Welcome to Spine and Disc Center of Arizona

First Name _____ **Last Name** _____ **Date** _____

Address: _____

City _____ **State** _____ **Zip Code** _____

Cell Phone (____) _____-_____ **Work Phone** (____) _____-_____

Email _____

Date of Birth _____/_____/_____ **Sex:** Male Female

Social Security Number: _____-_____-_____ **Marital Status:** Single Married

Spouse Data

First Name _____ **Middle Initial** _____ **Last Name** _____

Home Phone (____) _____-_____ **Work Phone** (____) _____-_____

Employer Data

Name _____

Your Occupation _____

How did you hear about our office? _____

Payment/Insurance Information:

Who is responsible for your bill? Self Health Insurance Auto Insurance Worker's Comp. Other _____

Consent to Treat:

As a part of the analysis, examination, and treatment, you are consenting to the following procedures: spinal manipulative therapy, palpation, vital signs, range of motion testing, orthopedic testing, hot/cold therapy, EMS, cold laser, radiographic studies, stretching, massage/myofascial release, laboratory services, trigger point injections. As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, skin irritations, allergic reactions and burns. Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contraindications to care however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me. Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the taking of your history and during examination. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare. Other treatment options for your condition may include: self-administered, over-the-counter analgesics and rest, Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers, Hospitalization, Surgery. If you choose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician. There are risks and dangers to remaining untreated; Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility.

By signing this form I am acknowledging that I have read or have had read to me the above explanation of the chiropractic adjustment and related treatment.

_____ _____

Patient Signature / Date Signature of Parent/Guardian/ Date

Review of Systems – (Check box if you have had trouble with any of the following, circle NO if none)

Cardiovascular			**No**	**Respiratory**			**No**	**Allergic/Immunologic**			**No**
	Past	Present			Past	Present			Past	Present	
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**			**No**
Jaw Pain				**Eyes**			**No**		Past	Present	
Irregular Heartbeat					Past	Present		Difficulty Swallowing			
Swelling of legs				Glaucoma				Dizziness			
				Double Vision				Hearing Loss			
Genitourinary			**No**	Blurred Vision				Sore Throat			
	Past	Present						Nosebleeds			
Kidney Disease				**Psychiatric**			**No**	Bleeding Gums			
Burning Urination					Past	Present		Sinus Infections			
Frequent Urination				Depression							
Blood in Urine				Anxiety				**Gastrointestinal**			**No**
Kidney Stones				Stress					Past	Present	
Lower Side Pain								Gall Bladder Problems			
				Endocrine			**No**	Bowel Problems			
Neurologic			**No**		Past	Present		Constipation			
	Past	Present		Thyroid				Liver Problems			
Stroke				Diabetes				Ulcers			
Seizures				Hair Loss				Diarrhea			
Head Injury				Menopausal				Nausea/Vomiting			
Brain Aneurysm				Menstrual				Bloody Stools			
Numbness								Poor Appetite			
Severe Headaches				**Hematologic**			**No**				
Pinched Nerves					Past	Present		**Musculoskeletal**			**No**
Parkinson's				Hepatitis					Past	Present	
Carpal Tunnel				Blood Clots				Gout			
Vertigo				Cancer				Arthritis			
				Bruising				Joint Stiffness			
Constitutional			**No**	Bleeding				Muscle Weakness			
	Past	Present		Fever, Chills				Osteoporosis			
				Sweating				Broken Bones			
Weight Loss/Gain								Joints Replaced			
Low Energy Level											
Difficulty Sleeping											

Surgeries: (List any)

_____

Medications: (Currently being taken)

_____

Family History: (List any family history of illness)

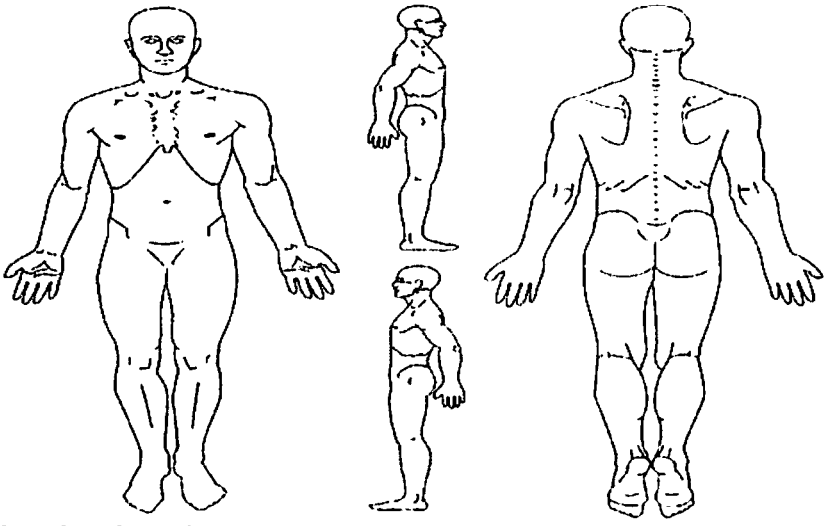
_____

Are you pregnant? Yes_____ No _____N/A_____

Primary Complaint:

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

N=Numbness **B=Burning** **S=Stabbing** **T=Tingling** **A=Dull Ache**



Describe your symptoms in order of severity and when it began:

_____

_____

_____

_____

ADL, and Recreation Information:

Condition's Effect on Job Performance: ☐ **No Effect** ☐ **Mild** (painful can do) ☐ **Mod** (painful limited ability) ☐ **Mod/Sev** (limited duty) ☐ **Sev** (no limited duty) ☐ **Sev** (can't do limited duty)

Daily Activities: Effects of Current Condition on Performance

Bending:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Sev Unable to Perform
Change Posn–Sit-Stand:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Sev Unable to Perform
Climb Stairs:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Sev Unable to Perform
Driving:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Sev Unable to Perform
Extended Computer Use:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Sev Unable to Perform
Feeding:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Sev Unable to Perform
Household Chores:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Sev Unable to Perform
Kneeling:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Sev Unable to Perform
Lifting:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Sev Unable to Perform
Reading (Concentration):	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Sev Unable to Perform
Self Care-(ie bathing):	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Sev Unable to Perform
Sexual Activities:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Sev Unable to Perform
Sleep:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Sev Unable to Perform
Static Sitting:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Sev Unable to Perform
Static Standing:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Sev Unable to Perform
Walking:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Sev Unable to Perform

Recreational Activity: Effects of Current Condition on Performance

_____	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (limited)	☐ Sev Unable to Perform
_____	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (limited)	☐ Sev Unable to Perform

Assignment Of Benefits

I authorize Spine & Disc Center of Arizona to receive direct payment from my insurance company or attorney for all monies due on my account .I understand that all coverage's in effect will be billed. If multiple sources of coverage exist, all will be billed and collected from, including group(s), med pay and attorney liens. Any overpayments will be promptly returned to the patient. In the event there is no valid coverage or that I have exceeded my annual limit, I will remain responsible for charges incurred. I agree to provide Spine & Disc Center of Arizona with all valid insurance forms and billing information within 5 days. I agree to the above terms and acknowledge that I will remain responsible for any deductible, co-payments, co-insurance or non-covered services. Should I receive any payment(s) or settlements for services rendered I agree to forward those on to Spine & Disc Center of Arizona within 5 days. I understand that verification of benefits is done as a courtesy by Spine and Disc and not guaranteed.
_____(Initial)

Insurance Subscribers Acknowledgement

The Spine & Disc center of Arizona continues to provide as many options for in network insurance coverage as possible. Unfortunately, it is not possible to be in network with all insurance providers. This will not affect your care. As a courtesy, we send all claims in for processing. Patient is responsible for visits exceeding their insurance plan benefits. **However, in the situation of non network coverage, the insurance companies DO NOT send reimbursements for services to the office; the payments will be sent directly to you, the patient/ subscriber. We reserve the right to add a fee of up to 30% of any unpaid balance that goes to collections.**

The Spine & Disc Center will receive notification of payment status. In an effort to continue to provide you with the best care possible, we ask you that you agree to the following.

_____ (Initial) **Any correspondence with your individual insurance provider that relates to services performed by The Spine & Disc Center should be brought in immediately to the office so that we may reconcile your account. (Checks,EOB,Denials)**

_____(Initial) **If the documentation for your claim is not provided, or in the event that you happen to cash the checks that are for services rendered, you will be financially responsible for the entire claim.**

I acknowledge that I have received and /or have been given the opportunity to review Spine & Disc HIPAA Privacy Practices (additional HIPAA available upon request) for protected health information/ Assignment Benefits/ Auth to bill insurance.

Patient's Signature _____Parent/ Guardian Signature_____

Financial Agreements:

It is your appointment that allows us to continue providing high levels of professional care, maintain our facility, and pay our staff. If for any reason you can not keep or need to change financial agreement, please inform us immediately to eliminate any misunderstandings. If you have the desire to receive care in our office we will make any attempt to make affordable arrangements. Spine and Disc Center and its providers perform professional work for entities outside this office. This may include serving as board members, teachers, researchers, and stockholders in entities that may provide salaries, royalties, intellectual property rights, consulting fees or other financial benefit to a provider of this clinic. The providers at Spine and Disc Center pledge and promise not to allow a conflict of interest to occur that would impact any treatment or recommendations that you receive from them. It is your right to ask your providers if they have any financial relationships related to your treatment or recommended treatment, and all providers are required to disclose any financial relationships to you. If you believe that a conflict of interest exists, you have the right to ask for alternative resources to continue your care.

Patient's Signature _____Parent/ Guardian Signature_____

Blue Cross Blue Shield
&
United Healthcare
(other insurance companies may also apply)
Consent & Agreement

We are pleased to file on your behalf to your insurance carrier. Please be aware, that the check for the services being rendered will be issued to you and in your name. By signing below you are agreeing that you will be required to forward the check to us as a payment. Upon request we will provide you with a stamped, self-addressed envelope to forward the check to us. Please open all correspondence from your insurance company, as it if difficult to see that a check is in fact enclosed. Again please forward immediately. If you have any questions, feel free to contact us.

Thank you!

Patient Signature / Date

Signature of Parent/Guardian/ Date

ARIZONA
SPINE AND DISC CENTERS

Thank you for being a valued patient and choosing us for your care. Please take a moment to review and sign our **No SHOW/Cancellation** and **Delinquent Account** policies. If you have any questions, please feel free to ask us!

Cancellation/No Show – When an appointment is not kept, it creates and unused slot that a patient on our Waiting List could have used. We use an automated text reminder system for reminders of appointments. Please understand that this is a **COURTESY**. We are not responsible for reminders not received. If for any reason you can not keep your appointment, please notify us **24 hours** in advance (we accept messages left on our voice mail after hours and over the weekend). We understand that emergencies and circumstances beyond your control do occur, and to keep our patients completely satisfied, we would be more than happy to offer a 1 time annual courtesy waive. A **No Show/Cancelation fee of $25.00 will be charged to you for missed or broken appointments without 24 hour notice.** _____**Please Initial**

Please understand that we will send out a text and/or email reminder, however, sometimes our program may fail to send out a reminder and it is up to you to make sure that you have all your appointments marked in your calendar. _____ Please Initial**

Delinquent Accounts – Account balances should be paid within 30 days of the account statement. If you are going through your insurance company, please understand that verification of your benefits are done by us as a courtesy. We are not responsible for your benefits as each insurance plan is different and has it's own benefit contract that you are responsible for. Benefits quoted to us states that it is not a guarantee of benefits and that it is the insured's responsibility. Please also understand that some insurance companies may submit payment directly to the insured instead of the provider. Please submit payments to us and bring in the Explanation of Benefits attached to the payment so we can promptly apply it to the appropriate date of service. In this case, any payment which are due, including those starting 30 days after the insurance coverage has been completed will be charged a $15.00 monthly service/late charge. You understand that you are financially liable in the event of non payment; you agree to pay and collection agency cost(s), and/or court cost (s) and reasonable attorney fees. Accounts not cleared within 90 days may cause and adverse incident on your credit report. You understand and agree that if a check is returned for insufficient funds, Spine and Disc Center will only accept cash or credit card payments thereafter, and you will be obligated to pay a returned check fee of $30.00. All balances must be settled. _____**Please Initial**

By signing below, you acknowledge you have read, understand and agree to Spine and Disc Center of Arizona's Policy.

Printed Patient Name:_____

Signature of Patient:_____ **Date:**_____

Printed Name of Parent Guardian:_____

Signature of Office Representative:_____ **Date:**_____

1 time No Show Waiver initialed by Office Representative:_____