First Name: _____ **M.I.** ____ **Last:** _____ **Nickname:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Phone: Home (___) _____ **Mobile (___)** _____ **Work (___)** _____

Primary Contact: ☐ Home ☐ Cell Phone ☐ Work **Cell Phone Carrier:** _____

Sex: ☐ **Male** ☐ **Female** **Date of Birth:** ___/___/_____ **Social Security NO.** _____

Race ☐ **Native Hawaiian or other Pacific Islander** ☐ **Asian** **Ethnicity** ☐ **Hispanic or Latino** **Language:** _____
☐ **American Indian or Alaska Native** ☐ **White** ☐ **Not Hispanic or Latino**
☐ **Black or African American** ☐ **Other Race**

Email Address: _____ **Primary Care Provider:** _____

Marital Status: married – single – widowed – separated – divorced **Spouse's Name**: _____

Employer/School: _____

Employer/School Phone: _____ **Occupation**: _____

Referring Doctor/Patient: _____

Emergency Contact: _____ **Phone #:** _____

Signature_____ **Date**_____

Copy of Photo Id & Insurance Card

The Spine Center of Williamsburg, 219 McLaws Circle, Williamsburg, VA 23185
Patient Financial Responsibility Contract
Please read and sign where indicated-this document describes your financial responsibilities.

I agree to be financially responsible for payment of The Spine Center of Williamsburg's services. Cash, check or credit cards are acceptable forms of payment for these services.

Current insurance cards must be presented at every office visit. The Spine Center of Williamsburg is not responsible for filing your insurance claim, but as a courtesy we will do so. I agree to pay the remaining balance after my insurance has paid on my claim immediately upon receipt of a statement.

I agree to give The Spine Center of Williamsburg my complete and accurate insurance information for primary and secondary insurance benefits including referral documents from other providers, if needed. I understand that if I fail to give complete and accurate information about my insurance benefits this may result in a denial of my claim or a delay in payment. I agree to pay The Spine Center of Williamsburg the balance on my account after my insurance claim has been processed.

I agree that if my insurance benefit requires me to provide a referral and if the referral is not in place before my appointment, that I will pay in advance an estimate of charges for my office visit or reschedule my appointment.

I understand that I will be responsible for any missed appointment or any cancelled appointment in which a 24-hour notice was not given. There will be a $25.00 fee for any missed office visit.

I understand there will be a $25.00 for all returned checks.

I understand that all services provided to me by The Spine Center of Williamsburg are considered medically necessary, if I fail to comply with my provider's instructions it may be against medical advice and may void my insurance benefits. Should this occur, I agree to pay the balance remaining on my account after my insurance has processed claims.

I understand that my insurance may or may not agree to the usual, customary or reasonable charges for my local area. I understand that my benefits may not cover all services or might deny payment for services that have been approved of in advance. I agree to pay the balance remaining on my account after insurance has been processed.

If I have a high deductible policy or do not currently have insurance benefits, I agree to pay an estimate of charges for my office visit in advance and understand that other charges may apply.

The Spine Center of Williamsburg has a contract with my insurance company. The Spine Center of Williamsburg will receive payments from my insurance company for **covered** services provided by my insurance benefits. I agree to pay copayments and deductibles at the time of service. If copayments are not made at the time of service, I understand that my appointment may be rescheduled.

I agree to pay the balance remaining on my account for any reason upon receipt of a statement and I understand that when requested, I must give The Spine Center of Williamsburg my current address and other

contact information. I understand that if I fail to pay the balance on my account this may result in The Spine Center of Williamsburg pursuing any collection means possible.

If my account become delinquent, it may be forwarded to an outside collection agency without notice. If this happens, I will be responsible for all costs of collection, including but not limited to interest (18%), rebilling fees, court costs, attorney fees and collection agency costs (33%).

If the reason for my appointment is related to a work injury or auto accident, I agree to give The Spine Center of Williamsburg the case number or policy number, the workman's compensation or insurance carrier's name, address or other contact information at the time of my appointment so that The Spine Center of Williamsburg can bill workman's compensation or the auto insurance carrier for my visit. If I do not provide this information at the time of the visit, I agree to pay all charges for my visit.

I have read and I understand The Spine Center of Williamsburg's financial policies and I accept responsibility for the payment of any fees associated with my care.

_____ _____

Patient Signature **Date**

Assignment of Benefits

I hereby authorize direct payment of medical benefits, including medical benefits to which I am entitled to The Spine Center of Williamsburg. This is a **DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS**. This authorization will remain in effect until cancelled by me in writing. A copy of this authorization is as valid as the original document.

I authorize the release of any medical information necessary in order to obtain payment and I understand that I am financially responsible for all charges, late fees, interest, attorney fees and collection charges considered patient responsibility by my insurance company. I understand that if I am not insured, I am responsible for the charges of all services provided to me. I authorize The Spine Center of Williamsburg to deposit checks received on my account when made out in my name.

I have read and I understand The Spine Center of Williamsburg's financial policies and I accept responsibility for the payment of any fees associated with my care.

_____ _____

Patient Signature **Date**

_____ _____

Witness Signature **Date**

Medical Information Release Form

HIPAA Release Form

Name: _____ **DOB**: _____

Release of Information

I understand that, under the Health Insurance Portability and Accountability Act of 1996 ("HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among multiple providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and accreditations.

In addition to *health* care *providers*, my protected health information may be disclosed to:

☐ *Spouse*: _____

☐ *Children:* _____

☐ *Other:* _____

☐ *Information is not to be release to anyone*

This Release of Information will remain in effect until terminated by me ***in writing given to The Spine Center of Williamsburg.*** ***Patient Initials*** _____

Appointment Reminders

I prefer that ***The Spine Center of Williamsburg*** send a reminder to and/or leave a message on my:

☐ Home Phone ☐ Work Phone ☐ Cell Phone ☐ Email ☐ No Reminders

_____ _____/____/_____

Patient or Legal Guardian's Signature **Date**

OFFICE USE ONLY I attempted to obtain written acknowledgement of receipt of this Notice of Privacy Acknowledgement, but was unable to do so as documented below:		
Date:	**Initials**:	**Reason:**

Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures, if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to improve mobility of anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including, but not limited to, hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an arterial dissection that involves an abnormal change in the wall of an artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. This occurs in 3-4 of every 100,000 people, whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately, a percentage of these patients will experience a stroke. As chiropractic can involve manually and/or mechanically adjusting the cervical spine, it has been reported that chiropractic care may be a risk for developing this type of stroke. The association with stroke is exceedingly rare and is estimated to be related in 1 in one million 1 in 2 million cervical adjustments.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: _____ Signature: _____ Date: _____
Parent or Guardian: _____ Signature: _____ Date: _____
Witness Name: _____ Signature: _____ Date: _____

CHART# _____

MEDICATIONS

ALLERGIES

_____

_____

PAST SURGICAL HISTORY (procedure/approximate dates)

_____

_____

MEDICAL HISTORY (prior & current)

- ☐ Heart Attack (year) _____
- ☐ Cancer (type) _____
- ☐ Stroke (year) _____
- ☐ Heart Failure
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Asthma
- ☐ Rheumatoid Arthritis
- ☐ Kidney Stone
- ☐ Hepatitis
- ☐ Tuberculosis
- ☐ Anxiety/Depression
- ☐ Gallbladder Disease
- ☐ Diabetes
- ☐ Osteoporosis
- ☐ Prostate Disease
- ☐ High Cholesterol

Other:

_____

FAMILY HISTORYs

_____

_____

SOCIAL HISTORY

Marital Status: Single Married Separated Divorced Widowed

Tobacco Use: Never Current Former (quit) _____

Alcohol Use: None Casual Moderate Heavy

Caffeine: None Casual 1-3 Moderate 3-6 Heavy 6 or more

Drug Use: None Recreational User Addiction

Exercise: Never Daily Weekly Other_____

Signature: _____ **Date**: _____

STAFF SECTION: Height _____ Weight _____ BP _____/_____ Pulse _____ BMI

NAME_____**NO.**_____**DATE**_____

PATIENT SECTION

Was this injury auto accident related? Yes or No **Was this injury work related?** Yes or No

When did your symptoms start? _____

Are your symptoms (Circle one): Constant Frequent Intermittent Occasional

What makes it better?_____

_____

What makes it worse?_____

_____

Have you had these symptoms before? (Circle)
YES or NO

What other treatments have you had for this condition? _____

_____

Have there been any recent changes in bowel or bladder function? YES or NO

Is the pain? (Circle all that apply)

Aching, Burning, Numb/Tingling, Sharp, Throbbing

Primary Care Physician:

_____

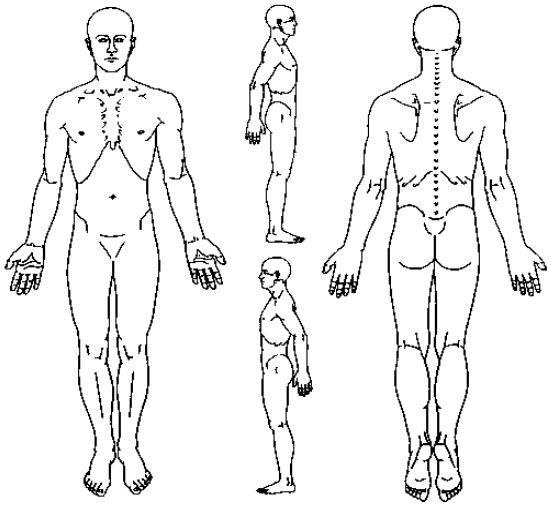
Are you pregnant?
Yes or No

OTHER

_____

_____

Draw in the area of your pain/symptoms



Circle a number on the pain scale:

No Pain 0 1 2 3 4 5 6 7 8 9 10 Unbearable

Signature_____**Date**_____