

PHENIX CITY SPINE & JOINT CENTER WELCOMES YOU !!



Name: _____ Apt# _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Date of Birth: _____ Age: _____ SSN: _____

Employer: _____ Occupation: _____

Work Phone: _____ Email: _____

Marital Status: M S D W Spouse Name: _____

Insurance Information: Please give a copy of the insurance cards to the front desk.

Name of Insurance Co: _____

Policy #: _____ Group #: _____

Phone #: _____ Address: _____

If Using Spouse's Card: Their DOB: _____ SSN: _____

Emergency Contact Info: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

Do you have an Attorney? Firm: _____

Name: _____ Phone: _____

Date of Accident: _____

Location: _____

City/State of Accident: _____

Circle correct choice. Fill in all blanks completely Please.

Auto Accidents: _____

You were the: (driver) (passenger- front seat) (passenger- driver's /passenger side rear seat)

Describe the accident as completely as possible: _____

Which of the following Apply: (My seat was tilted back before the accident) (My seat broke) (I was thrown from the car) (I don't remember anything) (I was wearing a lap belt) (I was wearing a 3pt seat belt) (My airbag exploded into me) (the car flipped over) (The car spun around) (The glass broke)

Other Important notes: _____

For Work Related Accidents or Slip and Falls:

Where were you working? _____

What Happened: _____

Witnesses Y N Reported Y H

Have you gone to the company doctor? Y N Who: _____
What did they tell you? _____

Were you cut or bleeding? Y H Where: _____ Bruises? Y N Where: _____

There was immediate pain into the: (Head)(Neck)(Upper Back) (Mid Back) (Lower Back) (Hips) (Legs)

Pain began later into the: (Head)(Neck)(Upper Back) (Mid Back) (Lower Back) (Hips) (Legs)

After the accident, what did you do? (circle) Went home and took it easy / went back to work

Took over the counter medications/ Was taken by hosp by ambulance/ taken by a friend/ Drove to hospital/ Drove to Medical Doctors Office/ Drove of Chiropractors Office/ Went to work

* Which Hospital: _____ Admitted Y H

Day and time you went to the Hospital? _____

X-rays Taken: Neck Back Chest Shoulder Knee Other CT Scan? Y H MRI? Y H

Were you given a prescription? Y H What: _____ Filled? Y H

What did they tell you? _____

Have you seen any other doctors: Y N Who? _____

Have you seen a Chiropractor before? Y N Who? _____

List your current complaints in order of severity.

What hurts worse	(Rate 0-10)	How & When does it hurt??
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____

On a scale of 0 to 10 with zero being no pain and 10 being unbearable pain rate each of the 5 by circling the number you feel best describes your pain on that line.

Past Health History:

Have you been in an accident or had a major injury prior to this one? Y H
Tell us about it: _____

Are you pregnant? Y H Please list in detail any previous surgeries or hospitalizations: _____

Circle if you have or had: Sickle Cell Diabetes HIV Cancer Osteoporosis Epilepsy Rheumatoid
Did you enjoy good health prior to the accident? Y N

Please print your name or sign where indicated. If you are under 18, you need a parent or legal guardian to sign.
CONSENT FOR TREATMENT

I, _____ (PRINT), do hereby authorize Dr. Stephen B. Cooper and whomever he may designate as his assistants to perform diagnostic tests, including but not limited to radiographs, physical examination and administer treatment as directed, indicated or deemed necessary. This includes emergency actions that may need to be performed should I be physically incapacitated.
I ALSO CERTIFY THAT IN NO WAY HAS ANY GUARANTEE OR ASSURANCES AS TO THE RESULTS THAT MAY BE OBTAINED.

I understand and agree that health and medical insurance policies are an arrangement between an insurance carrier and myself (patient). Furthermore, I understand and agree that this office and contracted representatives may prepare any necessary reports and forms to assist me in making collection from the insurance company, and that any amount authorized to be paid and sent directly to this office will be credited to my account upon receipt. I permit this office to endorse remittances for the conveyance of credit to my account. However, I clearly understand and agree that I have sought treatment, received treatment, and am directly responsible for the bills that accumulate from this treatment.

Patient/Guardian
Name Printed: _____ Date: _____

Name Signed: _____ Date: _____
Witness

Name Signed: _____ Date: _____

Consent for Treatment of a Minor:

I hereby authorize the Phenix City Spine & Joint Center, LLC, Stephen B Cooper, DC and whomever they may designate as an associate or contractor of this clinic to perform diagnostic tests, radiographic studies, physical evaluations, and to administer treatment as he deems necessary to _____ a minor child under my guardianship. I also accept all terms and conditions named herein with regards to payment of the account and lien arrangements and am responsible for the execution of these agreements on this minors behalf.

Patient/Guardian
Name Printed: _____ Date: _____

Name Signed: _____ Date: _____
Witness

Name Signed: _____ Date: _____

Name Signed: _____ Date: _____

ASSIGNMENT OF BENEFITS

I hereby authorize the following insurance companies or liable direct pay parties:

- 1: _____
- 2: _____
- 3: _____
- 4: _____

to pay by check or credit card through either mailing the check payable to Phenix City Spine & Joint Center, LLC at PO Box 1611 Phenix City, AL 36867. This covers the expense benefits allowable and otherwise payable to me under my current policy, as payment towards the total charges for professional services rendered I have agreed to pay, in a current state and agree that this of said applicable charges. I further state and agree that this office is given a limited power of attorney to endorse/sign my name on any and all drafts directed for the payment of my bill.

Patient
Name Printed: _____

Name Signed: _____ Date: _____

Witness

Name Printed: _____

Name Signed: _____

Patient Name: _____ Date: _____

released from this binding lien if there is no settlement of any amount for the above mentioned injury or; if the patient acquires new counsel the contract is now binding on the new counsel in its entirety, and if all legal representation in reference to this accident has been terminated prior to the settlement with the previous attorney, the previous attorney mentioned in this document is therefore released from all aspects of this contract upon written notice received in this office by US Mail according to the post marked date. The patient and attorney understand that not honoring the full extent and purpose of this contract constitutes default and binds upon both parties separately and individually all charges, collection costs, attorney fees and finance charges. This contract can only be altered with the amount of settlement by written signed verification from Phenix City Spine & Joint Center, LLC and the bound third party or attorney.

Date of injury: _____ Policy/Claim # _____
Contract for Services including the Lien Agreement and Irrevocable Assignment:
This document and all that is contained herein is a specifically designed instrument to detail an irrevocable assignment, enforceable contract and lien. This contract and lien is entered into between Phenix City Spine & Joint Center, LLC & our appointed counselor, (print patient's name clearly) _____ (patient or legal guardian) here forth known as the "patient" and (print attorney/ insurance company) _____ here forth known as the "attorney" and/or "insurance company" and is binding on these listed parties for the following text. The patient hereby directs the attorney or insurance company that for any balance such as may be due owing to this office for services rendered to the patient to withhold such funds from any disability benefits, medical payment benefits, health and accident benefits, medical or personal injury settlements or any such other insurance benefit obligated to reimburse the patient, or from any settlement, judgment or verdict on my behalf as may be necessary to adequately satisfy any balance owing and protect the interests of the Phenix City Spine & Joint Center, LLC.

I Authorize this clinic to release or receive any information pertinent to this injury to or from the attorney and to or from any insurance company or responsible third party attorney or adjuster to facilitate collection under this assignment and contract.

I further irrevocably authorize this clinic to obtain a perfected lien attaching any and all insurance benefits, judgments, and settlements named herein. Once I have accepted terms and or conditions or made an agreement with any third party for any amount relating to this injury or claim, this document is to serve as an irrevocable assignment and lien of these benefits or proceeds of the agreement or settlement to the amount necessary to adequately satisfy any balance owing and protect the interests of the Phenix City Spine & Joint Center, LLC.

Patient Name - Printed: _____
Signed: _____ Date: _____

_____ here forth known as the "attorney" and/or "insurance company" and is binding on these listed parties for the following text. The patient hereby directs the attorney or insurance company that for any balance such as may be due owing to this office for services rendered to the patient to withhold such funds from any disability benefits, medical payment benefits, health and accident benefits, medical or personal injury settlements or any such other insurance benefit obligated to reimburse the patient, or from any settlement, judgment or verdict on my behalf as may be necessary to adequately satisfy any balance owing and protect the interests of the Phenix City Spine & Joint Center, LLC.

Witness Name - Printed: _____
Signed: _____ Date: _____

_____ here forth known as the "attorney" and/or "insurance company" and is binding on these listed parties for the following text. The patient hereby directs the attorney or insurance company that for any balance such as may be due owing to this office for services rendered to the patient to withhold such funds from any disability benefits, medical payment benefits, health and accident benefits, medical or personal injury settlements or any such other insurance benefit obligated to reimburse the patient, or from any settlement, judgment or verdict on my behalf as may be necessary to adequately satisfy any balance owing and protect the interests of the Phenix City Spine & Joint Center, LLC.

Attorney Name - (Firm or Individual) _____
Signed: _____ Date: _____

_____ here forth known as the "attorney" and/or "insurance company" and is binding on these listed parties for the following text. The patient hereby directs the attorney or insurance company that for any balance such as may be due owing to this office for services rendered to the patient to withhold such funds from any disability benefits, medical payment benefits, health and accident benefits, medical or personal injury settlements or any such other insurance benefit obligated to reimburse the patient, or from any settlement, judgment or verdict on my behalf as may be necessary to adequately satisfy any balance owing and protect the interests of the Phenix City Spine & Joint Center, LLC.

If another attorney is involved:
Attorney Name - (Firm or Individual) _____
Signed: _____ Date: _____

_____ here forth known as the "attorney" and/or "insurance company" and is binding on these listed parties for the following text. The patient hereby directs the attorney or insurance company that for any balance such as may be due owing to this office for services rendered to the patient to withhold such funds from any disability benefits, medical payment benefits, health and accident benefits, medical or personal injury settlements or any such other insurance benefit obligated to reimburse the patient, or from any settlement, judgment or verdict on my behalf as may be necessary to adequately satisfy any balance owing and protect the interests of the Phenix City Spine & Joint Center, LLC.

Insurance Company - _____
Adjuster Name: _____ Date: _____
Signed by a representative: _____

_____ here forth known as the "attorney" and/or "insurance company" and is binding on these listed parties for the following text. The patient hereby directs the attorney or insurance company that for any balance such as may be due owing to this office for services rendered to the patient to withhold such funds from any disability benefits, medical payment benefits, health and accident benefits, medical or personal injury settlements or any such other insurance benefit obligated to reimburse the patient, or from any settlement, judgment or verdict on my behalf as may be necessary to adequately satisfy any balance owing and protect the interests of the Phenix City Spine & Joint Center, LLC.

by CFR 164.522
HIPAA Privacy Statement for Phenix City Spine & Joint Center, LLC

This Notice Describes how Medical Information about you may be used and disclosed and how you can get access to this information.

Understanding your health record information

Each time you visit a hospital, physician or other health care provider, a record of your visit is made. Typically this record contains your symptoms, examination, test results, diagnosis, treatment and a plan for future care and treatment. This information is often referred to as your health and medical record and serves as, but not limited to the following:

- ⇒ A Basis for planning your care and treatment.
- ⇒ Means of communication along the many health professionals who contribute to your care
- ⇒ Legal documentation describing the care you received
- ⇒ Means by which your third party payer can verify that services billed were actually provided
- ⇒ A tool in educating health care providers
- ⇒ A source of data for medical research
- ⇒ A tool we utilize to assess, analyze and improve the care we render and the outcomes we have achieved.

This information is shared with you to help you:

- ⇒ ensure its accuracy
- ⇒ Understand who and under what circumstances they may access your health information
- ⇒ Make a more informed decision when signing disclosure statements to authorize access by others.

Your Health Information Rights

Although your health record is the physical property of the health care provider or the facility who compiled it, the information belongs to you. You have a right to:

- ⇒ Request a restriction on certain uses and disclosures of your information as provided

⇒ Obtain a paper copy of notice of information practices upon request

⇒ Inspect and copy your health record as provided in 45 CFR 164.524

⇒ Amend your health record as provided in 45 CFR 164.528

⇒ Obtain an account of the disclosures of your health record.

⇒ Revoke authorization for future disclosure except that which has already been provided.

Our Responsibilities

This Organization is required to:

- ⇒ Maintain privacy of your health information
- ⇒ Provide you with notice as to our legal duties and privacy practices with respect to information we collect and maintain about you.
- ⇒ Abide by all the terms of this notice
- ⇒ Notify you if we are unable to agree to a requested restriction
- ⇒ Accommodate reasonable requests you may have to communicate health information by alternative means to alternative locations.

We reserve the right to change or practices and make new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notices to the addressed you have supplied to us.

We will not use or disclose your health information without your authorization, except as described in this notice.

For More Information Or To Report A Problem

If you have questions and would like additional information, you may contact our HIPPA Privacy Officer at (412) 446-9100. If you believe your privacy rights have been violated, you may file a complaint with our HIPPA Privacy Officer. There will be no retaliation for filing a complaint.

I Have Read and Understand: _____ Initial

PHENIX CITY SPINE & JOINT CENTER, LLC 1000 W. WASHINGTON ST. PHENIX CITY, AL 36860-1000