Primary Spine & Rehab

Multi-Specialty Musculoskeletal Pain Relief Center

physical medicine | physical therapy | chiropractic

Name _____ **Date** _____

Social Security # _____ **Date of Birth** _____ **Home #:** _____

Address _____ **Work #:** _____

City _____ **State** _____ **Zip** _____ **Cell #:** _____

Email Address _____

Marital Status M S W D **# Children** _____

Spouse's Name _____ **Your Occupation** _____

Emergency Contact Name and Tel # _____ ( )

HEALTH INFORMATION

Main complaint _____

_____

Other complaints _____

How long have you had this condition? _____

Other Doctors seen for this condition _____

Have you had similar conditions in the past? Yes / No **If yes, please list.** _____

_____

Are you taking any medication? Yes / No **If yes, please list.** _____

_____

_____

Have you had any previous surgeries? Yes / No **If yes, please list.** _____

_____

_____

Pregnant? Yes / No **If yes, # of weeks** _____

Who is your Primary Care Physician? _____

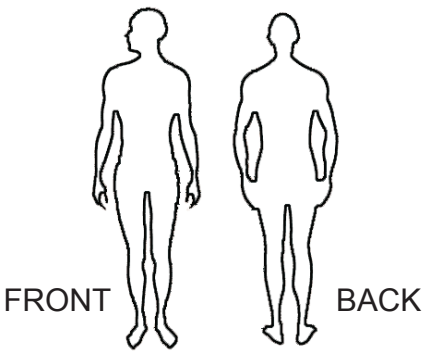
Name **Date of Birth**

REVIEW OF SYMPTOMS

Please check yes or no to the following conditions or symptoms you currently have or have had in the past:

YES	NO		YES	NO	
☐	☐	*Abdominal Pain*	☐	☐	*Heart Problems*
☐	☐	*Anemia*	☐	☐	*High or Low Blood Pressure*
☐	☐	*Arm or Shoulder Pain*	☐	☐	*Hip or Leg Pain*
☐	☐	*Arthritis: rheumatoid, gout, osteoarthritis*	☐	☐	*Immune System Problems*
☐	☐	*Back Pain*	☐	☐	*Kidney Problems*
☐	☐	*Bladder Problems*	☐	☐	*Liver/Jaundice/ Hepatitis*
☐	☐	*Cancer (Where): _____*	☐	☐	*Lung or Bronchial Disorder*
☐	☐	*Chest Pain*	☐	☐	*Neck Pain*
☐	☐	*Diabetes*	☐	☐	*Neurological: Strokes, Seizures, Numbness*
☐	☐	*Digestive Disorder*	☐	☐	*Thyroid*
☐	☐	*Dizziness*			
☐	☐	*Eyes or Blurred Vision*			
☐	☐	*Headaches*			

Please mark on the diagram where you are having pain, numbness or tingling.



☐☐ *Allergies: Medications* _____

☐☐ *Other Allergies:* _____

SOCIAL HISTORY

Are you employed? Yes / No

Do you smoke? Yes / No If yes, how long? How much? ( ) pack(s) per day

Do you use recreational drugs? Yes / No If yes, how long? How much?

Do you drink alcohol? Yes / No How much per day? Per week? Per month?

Name **Date of Birth**

FAMILY HISTORY

Any cancer in your immediate family? Alive / Deceased

Mother: Yes / No What kind? ❑ ❑

If deceased, cause of death:

Father: Yes / No What kind? ❑ ❑

If deceased, cause of death:

Brother: Yes / No What kind? ❑ ❑

If deceased, cause of death:

Sister: Yes / No What kind? ❑ ❑

If deceased, cause of death:

HEALTH INSURANCE INFORMATION

Do you have Health Insurance? Yes / No

Insurance Company: Member ID #:

Is this condition due to:

work-related injury? Yes / No **auto accident?** Yes / No **slip or fall?** Yes / No **Date of Injury:**

ASSIGNMENT OF BENEFITS: PLEASE REVIEW & SIGN

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and other dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that will be bound by signature as though the undersigned had personally signed the particular claim. Pay and hereby assign directly to Primary Spine & Rehab, LLC all benefits, if any, other wise payable to me for the services provided as described on the attached forms. I understand I am financially responsible for all charges incurred. I further acknowledge that any insurance benefit, when received by and paid to Primary Spine & Rehab, LLC to be applied to my account, in accordance with the above said assignment. I also acknowledge that any insurance benefit paid directly to me for services rendered need to be signed over to Primary Spine & Rehab, LLC to be applied to my account.

Patient's Signature Date

Parent / Guardian's Signature Date

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FINANCIAL AGREEMENT

We would like to take a moment to welcome you to our office and to assure that you will be receiving the very best care available for your condition. To familiarize you with the financial policies of our office, we would like to explain how your medical bills will be handled.

PRIMARY CARE PHYSICIAN REFERRAL(S)

In the event that your insurance company requires a referral from your primary care physician, you agree that you are responsible for providing this office with the original referral within five (5) days of your first office visit. If the referral condition is not met, you agree to pay in full for all services provided to you within (30) days of receiving a bill from this office.

EXPLANATION OF INSURANCE COVERAGE

Many insurance policies cover chiropractic/physical therapy care and we participate with most plans. It is your responsibility to become familiarized with your allowed benefit. As a courtesy to you, our office will be happy to verify your insurance and bill your insurance company in a timely manner. We require that you, the patient, be aware and responsible for the payment of your deductibles, co-insurance and/or co-payments on the day that services are rendered before you are seen by your healthcare provider. For patients with deductible, we require that you pay an "estimated" fee for service based on our cash fee for service plan. This per visit payment plan will help to avoid you receiving a large bill at the end of treatment.

CANCELLATION POLICY

All services are provided by appointment only and this time is reserved for your exclusive use. We must request 24 hours notice to cancel or change an appointment, or you will be subject to a $25 fee for missing a scheduled appointment.

VOLUNTARY TERMINATION OF CARE

If you suspend or terminate your care at any time, your portions of all charges for professional services are immediately due and payable to this office. All services rendered by this office are charged directly to you, and you ultimately, will be personally responsible for payment, regardless of your insurance coverage.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the office will prepare any necessary reports and forms to assist me in obtaining payment from the insurance company and that any amount authorized will be paid directly to Primary Spine & Rehab, LLC and be credited to my account on receipt. However, I clearly understand and agree that all services rendered 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 or treatment, any fees for professional services rendered me will be immedicately due and payable.

I have read and understand the office's financial policy.

Patient's Signature: _____ Date: _____

CONSENT TO TREAT

Medical Visit and/or Treatment

I hereby request and consent to the treatment plan as explained to me for my medical symptoms, complaints, illness. If I am referred for chiropractic or physical therapy services, I understand it is part of this practice and consent.

Chiropractic / Physical Therapy

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic and physical therapy procedures, including various modes of physical therapy on me (or on the patient named below, for whom I am legally responsible) by the chiropractors and physical therapists who now or in the future work at the clinic or office listed above or any other office or clinic.

I understand and am informed that, as in the practice of medicine, in the practice of physical therapy and chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor and/or physical therapist to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor/therapist to exercise judgment during the course of the procedure which the doctor/therapist feels at the time, based upon the facts then known to him or her, is in my best interest.

I have read, or have had read to me, the above consent. By signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

All procedures (medical, chiropractic and physical therapy) will be covered by this consent and will be in effect until the patient revokes the consent in writing to this practice.

I understand that results are not guaranteed.

Patient's Signature_____ Date _____

Parent/Guardian Signature _____ Date _____

NOTICE OF PRIVACY PRACTICE

This notice of privacy practice discloses how health information about you may be used.

Primary Spine & Rehab, LLC uses health information about you for treatment, to obtain payment for treatment with your authorization as required (check your state laws), for administrative purposes, and to evaluate the quality of care that you receive.

Primary Spine & Rehab, LLC will not disclose your information to others unless you tell us to do so, or unless the law authorizes or requires us to do so.

Primary Spine & Rehab, LLC may use your information to provide appointment reminders, information about treatment alternatives or other health-related issues.

Primary Spine & Rehab, LLC may disclose your information for public health activities, to funeral directors to enable them to carry out their activities, for organ and tissue donations, research, health and safety, governmental function in order to comply with workers compensation laws and regulations, a right to request restriction, report and retain a copy of your health record, request communication of your information by alternative means at alternative locations, revoke your authorization and request an accounting of your health records.

You may complain to the Privacy Officer and to the Department of Health and Human Services if you believe your privacy rights have been violated. You will not be retaliated against for filing a complaint.

Primary Spine & Rehab, LLC must maintain the privacy of protected health information, provide you with notice of its legal duties and privacy practices with respect to your health information, abide by the terms of the notice, notify you if it was unable to agree to the requested restriction on how your information is used or disclosed, accommodate reasonable requests you may make to communicate with health information by alternative means or by alternative locations and obtain your written authorization to use or disclose your health information for reasons other than those listed above and permitted under law.

This notice of privacy practice will stay in effect until the patient revokes it in writing to this office.

If you have any questions or complaints please contact our office @ 860-763-2225.

Patient's Signature: _____ Date: _____

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MEDICAL RELEASE

I, _____, DOB _____, authorize _____ to release my Protected Health Information, as described below, to:

PRIMARY SPINE & REHAB, LLC
143 Hazard Avenue
Enfield, CT 06082

Please fax all records to:
(860) 763-3161

I request that the information to be released consist of the following (CHECK ALL THAT APPLY):

❏ Complete Medical Record ❏ Medical History, Evaluation Records ❏ Immunizations
❏ Treatment or Tests ❏ Hospital Records including Reports ❏ X-ray Reports
❏ Allergy Records ❏ Laboratory Reports ❏ Px Data
❏ Consultation Documentation ❏ Surgical Reports
❏ Other (Specify):_____

I also specifically authorize that any sensitive information be released to the above referenced recipients regarding (CHECK ALL THAT APPLY):

❏ HIV/AIDS ❏ Substance Abuse (alcoholism or drug abuse) ❏ Mental Health

It is my understanding that the information to be released will be used for the following purposes (CHECK ALL THAT APPLY):

❏ At the request of the individual (no purpose need be specified) ❏ Additional Medical Care
❏ Insurance Eligibility/Benefits ❏ Change of Provider ❏ Legal Investigation or Action
❏ Other (Specify): _____

INDIVIDUAL'S RIGHTS RELATING TO THIS AUTHORIZATION:

I understand that I must be provided with a copy of this form if I choose to sign it. I understand that I am under no obligation to sign this form and that the practice may not condition my treatment, payment, or enrollment/ eligibility for benefits on my decision to sign this form. I understand that I may revoke my Authorization or to receive a copy of my revocation, I am to contact Dr. Sadowski @ (860) 763-2225. I am aware that my revocation will not be effective as to uses and/or disclosures of my health information that the person(s) and or organization(s) listed above have already made in reliance on this Authorization.

I have had an opportunity to review and understand the content of this Authorization form. By signing this Authorization, I am confirming that it accurately reflects my wishes. This release will be in effect until the patient notifies the office in writing to terminate the release.

Patient's Signature:_____ Date:_____

Guardian's Signature (if applicable):_____

Description of Guardian's Relationship: _____