CONFIDENTIAL PATIENT REGISTRATION AND HISTORY

1 PATIENT INFORMATION

Date: _____

Name: _____
Last Name

_____
First Name Initial

Address: _____

City_____ State _____ Zip_____

Home Phone #: _____

Work Phone #: _____

Cell Phone #: _____

E-mail Address: _____

Sex: ☐ M ☐ F Age: _____ Birth date: _____

☐ Single ☐ Married ☐ Divorced ☐ Widowed

Social Security #: _____

Occupation: _____

Employer: _____

Employer Address: _____

City _____ State_____ Zip_____

Hours / Week Worked: _____

IN CASE OF AN EMERGENCY, CONTACT:

Name: _____

Phone #: _____

Relation: _____

How did you hear about us? _____

2 INSURANCE INFORMATION

Health Insurance *(Primary)*

Ins Co.: _____

Phone: _____

Policyholder name:_____

Relationship to policyholder: _____

Policyholder DOB: _____

Policy #: _____

Group#: _____

Health Insurance *(Secondary)*

Ins Co.: _____

Phone: _____

Policyholder name:_____

Relationship to policyholder:_____

Policy #: _____

Group#: _____

Pharmacy Information:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____

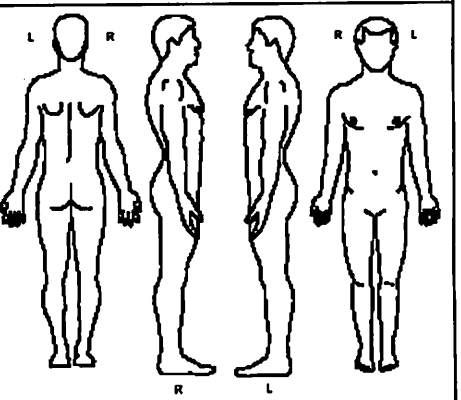
Is this condition due to an accident? ☐ Yes ☐ No

☐ Auto ☐ Work ☐ Home ☐ Other

3 CURRENT COMPLAINTS

What are your present complaints? *(Location of pain, etc.)* _____

_____



Use an "X" on the drawing to mark where you are experiencing pain *(or other symptoms)*.

When did these symptoms first appear? _____

Do your symptoms interfere with: ☐ Sleep ☐ Daily routine ☐ Work ☐ Recreation

Are you working less hours / days as a result of your injuries? ☐ Yes ☐ No

If yes, please explain _____

Activities or movements that are painful to perform:

☐ Sitting ☐ Standing ☐Walking ☐ Bending ☐ Lying Down

How would you rate your symptoms: ☐ Mild ☐ Moderate ☐ Severe

How would you rate your current symptoms (pain): ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

No Symptoms Worst Possible

Since the accident *(if applicable)*, are your symptoms: ☐ Improving ☐ Unchanged ☐ Worsening

4 Review of Symptoms

HAVE YOU EVER BEEN DIAGNOSED AS HAVING OR SUFFERING FROM: *(place "X" in boxes that apply)*

- ☐ Muscle disorder
- ☐ Nervous System Disorder
- ☐ Bone Disorder
- ☐ Rheumatoid Arthritis
- ☐ Allergies
- ☐ HIV
- ☐ Gallbladder
- ☐ Diabetes
- ☐ Depression
- ☐ Coughing Blood
- ☐ Stomach, Intestines (GI)
- ☐ Vertigo
- ☐ Ringing in the ears
- ☐ Arm / Hand Pain
- ☐ Asthma
- ☐ Fatigue
- ☐ Blurred Vision
- ☐ Pinched Nerve
- ☐ Liver Disease
- ☐ Lungs, Asthma
- ☐ Broken Bones
- ☐ Eating Disorder
- ☐ Pace Maker
- ☐ Seizures/Convulsions
- ☐ A Congenital Disease
- ☐ Excessive Bleeding
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Kidney, Bladder (GU)
- ☐ Circulatory Problems
- ☐ Dizziness
- ☐ Neck Pain/Stiffness
- ☐ Leg / Knee Pain
- ☐ Pins / Needles in Arms
- ☐ Sleeping Difficulties
- ☐ Light bothers Eyes
- ☐ Herniated Disc
- ☐ Osteoporosis
- ☐ Osteoarthritis
- ☐ Epilepsy
- ☐ Alcoholism
- ☐ Drug Addiction
- ☐ Strokes
- ☐ Cancer
- ☐ Ulcer
- ☐ Hernias
- ☐ Ears, eyes, nose, throat
- ☐ Tumors
- ☐ Heart Disease
- ☐ Loss of Balance
- ☐ Back Pain/Stiffness
- ☐ Headaches
- ☐ Pins / Needles in legs
- ☐ Loss of Smell
- ☐ Nervousness
- ☐ Migraines
- ☐ Fibromyalgia
- ☐ Tension
- ☐ Cold Sweats
- ☐ Night Pain
- ☐ Nausea
- ☐ Cold Feet
- ☐ Chest Pain
- ☐ Fever
- ☐ Fainting
- ☐ Sudden Weight Loss
- ☐ Loss of Taste
- ☐ Loss or Memory
- ☐ Jaw Problems
- ☐ Constipation
- ☐ Shortness of Breath
- ☐ Bowel/Bladder Changes
- ☐ High Cholesterol
- ☐ Heart Disease
- ☐ Arthritis
- ☐ Thyroid Problems

5 Health History / Injuries / Treatments

INJURIES YOU MAY HAVE HAD IN THE PAST Description Date (s)

Auto Accident (s) _____ _____

Work Injuries _____ _____

Broken Bones _____ _____

Falls _____ _____

Other _____ _____

SURGERIES YOU MAY HAVE HAD FOR THIS CONDITION: Spine Surgeries ☐ Discectomy ☐ Laminectomy ☐ Fusion

Other Surgeries _____ Date _____

NON-SURGICAL TREATMENTS YOU MAY HAVE RECEIVED FOR THIS CONDITION: *(place "X" in boxes that apply)*

- ☐ Medication *(OTC / Prescription)*
- ☐ Injections
- ☐ Physical Therapy *(Dates:_____)*
- ☐ Massage
- ☐ Chiropractic
- ☐ Acupuncture
- ☐ Other: _____
- ☐ List ALL Meds: _____

Female patients: Start date of most recent menstrual cycle: _____ Are you currently pregnant? ☐ Yes ☐ No

Medications currently taking: _____

Allergies: _____

6 Medical Review of Symptoms

	Yes	No
1. Do you have any weakness, numbness, or tingling in your arms or hands?	☐	☐
2. Do you suffer from headaches?	☐	☐
3. Do you experience any joint pain? If yes, signify where _____	☐	☐
4. Do you suffer from poor energy, fatigue and/or loss of sleep?	☐	☐
5. Have you experienced any loss of balance or dizziness?	☐	☐
6. Have you experienced forgetfulness or loss of mental clarity?	☐	☐
7. Do you have any issues maintaining your ideal weight?	☐	☐
8. Do you experience hot flashes, night sweats, or irritability with sleeping?	☐	☐
9. Do you have pain in the morning or increases pain in the morning?	☐	☐

7 HOSPITALIZATION / EXAMINATION HISTORY

Have you been to the hospital for *this* condition? ☐ Yes ☐ No If yes, name of hospital? _____

When did you go? _____ How did you get there? ☐ Ambulance ☐ Self ☐ Others

Were x-rays taken? ☐ Yes ☐ No If yes, what area(s)? _____

Were you prescribed any medication? ☐ Yes ☐ No

If yes, what medications? _____

Have you seen any other doctor or received any other treatment for your current condition? ☐ Yes ☐ No

If yes, explain _____

Doctor's name and address: _____

Phone #: _____ Date(s) seen: _____ Diagnosis: _____

DIAGNOSTIC TESTING YOU MAY HAVE RECEIVED: (place "X" in boxes that apply)

Test	Region / Body Part(s)	Date(s)	Test	Region / Body Part(s)	Date(s)
☐ Examination	_____	_____	☐ EMG / NCV	_____	_____
☐ MRI / CT	_____	_____	☐ _____	_____	_____

8 YOUR DOCTORS

Please List ALL Doctors involved in your healthcare, present and past. (Use back if necessary)

	Name	*Phone*
Primary / Family Doctor:	_____	_____
Orthopedic Doctor:	_____	_____
Pain Management:	_____	_____
Neurologist:	_____	_____
Chiropractor:	_____	_____
Other:	_____	_____

9 AUTHORIZATION FOR TREATMENT

I hereby authorize the Doctor to treat my condition as he/she deems appropriate and to furnish any authorized requests for information regarding treatment. It is understood and agreed that the amount paid to the Doctor for x-rays is for examination only and the x-ray negatives will remain the property of this office. They will be kept on file where they may be seen at any time while the patient is being treated at this office. The patient also agrees that he/she is responsible for all bills incurred at this office. (The Doctor will not be held responsible for any preexisting medically diagnosed conditions, nor for any medical diagnosis). The patient also agrees that statements made in this questionnaire are true and correct.

Patient's Signature: _____ Date: _____

Guardian's Signature: _____ Date: _____

Maryland Spine Institute Consent To Services

PATIENT'S RIGHTS **Pt. Initials_____**

The Maryland Spine Institute (MSI) respects the unique differences of our patients, and will ensure that health care ethics are maintained for all patients. The following rights will be exercised on our patients' behalf:

1. The patient has the right to considerate and respectful care.
2. The patient has the right to and is encouraged to obtain from the doctor relevant, current, and understandable information concerning diagnosis, treatment, and prognosis.
3. The patient has the right to know the identity of the doctor, staff, and all involved in patient care.
4. The patient has the right to make decisions about the plan of care prior to and during the course of treatment, and to refuse a recommended treatment or plan of care to the extent permitted by law, and to be informed of the consequences of this action.
5. The patient has the right to every consideration of privacy.
6. The patient has the right to expect that all communications and records pertaining to his/her care will be treated as confidential, except in cases where reporting is permitted or required by law.
7. The patient has the right to expect reasonable continuity of care when appropriate and to be informed by the doctor of available and other care options.

CONSENT TO TREATMENT OF A MINOR CHILD *(Under the age of 18)* **Pt. Initials_____**

I authorize Spinal Decompression, Cold Laser, Chiropractic &/or Physical Therapy care as deemed necessary to my (relationship) _____.

FEMALE PATIENTS *(ONLY)* **Pt. Initials_____**

This is to certify that, to the best of my knowledge, I am NOT pregnant and that MSI has my permission to take x-rays.

INITIAL EXAM & CONSULT VISIT (FIRST & SECOND Visit) **Pt. Initials_____**

There will be NO treatment done during these visits without reviewing insurance information and patient's consent.

PAYMENT, INSURANCE, MEDICAL RECORDS, AND USE OF NAME (for treatment; if you take care) **Pt. Initials_____**

I hereby authorize release of any medical information necessary to process this claim and request payment of insurance benefits either to myself or to the party who accepts assignment.

I authorize payment of any medical benefit from third-parties for benefits submitted for my claim to be paid directly to this office. I authorize the direct payment to this office of any sum in now or hereafter owe this office by my attorney, out of proceeds of any settlement of my case and by any insurance company contractually obligated to make payment to me or you based upon the charges submitted for products and services rendered.

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, and fees for products or professional services rendered will be immediately due and payable.

CONSENT TO X-RAY ASSIGNMENT AGREEMENT **Pt. Initials_____**

I consent to allow MSI to use the services of an outside Radiologist if needed to insure the highest quality interpretation of my x-rays. I acknowledge that these services are separate from those of the clinic where I am receiving care, and that the charges for these services will be submitted to my insurance carrier, Workers' Compensation carrier of State Bureau, and/or to my attorney in the case of personal injury.

In the event that I receive payment for these services, I agree to promptly remit payment to the Radiologist or radiology service.

I assign my insurance benefits and rights to payment to the Radiologist to the extent of their charges, and authorize them, or their agents, to bill and release information to my insurance company, attorney, and/or any third-party payer. I authorize my treating physician, insurance company, attorney, and/or third-party payer to provide the Radiologist or their agents with any information concerning my claim, their services, and/or payment for the services provided.

CONSENT TO CHIROPRACTIC &/OR PHYSICAL THERAPY SERVICES **Pt. Initials_____**

I hereby request and consent to comprehensive examinations (chiropractic &/or physical therapy orthopedic &/or neurological), chiropractic adjustments/treatments *(and other procedures including various modes of physiotherapy modalities)*, physical therapy intervention *(including soft tissue mobilization, therapeutic exercises, stretching, posture and ergonomic training, and home exercise program)*, nutritional counseling/advice, and diagnostic x-rays by MSI *(& it's staff)*, who now or in the future treat me in this office. I have had an opportunity to discuss with the MSI Staff the nature and the purpose of the treatment indicated. I understand that results are not guaranteed and am informed that, as in the practice of medicine, the practice of chiropractic and in the practice of physical therapy there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations, and sprains. I do not expect the doctor(s) to be able to anticipate and explain all risks and complications, and wish to rely on the doctor(s) to exercise judgment during the course of any procedure which the doctor(s) feels at the time is in my best interest. I have read, or have had read to me, the full above consent and have also had an opportunity to ask questions about its content and by signing below I agree to the above terms and procedures. I intend this consent to cover any treatment for my present condition and for any future conditions for which I seek treatment by MSI and/or employed staff.

OUTSIDE SERVICE PROVIDERS

MSI may refer you to, or bring a product or service in to MSI to help you with your care. In such cases, I authorize MSI to release my personal, medical and/or insurance information/records to my primary care physician, or other healthcare providers, attorney and such companies to include, but not limited to: A1 DME, Apex Medical Services, Breg, Compliance Medical Services, etc. I authorize payment for such medical services or products as it applies.

Pt. Initials _____

By my signature below, I acknowledge that I have read, understand, and agree to the above provisions, and I assign my insurance benefits as described above.

PRINTED_____ **SIGNED**_____ **DATE**_____

Maryland Spine Institute Integrative Healthcare

Assignment of Benefits (AOB)

This AOB form is required to bill on your behalf!

My signature and date in the box below authorizes each of the following:

1. Assignment of Medicare, Medicaid, Medicare Supplemental or other insurance benefits to Maryland Spine Institute Integrative Healthcare for medical supplies and/or medication(s) furnished to me by Maryland Spine Institute Integrative Healthcare .

2. Direct billing to Medicare, Medicaid, Medicare Supplemental or other insurer(s).

3. Release of my medical information to Medicare, Medicaid, Medicare Supplemental or other insurers and their agents and assigns.

4. Maryland Spine Institute Integrative Healthcare to obtain medical or other information necessary in order to process my claim(s), including determining eligibility and seeking reimbursement for medical supplies and/or medication(s) provided.

5. Maryland Spine Institute Integrative Healthcare to contact me by telephone or mail regarding my medical supplies and/or medication(s) order.

I agree to pay all amounts that are not covered by my insurer(s) including applicable co-payments and/or deductibles for which I am responsible.

Your Phone # (___) _____

SIGN YOUR NAME HERE | **TODAY'S DATE** 1/ /

I request that payment of Medicare, Medicaid, Medicare Supplemental or other insurance benefits be made on my behalf to Maryland Spine Institute Integrative Healthcare for any medical supplies and/or medications furnished to me Maryland Spine Institute Integrative Healthcare. I authorize any holder of medical information about me to release to Maryland Spine Institute Integrative Healthcare, my physician(s), caregiver, CMS, its agents and to my primary and/or other medical insurer any information needed to determine or secure eligibility information and/or reimbursement for covered services. I agree to pay all amounts that are not covered by my insurer(s) and for which I am responsible.

I _____ appoint _____ to act as
(name of beneficiary) (name of representative)
my personal representative with Medicare, Medicaid or private insurance.

Their relationship to me is spouse, child, parent, sibling, other _____.
(choose one) (or write in)

The reason I cannot sign is: _____.
(list reason)

My representative does or does not live with me.
(choose one)
If not, their address and phone number is:
Address: _____ Phone: _____

City/St/Zip: _____

Signature: _____ Date: _____
My signature and date above authorizes the above named person to sign on my behalf.

HIPAA Information and Consent form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14,2003. There are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with the office services. HIPAA provides certain rights and protection to you as the patient. We balance these needs with our goal of providing you with quality professional service and care.

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to normal procedures utilized within the office for the handling of charts, patient records, PHI, and other documents or information.
2. It is the policy of this office to remind patients of their appointments. We may do this via telephone, email, text, U.S.mail, etc. We may send you other communications informing you of changes to office policy and new technology that you may find valuable or informative.
3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must abide by the confidentiality rules of HIPAA.
4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.
5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.
6. Your confidential information will not be used for the purpose of marketing or advertising of products, goods or services unless written consent is provided by the patient.
7. We agree to provide patients with access to their records in accordance with state and federal laws.
8. We may change, add, delete or modify any of these provisions to better serve the needs of both the practice and the patient.
9. You have the right to request restrictions in use of your PHI and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, _____ do hereby acknowledge receipt of the HIPAA Information form and do consent to the terms set forth in the HIPAA Information form and any subsequent changes in office policy. I understand that this shall remain in force from this time forward.

Sign: _____ Date: _____