THE BACK PAIN CENTER

PATIENT RECORD

Home Phone: _____

Name: _____ Work Phone: _____

Street: _____ Cell Phone: _____

City: _____ State: _____ Zip: _____ E-mail: _____

Mailing Address (If different): _____ City: _____ State: _____ Zip: _____

Age: _____ Date of Birth: _____ / _____ / _____ Social Security Number: _____

Employer: _____ Occupation: _____

Marital Status (Check) ❑ Single ❑ Married ❑ Widowed ❑ Separated ❑ Divorced How Many Children? _____

Spouse's Name: _____ Work Phone: _____

Employer: _____ Occupation: _____

Other Nearest Relative: _____ Phone: _____

Insurance Company: _____ Insurance ID#: _____

Insured's Social Security #: _____ Insured's Date of Birth: ____ / ____ / ____

Type of Coverage: ❑ Major Medical ❑ Worker's Comp ❑ Personal Injury (Auto Acc.) ❑ Medicare ❑ Cash

If this is major medical insurance, is this condition the result of an accidental injury? ❑Yes ❑No If Yes, Date: ____ / ____ / ____

Describe Injury: _____

Referred by: ❑ Friend _____ ❑ Phone Book ❑ Sign ❑ Mailer ❑ Other _____

List present complaints:

1. _____
2. _____
3. _____

Is this condition interfering with your:

❑ Work ❑ Sleep ❑ Daily Routine ❑ Other _____

Have you seen any other Doctors for this condition? ❑ Yes ❑ No

If Yes, Describe _____

List Surgical Operations & Years: _____

_____

_____

Family History of Health Problems: _____

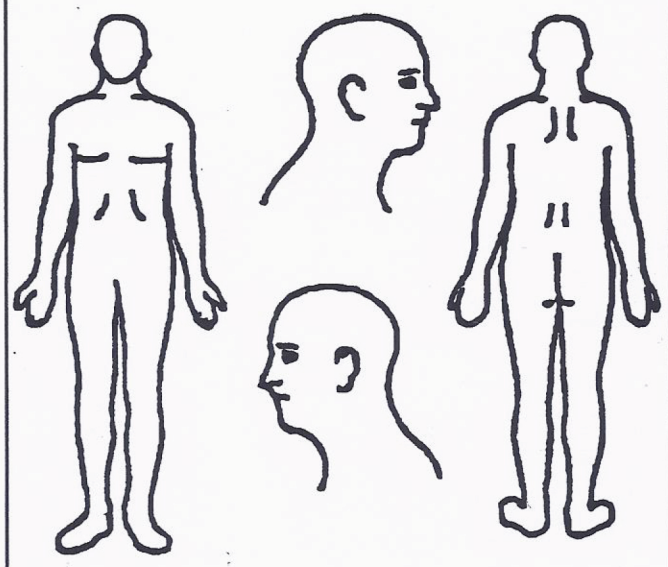
_____

List Current Medications: _____

_____

_____

Please mark your areas of pain on the figures below.



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 and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient's Signature: _____ Date: _____

Parent Guardian or
Spouse's Signature Authorizing Care: _____ Date: _____

AUTOMOBILE OR WORK INJURY QUESTIONNAIRE

Date of Accident: _____ Hour _____ ❑ AM ❑ PM Location: _____

How Did the Accident Occur? ❑ Auto Collision ❑ On-the-Job Injury ❑ Other: _____

Please Describe the Accident or Injury: _____

_____

_____

List the extent of the injuries as you know them: _____

_____

_____

Did you require Post-Accident Hospitalization? ❑ Yes ❑ No If yes, when? _____

Please describe: _____

_____

Have you had similar accidents or injuries? ❑ Yes ❑ No If yes, when? _____

Have you lost any days of work? ❑ Yes ❑ No If yes, dates _____

Insurance companies involved:

Company of person responsible for injuries: _____ Phone: _____

Address: _____ Adjuster _____

City _____ State _____ Zip _____ Claim # _____

Your Company: _____ Phone: _____

Address: _____ Adjuster _____

City _____ State _____ Zip _____ Claim # _____

Other Company(s): _____ Phone: _____

Address: _____ Adjuster _____

City _____ State _____ Zip _____ Claim # _____

Do you have an attorney that has advised you in this case? ❑ Yes ❑ No If yes, please give:

Attorney's Name: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

COMPLETE THIS SECTION ONLY IF WORK INJURY

If Work Related, Did You Report The Injury To Your Foreman or Employer? ❑ Yes ❑ No

Name of the Foreman or Authorized Person _____ Phone # _____

AUTHORIZATION AND ASSIGNMENT

TO _____ D.C.

In consideration of your undertaking to treat me, I agree to the following:

Authorization To Release Information

You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred by me as a result of professional services rendered by you, and I hereby release you of any consequence thereof.

Assignment of Cause of Action

In the event any insurance company is obligated by contractual agreement to make payment to me or to you for the demand by you, I hereby assign and transfer to you the cause of action that exists in my favor against any such company (the name(s) of which is/are believed to be correctly set forth under pertinent data below) and authorize you to prosecute said action either in my name or your name as you see fit and further authorize you to compromise, settle or otherwise resolve said claim as you see fit. However, it is understood that until all reasonable efforts have been made to collect the sums due from the insurance company (or companies) contractually obligated, you will refrain from attempts and efforts to collect the amounts owed directly from me. I understand that whatever amounts you do not collect from insurance proceeds (whether it be all or part of what is due), I personally owe you, and agree to pay in a current manner.

Authorization to Pay Directly to Doctor

To _____

(Name of attorney and/or insurance company)

In consideration of the chiropractic services rendered and to be rendered by him, I authorize and direct the payment to the doctor named above of any sum I now or hereafter owe him by you, my attorney, out of the proceeds of any settlement of my case, and/or by any insurance company obligated to reimburse me for the charges for his services or otherwise obligated to reimburse me for the charges for his services or otherwise obligated to make payment to me or him based in whole or in part upon the charges made for his services. If my current policy prohibits direct payment to the doctor, then I hereby also instruct and direct you to make out the check to me and mail it as follows:

c/o

_____

_____

_____

Acknowledgement and Understanding

I hereby acknowledge that I am receiving (or about to receive) health care services at the Back Pain Center Chiropractic Offices, and that I have been advised that the doctor(s) providing the services is/are willing to wait for payment for these services, provided that there continues to be a reasonable chance that payment will be made either by insurance proceeds or out of the settlement of a liability claim.

I understand that if it is determined either:

(a) That there is no insurance company obligated to pay for the services, or if the insurance company involved refuses to acknowledge an assignment to the doctor(s) or make other provisions for the protection of the interest of the doctor(s); or

(b) If a liability claim exists, and my attorney refuses to agree to protect the interest of the doctor(s), or if I have not engaged the services of an attorney;

then payment for services rendered by the doctor(s) at the Back Pain Center Chiropractic Offices will be made on a current basis and my bill paid in full as soon as my liability claim is settled or the passage of three months from my last treatment, whichever occurs first.

Dated the _____ day of _____ , 20 _____ .

_____

(Patient's Signature)

_____

(Witness)

Informed Consent to Chiropractic Treatment

The nature of chiropractic treatment: The doctor will use his/her hands or mechanical device in order to move your joints. You may feel a "click" or "pop", such as the noise when a knuckle is "cracked", and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic Ultrasound, cervical and lumbar traction, intersegmental traction or exercise rehabilitation may also be used.

Possible Risks: As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon sever injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or minor complications.

Probability of risks occurring: The risks of complications due to chiropractic treatment have been described as "rare", about as often as complications as seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke, has been estimated at one in one million to one in twenty million, and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered "rare".

Other treatment options which could be considered may include the following:

- *Over-the-counter medications.* The risks of these medications include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases. Medications often mask the cause of the pain.

- *Massage.* Treats muscle tightness and soreness. The risks with massage are very low. A massage therapist cannot diagnose your condition.

- *Medical care,* typically anti-inflammatory drugs, muscle relaxers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.

- *Hospitalization* in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.

- *Surgery* in conjunction with medical care adds the risks of adverse to anesthesia, as well as an extended convalescent period in a significant number of cases.

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue, nerve irritation and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is possible that delay of treatment will complicate the condition and make further rehabilitation more difficult.

I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and hereby give my full consent to treatment.

Printed Name Signature Date

WITNESS:

Printed Name Signature Date

THE BACK PAIN CENTER

1796 West Causeway Approach
Mandeville, LA 70471
985.626.1671

Consent to use PHI

Acknowledgment for Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of your Protected Health Information

Your Protected Health Information will be used by The Back Pain Center, or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. I have received a copy of the Notice of Patient Privacy Policy. _____Patient Initials

E-mail and Texting Correspondence Disclosure

We send all appointment reminders and other communication via e-mail and phone correspondence. We also offer text messaging appointment reminders. I understand that certain charges may apply according to my phone carrier contract. I understand I can opt in or out of e-mail or text communication anytime. _____Patient Initials

Requesting a Restriction on the Use or Disclosure of Your Information

- You may request a restriction on the use or disclosure of your Protected Health Information.
- This office may or may not agree to restrict the use or disclosure of your Protected Health Information.
- If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Notice of Treatment in Open or Common Areas

Describe and Notify private areas available upon request

Revocation of Consent

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

By my signature below I give my permission to use and disclose my health information.

Patient or Legally Authorized Individual Signature _____ Date _____

Print Patient's Full Name _____ Time _____

Witness Signature _____ Date _____