Alpine Spinal Rehabilitation

Name _____ Hm# _____ Cell # _____

Local Address _____ City _____ State ____ Zip_____

Perm. Address _____ City _____ State ____ Zip_____

Email _____

Sex M F

Age _____

B-Day _____

Social Sec# _____

Marital Status S M D

Spouse _____

Guardian _____

Primary Doctor _____

Address: _____

Dentist _____

Address: _____

_____

Your Employer _____

Phone # _____

Accidents

Were you in an auto accident?_____

Was it work related? _____

Were you at fault? _____

Was anyone else in the car? _____

Do you have an attorney? _____

Attorney's Name_____

Insurance Information

Name of Company _____

Subscriber's Name _____

Policy # _____

Group # _____

Billing Information:

I understand and agree that health and accident insurance policies are an arrangement between the insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse co-issued remittances for the convenience of credit to my account. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. It is my understanding that my credit may be checked if Alpine Spinal Rehabilitation Center extends credit to me and I also hereby authorize the doctor at Alpine Spinal Rehabilitation Center and whomever he may designate as his assistants to administer treatment as they so deem necessary and I also authorize the release of any information acquired in the course of my examination or treatment. In the event that full payment for charges incurred in my medical care is not made, I agree to pay all costs of collection, not to exceed up 40% of the unpaid balance. As allowed by Utah Code Annotated Sec. 12-1-11. In the event a lawsuit is brought to collect the unpaid balance, the undersigned further agrees to pau all other costs and reasonable attorney fees, in addition to, the collection fee. The terms of this paragraph shall apply to all amounts(s) are incurred today or after today. I certify that the above information is true and correct.

This assignment will remain in effect until revoked by me in writing. A photocopy of this agreement is to be considered as valid as the original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment.

Print _____ **Sign** _____ **Date** _____

Consent to treat a minor:

I hereby authorize Alpine Spinal Rehabilitation Center and whomever they may designate as their assistants to administer diagnostic and chiropractic care as they deem necessary for _____ for whom I am the parent or legal guardian.

Signature of Parent/Guardian: _____ **Date:** _____

Personal History

Mark the following conditions that apply to you now or at any time in the past.

- __Cancer
- __Heart Disease
- __High Blood Pressure
- __Diabetes
- __Epilepsy
- __Arthritis
- __Osteoporosis
- __Dizziness
- __Facial Weakness
- __Headache
- __Limb Weakness
- __Loss of consciousness
- __Loss of memory
- __Numbness
- __Seizures/convulsions
- __Sleep disturbance
- __Slurred speech
- __Stroke
- __Tremors
- __Loss of balance
- WOMEN: Pregnant? Y___N___

Lifestyle Habits

How often do you exercise ___Never ___2x/week ___3x/week ___5x/week

Do you use tobacco? ___Yes ___No Pks/week_____ Alcohol? ___Yes ___No Number drinks/week?_____

How many hours per day do you use a computer? Number of hours spent driving daily?

Family History

Mark the following conditions as they pertain to an immediate family member:

	Mother	Father	Brother	Sister
Cardiovascular Disease	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____
Cancer	_____	_____	_____	_____
Stroke	_____	_____	_____	_____

Injuries

Auto Collisions, Job, Sports, Other Injuries: Please list all history.

type of injury | type of treatment received | date of injury

Hospital / Medicine

Have you ever been hospitalized? ___Yes ___No For What reason? _____

Please list all surgeries you have had. _____

Please list all broken bones or dislocations you have had. _____

Have you ever been knocked unconscious? ___Yes ___No

Do you have any implantable medical device in your body? ___Yes ___No List _____

Please list all **medications** you are currently taking and for what purpose. _____

I understand and agree to the following:

- It is my responsibility to complete the clinic's forms accurately and to notify the doctor if any of my information changes.
- A history, consultation, examination and x-rays are conducted for diagnostic and informational purposes.
- My case may not be accepted for treatment at this clinic.
- If the doctors believe that I may respond to their care, additional service may be recommended and I will be advised of applicable cost.

patient printed name | patient signature | date

ALPINE
SPINAL REHABILITATION CENTER

Welcome to our Office

We are so glad you are here today. If you need help with this form or any of our procedures, just ask. It is our pleasure to help you. Please fill this form out as completely as possible.

Our Privacy Practices

In our office, all health information is considered confidential and we are careful about how we use it. This notice describes how your health information may be used and disclosed and how you can get access to this information.

We may share your health information to:

- Treat you
- Discuss your case with family
- Collect payment
- Do Research
- Run our office
- Include you in care classes
- Inform you about services
- Thank you for referring other patients
- Health & Safety reasons
- Reporting to worker's compensation
- Reporting to law enforcement officials
- Reporting victims of abuse
- Court hearings and filings

You have the right to:

- Request a copy of your health record (an additional fee may be involved)
- Request confidential communications
- Request a list of whom we share your health information with
- Amend you protected health information
- Ask us to limit the information we share
- Advise our management if you believe your privacy rights have been violated

These privacy practices are effective: October 15, 2009
For further information, please contact: Julie@alpinespinalrehab.com

Assignment of benefits

By signing below, I authorize that payment of charges be made directly to the doctor of this clinic. This authorization includes:

-All insurance reimbursement for services rendered including those which may be payable to me under my insurance plan.
-Amounts owed, on my behalf, from proceeds of any settlement related to my case.

Information Release

By signing below, I authorize the release of any necessary information to my insurance companies, pre-paid health plan or account, or government managed health plan or program to request payment of benefits to me or my assignee.

I understand and agree to the following:

- The privacy practices have been satisfactorily explained to me.
- I understand that the purpose of today's visit is to determine if I would likely respond to the doctor's care and that my case may not be accepted for treatment.
- I understand the assignment of benefits portion of this form.
- I understand the information release portion of this form.

patient printed name | patient signature | date

ALPINE
SPINAL REHABILITATION CENTER

You are invited to participate in our patient referral program. When you refer a friend we would like the opportunity to recognize you by posting your name on our referral board located in the front of our office and/or use your name for other marketing purposes including but not limited to: promotions, referrals and displays in our office.

I understand that by signing below I am allowing Alpine Spinal Rehab to use only my name. I understand that my protected health information will not be affected and that Alpine Spinal Rehab continues to be committed to protecting my privacy and remaining in compliance with all HIPPA laws regulations.

I also understand that I may revoke this consent at any time, by making a request in writing, except for information already used or disclosed.

I _____ hereby CONSENT to allow Alpine Spinal Rehab to use or disclose my name for marketing purposes including but not limited to: promotions, referrals and displays in the office

Signature: _____ Date: _____

OR

I _____ hereby DECLINE to give my consent to allow Alpine Spinal Rehab to use of disclose my name for marketing purposes including but not limited to: promotions, referrals, and displays in the office.

Signature: _____ Date: _____

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Missed Appointment Policy

In an effort to facilitate the patient scheduling process in an organized manner, Alpine Spinal Rehabilitation Center has a Missed Appointment Policy.

This policy states that failure to give notice of a missed appointment before your appointment time will result in a $20.00 missed appointment fee.

This policy is set up in order to cut wait time for our patients and to ensure that they keep to their schedules of care.

I have read and agree to the terms set up in the above stated policy.

Print Name Date

Signature

Consultation Record

Patient Information

last name | first name

Area of Complaint/Location (R/L side?):

Onset—What Caused it?

Date of onset_____ or Gradual Onset

Referred/Radiating—to where?

Localized:

Quality ° Dull/Achy ° Burning ° Stabbing ° Tingling ° Numbness ° Other_____

Pain at Rest 0 1 2 3 4 5 6 7 8 9 10 Pain with Activity 0 1 2 3 4 5 6 7 8 9 10

Timing: Constant/Come & Go:

Worse in the: Morning / Afternoon / Evening

Makes Better: ° Ice ° Heat ° OTC pain med ° Massage ° Rest ° Other_____

Makes Worse:

Have you seen another provider for this condition? Who/When/Diagnosis/Treatment

Additional Signs and Symptoms associated:

Bowel/Bladder changes? Yes / No If yes, explain

How did you hear about our office? Please circle one:

Google Search Facebook Ad in the Mail A Friend(Name:_____

)

Doctor/Attorney(Name:_____) Insurance Other(Please Specify:_____)