Spine Care of Tidewater, PC

Hampton • Newport News

Specializing in Chiropractic Care and Spinal Rehabilitation

Date_____ Name_____
Address_____ City_____ State _____ Zip _____
Email_____ Gender ☐M ☐F Age _____ Birth date_____
SS#_____ Check one that apply: ☐Married ☐Single ☐Widowed ☐Minor
Patient Employer/ School_____ Employer Phone_____
Spouse's Name_____ Spouse's Birthdate_____ Spouse's SS#_____

Whom may we thank for referring you?_____

Who is responsible for this account?
_____
Relationship to Patient_____
Insurance Co._____
ID#_____ __Group#_____
Is patient covered by additional insurance?_____

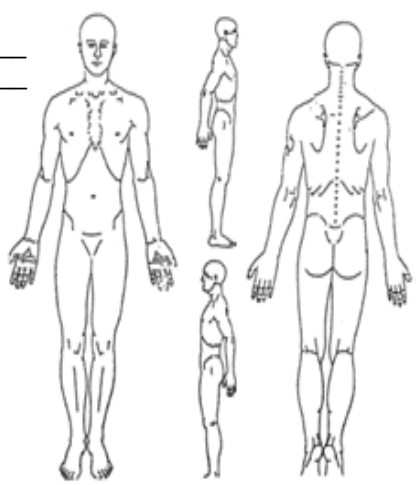
Subscriber's Name_____
Birth date_____ SS#_____
Relationship to Patient_____
Insurance Co._____
ID#_____ Group#_____

Home Phone_____
Cell Phone_____
Best time and place to reach you_____

IN CASE OF EMERGENCY, CONTACT
Name_____ Relationship_____
Home Phone_____
Cell Phone_____

Is condition due to an accident?
Yes No Date_____
Type of accident: ☐Auto ☐Work ☐Home ☐Other
To whom have you made a report of your accident
☐Auto Insurance ☐Employer
☐Worker Comp. ☐Other
Attorney Name(if applicable)_____
Phone No._____

Reason for visit_____
When did your symptoms appear?_____
Is this condition getting progressively worse? ☐Yes ☐No
Mark an X on the picture where you continue to have pain, numbness, or tingling.



Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain)_____

Type of pain: Sharp Dull Throbbing Numbness Aching Shooting
Burning Tingling Cramps Stiffness Swelling Other

How often do you have this pain?_____

Is it constant or does it come and go?_____

Does it interfere with your: ☐Work ☐Sleep ☐Daily Routine ☐Recreation

Activities or movements that are painful to perform: ☐Sitting ☐Standing ☐Walking ☐Bending ☐Lying Down

Which treatment have you already received for your condition?

☐Medications ☐Surgery ☐Physical Therapy ☐Chiropractic Services ☐None Other_____

Name of other doctor(s) who have treated you for your condition_____

Circle "Yes" or "No" to indicate if you have any of the following:

Headache	Yes	No	Migraines	Yes	No	Neck Pain	Yes	No
Arm/Hand Pain	Yes	No	Shoulder Pain	Yes	No	Low Back Pain	Yes	No
Hip Pain	Yes	No	Mid Back Pain	Yes	No	Leg/Foot Pain	Yes	No
Disc Problems	Yes	No	Other Joint Pain	Yes	No	Numbness	Yes	No
Joint Swelling	Yes	No	Dizziness	Yes	No	Nausea	Yes	No
Weakness	Yes	No	Fatigue	Yes	No	Nervousness	Yes	No
Insomnia	Yes	No	Heart Problems	Yes	No	Frequent Colds	Yes	No
Nose Bleeds	Yes	No	Ringing in Ears	Yes	No	Earaches	Yes	No
Hearing Loss	Yes	No	Cough	Yes	No	Chest Pains	Yes	No
Female Problems	Yes	No	Allergies	Yes	No	Asthma	Yes	No
Cancer	Yes	No	Osteoporosis	Yes	No	Diabetes	Yes	No
Hypoglycemia	Yes	No	Digestive Problems	Yes	No	Urinary Problems	Yes	No

EXERCISE

☐None
☐Moderate
☐Daily
☐Heavy

WORK ACTIVITY

☐Sitting
☐Standing
☐Light Labor
☐Heavy

HABITS

☐Smoking
☐Alcohol
☐Coffee/Caffeine drinks
☐High Stress Level

Injuries/Surgeries you have had	**Description**	**Date**
Falls	_____	_____
Head Injuries	_____	_____
Broken Bones	_____	_____
Dislocations	_____	_____
Surgeries	_____	_____

MEDICATIONS	**ALLERGIES**	**VITAMINS/HERBS/MINERALS**
_____	_____	_____
_____	_____	_____
_____	_____	_____

Thank you for being complete and thorough.

Signature _____ Date _____

Assignment of Proceeds, Contractual Lien, and Authorization
("Agreement")

I hereby direct any and all insurance carriers, attorneys, companies, individuals, and/or other legal entities ("payers"), which may elect or be obligated to pay benefits to me for any medical conditions, accidents, injuries, or illnesses, past of future ("condition"), to pay directly to, and exclusively in the name of Spine Care of Tidewater, P.C. such sums as may be owed to Spine Care of Tidewater, P.C. for charges incurred for charges incurred by me. I further grant a contractual lien to Spine Care of Tidewater, P.C. with respect to my charges, however, nothing in this Agreement shall be construed as an election of remedies under any statutory lien law. Furthermore, in the event of a conflict between the assignment, and the grant of contractual lien, the assignment shall control. For the purpose of this agreement, "benefits" shall include, but shall not be limited to, proceeds from any settlement, judgment, or verdict, as well as any proceeds relating to commercial health or group insurance, disability benefits, worker's compensation benefits, medical payments benefits, personal injury protection, lost wages benefits, lost services benefits, no-fault coverage, uninsured an underinsure motorist coverage, third-party liability distributions, attorney retainer agreements, and any other benefits or proceeds payable to me for the purposed stated herein, regardless of whether such proceeds are related to my charges or not.

I further agree that, in the event a payer refuses to pay Spine Care of Tidewater, P.C. pursuant to this Agreement, I hereby assign, insofar as permitted by law, all of my rights, remedies, and benefits to Spine Care of Tidewater, P.C. to the extent of my charges, as well as any and all causes of action that I might have against such payer, to prosecute such causes of action either in my name or in Spine Care of Tidewater's name, and to settle or otherwise resolve such causes of action as the office sees fit.

In the event that I retain one or more attorneys to represent me in this matter, I will direct each attorney to issue a letter of protection to his office regarding my charges. Upon issuance, I hereby agree that such letter(s) of protection cannot be revoked or modified without expressed written consent of this office. I further direct each attorney to provide immediate notice to the office regarding any funds received by the attorney relating to my accident, to promptly pay such office, and to provide a full accounting of such funds to the office upon its request.

I hereby direct all payers to release to Spine Care of Tidewater, P.C. any information regarding any coverage or benefits which I may have including, but not limited to, the amount of coverage, the amount pain thus far, and the amount of any outstanding claims.

I authorize this office to release any information regarding my treatment or pertinent to my case(s) to all payers as defined above to facilitate collection under this Agreement. I hereby direct this office to file a copy of this Agreement, together with any applicable charges, with any or all payers, regardless of whether a claim has been established with said payers. I hereby authorize Spine Care of Tidewater, P.C. to endorse/sign my name on any and all checks listing me as a payee, which are presented to this office for payment of an account relating to me. I further authorize Spine Care of Tidewater, P.C. to apply any credit balances on charges incurred by me to any other outstanding charges still owed by me whether or not these charges are related to my condition.

I understand that I remain personally responsible for the total amount due to Spine Care of Tidewater, P.C. for services rendered. I understand and agree to pay 1-1/2% a month service charge on the unpaid balance beginning 30 days from the date the bill is incurred. I also understand that unpaid balances are subject to late fees and rebilling charges. If this office must take any action to collect an outstanding balance on my account, I will be responsible for payment and will reimburse Spine Care of Tidewater, P.C. for all costs of such collection efforts, including, but not limited to, all court costs and all attorney fees.

This Agreement shall not be modified or revoked without the mutual written consent of Spine Care of Tidewater, P.C. and myself.

I agree that each and every provision of this Agreement is reasonably necessary for the protection of the rights and interest of Spine Care of Tidewater, P.C. and myself. However, should any provision of this Agreement be found to be invalid, illegal, or unenforceable, or for any reason cease to be binding on any party hereto, all other portions and provisions of this Agreement shall, nevertheless, remain in full force and effect.

Patient Name (please print): _____

Patient Signature: _____ Date: _____/_____/_____

Spine Care of Tidewater, P.C. Privacy Notice Summary

While the nature of a chiropractic practice requires that we gather personal financial and/or health information about you, we know that this information must be protected. The Spine Care of Tidewater, P.C. privacy notice applies to information gathered in connection with chiropractic services provided by Spine Care of Tidewater, P.C.

Information We Collect:

We get most information directly from you such as information provided to us on your patient information/insurance form, as well as medical information related to your treatment, either written or transcribed, by or for the physician. We also collect information about your insurance coverage including the company, your policy number, and benefits. We may obtain additional information from third parties. Third parties may include agents, employers, insurers, consumer reporting agencies, agencies of the Federal Government, or other health care providers. Information collected may relate to your finances, employment, health, treatment received, other personal information, as well publicly available information about you.

Information We Disclose:

We may disclose collected information to other health care providers, insurers, consumer reporting agencies, research studies, attorneys, governmental agencies, affiliates, and non-affiliated service providers when necessary to carry out our normal business activities. These activities may include: summary of treatment provided, recommended future treatment plans, information for evaluating and processing claims, and processing other transactions at your request. Service providers may include your physician and office staff who treat or assist in your treatment, as well as administrative personnel who process claims to be filed with your insurance company. We may also disclose collected information to law firms, consumer reporting agencies, or collection agencies with which we have an agreement. These non-affiliated companies are outside of Spine Care of Tidewater, P.C. and may also include banks, other insurance companies, service vendors and insurance agencies. We also may disclose information as permitted or required by law. We do not disclose collected information about our former patients to anyone except as permitted by law.

Protection of Information:

Our employees are trained and required to maintain our privacy policies and procedures. Employees who violate those policies and procedures are subject to disciplinary action. Affiliates and third parties to whom we disclose information are required to maintain adequate security standards for the protection of collected information. In addition, we maintain physical, electronic and procedural safeguards to protect information. Federal and State laws require us to provide our Privacy Notice to you each year unless your relationship, as a patient, with Spine Care of Tidewater, P.C. has terminated.

If you would like a copy of the entire Privacy Act Notice please ask the receptionist for a copy or you may write and request a copy from:

HIPAA Coordinator
Spine Care of Tidewater, P.C.
2216 Executive Dr., Ste. A
Hampton, VA 23666

I acknowledge receipt of this summery of Spine Care of Tidewater Notice of Privacy.
I understand that a more detailed version of this Notice of Privacy is available upon request.

Print Name: _____ **Signature:** _____ **Date:** _____