



Spine Care of Tidewater, PC

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) _____

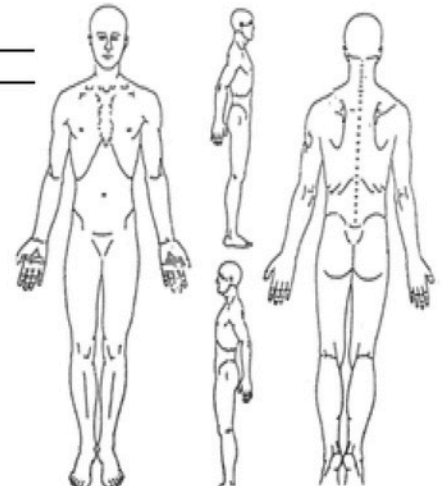
Type of pain: Sharp Dull Throbbing Numbness Aching Shooting
 Burning Tingling Cramps Stiffness Swelling Other

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 or 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 as 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 summary 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:** _____