Total Spine Chiropractic and Wellness Registration and History

Date:_____

Last Name:_____

First Name:_____

Street Address:_____

City:_____

State:_____

Zip Code:_____

Email:_____

Cell Phone:_____

Other Phone:_____

Birthdate:_____

Sex: Male Female

Occupation:_____

Work Phone:_____

Marital Status: _____

Please complete the following information if you have insurance in someone else's name

Name:_____

Relationship:_____

Birthdate:_____

Phone Number:_____

Patient History

Chief complaint? neck pain mid back pain lower back pain headache

Rate the severity of you pain on a scale from 1 (least) to 10 (most)
1 2 3 4 5 6 7 8 9 10

Describe your pain: Cramping Burning Sharp Dull ache Shooting Throbbing Tightness Tingling Numbness

How often are you in pain? Constantly, Comes and goes, only with movement

Does anything decrease the pain? Pain meds laying down sitting standing ice heat

Does the pain interfere with : work sleep exercising household duties taking care of children

Does anything make the pain worse? Standing Sitting Walking Bending Lifting Lying down

Please circle any of the following condition(s) that you have had

Spinal Surgery	Pacemaker	Fracture	Cancer	Epilepsy	Stroke
Bulging disc	Diabetes	Gout	Arthritis	Heart disease	
Bleeding Disorder	Headache	Neuropathy	Osteoporosis	Multiple Sclerosis	
Psychiatric Care	Parkinson's Disease	Rheumatoid Arthritis			

Occupation:_____

Work Activities: Sitting Standing Light labor Heavy labor

Pregnant: yes no

List surgeries:

_____

_____

_____

List all current medications/Allergies:

_____

_____

_____

List family history of Cancer, Stroke, High blood pressure, diabetes, heart disease, osteoporosis

_____

Auto Accident Information

Where you involved in a collision? Yes No

Date of collision:_____

Do you have an attorney? Yes No

Attorney name:_____

Attorney phone #:_____

Do you have health insurance? Yes No

Insurance name and plane #_____

Position in vehicle: Driver Passenger front rear Left Middle Right

Was the vehicle: Stopped Moving Turning Backing up

Were you wearing your seat belt? Yes No

Did the airbags deploy? Yes No

Did you hit your head? Yes No

Did you lose consciousness? Yes No

Did you have immediate pain? Yes No

Did you go to the hospital? Yes No

If yes, which hospital?_____

Date(s) you went to the hospital?_____

Where you transported by ambulance? Yes No

Have you had any X-rays, CAT Scans, or MRI'S? Yes No

If so where were they performed?_____

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

I, the undersigned, hereby authorize and direct any and all insurance claims, attorney, agencies, governmental departments, 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, present, or future ("conditions") to pay directly to and exclusively in the name of Total Spine Chiropractic and Wellness ("office") such sums as may be owing to Total Spine Chiropractic and Wellness with respect to my charges, applicable to all payers, however, I understand that nothing in this agreement shall be construed as an election of Total Spine Chiropractic and Wellness to claim protection under any statutory lien law. For the purposes of this Agreement, "benefits" shall include, but not be limited to, proceeds from any settlement, judgement, or verdict, as well as any proceeds relating to commercial health or group insurance, lost wage benefits, lost services benefit, attorney retainer agreements, medical payments benefits, personal injury protection, no-fault coverage, uninsured and underinsured motorist coverage, third party liability distributions, disability benefits, malpractice proceeds, and any other benefits or proceeds payable to me for the purpose 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 Total Spine Chiropractic and Wellness, I hereby assign, insofar as permitted by law, all of my rights, remedies, and benefits to Total Spine Chiropractic and Wellness 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 cases or action either in my name or in the Office's name, and to settle or otherwise resolve such cases 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 this office regarding my charges. Upon issuance, I hereby agree that such letter(s) of protection cannot be revoked or modified without the expressed written consent of this office. I further authorize Total Spine Chiropractic and Wellness to apply any credit balances on charges incurred by me to any other outstanding charges still owed by me, my spouse, or my dependents, regardless of whether these other charges are related to my condition.

I understand that I remain personally responsible for the total amount due Total Spine Chiropractic and Wellness for their services. This Agreement and Lien does not constitute any consideration for this Office to await payments and it may demand payment from me immediately upon rendering services at its option. If this Office must take any action to collect and outstanding balance on my account, I will be responsible for the payment and will reimburse Total Spine Chiropractic and Wellness for all costs of such collection efforts, including, but not limited to, all court costs and all attorney fees.

This Assignment and Lien shall not be modified or revoked without the mutual written consent of Total Spine Chiropractic and Wellness and myself. I hereby revoke any previously signed authorizations that conflict with the terms of this Assignment and Lien.

I agree that each and every provision of this Agreement is reasonably necessary for the protection of the rights and interest of Total Spine Chiropractic and Wellness 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:_____

Total Spine Chiropractic and Wellness
Informed Consent to Chiropractic Adjustments and Care

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical modalities and diagnostic x-ray, on me (or the patient named below, for whom I am legally responsible for) by Alfredo Vallejo III D.C.

I have had an opportunity to discuss with the doctor the nature and purpose of chiropractic adjustments and other procedures. I understand and am informed that, as in the practice of medicine, in the practice of chiropractic, there are some risks to treatment including, but not limited to, fractures, disc injuries, dislocations, and sprains. It is not reasonable to expect the doctor to be able to anticipate and explain all risks and complications of a given procedure on any particular visit, and I wish to rely on the doctor to exercise judgement during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interest.

Chiropractic treatment involves the science, art, and philosophy of locating and correcting spinal misalignments and as such, is oriented toward improvement of spinal function relative to range of motion, muscular and neurological aspects. There has been no promise, implied or otherwise of a cure for any symptom, disease, or condition as a result of treatment at this clinic. I understand that the chiropractor will use his hands or a medical device upon my body to adjust a joint, which may cause an audible pop. It is my intention to rely on the doctor to exercise professional judgement during the course of any procedures, which he feels at any time to be in my best interest. Neither the practice of the chiropractor or medicine is and exact science, but it relies upon information related by the patient, information gathered during examination, and the doctor's interpretation thereof, as well as the doctor's judgement and the expertise in working with like cases.

I understand that as a part of my healthcare, this practice originates and maintains health records describing my health history, symptoms, examinations, test results, diagnosis, treatment, and plans for future care and treatment. I understand that this information serves as a basis for planning my care and treatment; a means of communication among other health care professionals who may contribute to my care; a source of information for applying my diagnosis and treatment information to my bill; and a means by which a third party can verify that services were actually provided.

I have read or have had it read to me, the informed consent to chiropractic adjustments and care. I have also had the opportunity to ask questions about 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.

Date:_____

_____
Name (Print)

_____
Signature of Patient or Legal Guardian

Consent for use or disclosure of health information

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health care information.

1. We may have to disclose your health information to another health care provider or hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
2. We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
3. We may need to use your health information within our practice for quality control or other operational purposes.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or other healthcare operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree then your are bound to abide by my restrictions.

X _____
Patient Name (Print)

X _____ X _____
Signature Date

Designated Party Release

You may give Total Spine Chiropractic and Wellness Chiropractic written authorization to disclose your protected health information to anyone that you designate. If you would like to authorize a person to receive your protected health information, please complete the form below. You may also use this form to give your chiropractor and members of the practice staff consent to leave information on your voicemail, email, answering machine, or another party that you may designate.

This notice is effective as of _____. This authorization will expire seven years after the date on which you last received services from us.

At my request, I authorize Total Spine Chiropractic and Wellness to disclose my protected health information to:

For motor vehicle collisions, please list your attorney's name and phone number

Name:_____ Phone#_____

Name:_____ Phone#_____

X Authorized Signature:_____ X Date:_____

Emergency Contact

Name:_____ Relationship_____ Phone#_____

Total Spine Chiropractic and Wellness

Authorization for release of information

I hereby authorize the below health care facility/physician to release by health information to Total Spine Chiropractic and Wellness, including the treatment/testing for psychiatric problems, sexual assault, drug abuse and/or alcoholism, sickle cell anemia, and/or Acquired immunodeficiency syndrome (AIDS), or testing for infection with HIV.

Patient Name:_____

Birthdate:_____

Persons/organizations providing information: _____

Persons/organizations receiving information:_____

PLEASE FAX RECORDS TO _____

Information requested:

_____ Imaging Reports

_____ All Records Date:_____

X_____ X_____

Signature of patient/patient's representative Date

confidential information

This facsimile contains information that is confidential and/or legally privileged. The information is intended only for the use of the individual or entity named on this transmission sheet and may not be disseminated to any other party without permission. If you are not the intended recipient or the employee/agent responsible for delivering the message to the intended recipient you are hereby notified that any dissemination, disclosure, distribution copying or taking of any action in reliance on the contents of this information is strictly prohibited. If you have received this facsimile in error, please notify us immediately by telephone at (808) 259-2383 to arrange for the return of these documents without cost to you.