAB CENTER



DR. SHAY W. CORBIN
Certified Chiropractic Sports Physician

DR. JONATHAN HYMEL
Certified Strength and Conditioning Specialist

Acknowledgement Of Receipt Of Notice Of Privacy Practices For Protected Health Information

I _____ acknowledge that I have received
Chiropractic Spine & Sports Rehab Center's Notice of Privacy Practices for
protected health information.

Date: _____

Name of Patient: _____

Signature of Patient/Person Representative: _____

Relationship to Patient: _____



OFFICE FINANCIAL POLICY

Our policy is to extend to you the courtesy of allowing you to assign your insurance benefits directly to us. This policy reduces your out-of-pocket expense and allows you to place your family under care.

1. **If You Do Not Have Insurance:** All payments are expected at the time of service or by an authorized payment plan. Your personal balance may not exceed \$100 at any time or care may be terminated. Our payment plans make care an affordable part of your family budget.
2. **If You Have Insurance:** All deductibles and co-payments are expected at the time of service or by an authorized payment plan. Your co-insurance balance may not exceed \$100 or care may be terminated. Our payment plans make care an affordable part of your family budget.

You are considered a cash patient until you bring in your completed insurance forms, and we qualify and accept your insurance coverage. We do not accept assignment for secondary insurance carriers, but will be happy to provide you with a claim form for your secondary carrier.

Our fees are considered usual, customary and reasonable by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This statement does not apply to companies who reimburse based on an arbitrary schedule of fees bearing no relationship to the current standard and of care in this area.

If your carrier has not paid a claim within sixty (60) days of submission, you agree to take an active part in the recovery of your claim. If your insurance carrier has not paid within ninety (90) days of submission, you accept responsibility for payment in full of any outstanding balance and authorize us to use your credit card to collect full payment.

When your schedule of visits is once per month or longer, you will not be eligible for insurance assignment. Charges for services rendered will be due as they are rendered. We will continue to provide you with an insurance claim form.

If you discontinue care for any reason other than discharge by the doctor, all balances will become immediately due and payable in full by you, regardless of any claim submitted.

Patient's Printed Name: _____

Signature: _____ Date: _____

Finance Counselor: _____ Date: _____

Front Desk: _____ Date: _____