PHENIX CITY SPINE & JOINT CENTER

WELCOME

Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell #: _____

Cell Phone Carrier: _____ Race: _____

Ethnicity: Hispanic Non Hispanic

Date of Birth: _____ Age: _____ SSN: _____

Employer: _____ Occupation: _____

Work Phone: _____ Email: _____

Marital Status: M S D W Spouse Name: _____

Please list ALL medications

Name Of Medication	Dosage/ Strength	Frequency	Date Started

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

Name of Insurance Co: _____

Policy #: _____ Group #: _____

Phone #: _____

Address: _____

If Using Spouse's Card

Their Date of Birth: _____ Spouse SS #: _____

Known Allergies:

_____

_____

_____

Emergency Contact Information

Name: _____ Phone: _____

Name: _____ Phone: _____

PHENIX CITY SPINE & JOINT CENTER

Accident Information

Do you have an Attorney? Y N

Law Firm Name: _____

Attorney Name: _____

Phone: _____ **Fax:** _____

What type of accident: **AUTO** **WORK**

SLIP/FALL **OTHER**

Date of accident: _____

Location: _____

City/State of Accident: _____

AUTO ACCIDENT INFORMATION (circle one)

YOU were:

DRIVER **PASSENGER—Front**

PASSENGER REAR-(DRIVERS SIDE) or (PASSENGER SIDE)

Describe the accident as completely as possible:

_____

_____

_____

_____

Which of the following applies? Circle those that apply to you.

MY SEAT WAS TILTED BACK BEFORE THE ACCIDENT

MY SEAT BROKE **I WAS THROWN FROM CAR**

I DON'T REMEMBER ANYTHING **I WAS WEARING A LAPBELT**

I WAS WEARING A 3 POINT SEAT BELT

MY AIRBAG EXPLODED INTO ME **THE CAR FLIPPED OVER**

THE CAR SPUN AROUND **THE GLASS BROKE** **IN CARSEAT**

WORK—SLIP/FALL—OTHER ACCIDENT INFORMATION

Date of Slip / Fall: _____

City/State: _____

Where did the accident occur? _____

_____

What happened? _____

_____

_____

Where there Witnesses? Y N

Primary Medical Information

Who is your Primary Care Physician:

_____

PCP Phone: _____

PCP Fax: _____

Have you seen a Chiropractor before? Y N

Who was the Chiropractor? _____

How did you find out about this office? _____

Today's Date: _____

ALL ACCIDENT RELATED MUST FILL OUT THE FOLLOWING:

Have you gone to a Doctor? Y N Who? _____

What did they tell you? _____

_____

Were you cut or bleeding? Y N Where? _____

Bruises? Y N Where? _____

There was immediate pain : Head Neck Upper Back Mid Back Lower Back Hips Legs
Pain occurring later into the : Head Neck Upper Back Mid Back Lower Back Hips Legs
After the accident, what did you do? Went home & took it easy Went to work Took over the counter medications Taken to the hospital by ambulance Taken to hospital by friend Drove to Hospital Drove to Medical Doctor Drove to Chiropractic office

What Hospital did you go to: _____

Date & Time: _____ **Were you admitted? Y N**

X– Rays Taken : NONE Neck Chest Shoulder Knee Other

Were you given prescriptions? Y N What? _____

What did they tell you? _____

Have you seen any other Doctors or Chiropractors? Y N

Name of Doctor(s)? _____

List your current complaints in order of severity.

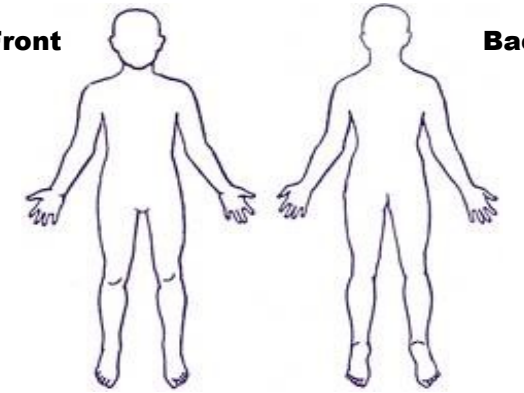
On a scale of 0 to 10 with 0 being NO PAIN and 10 being unbearable pain, rate each of your complaints listed.

What hurts the worst	Rate from 0—10	How & When does it hurt?

Please label the areas of complaint and tell us if the pain is:

sharp, dull, burning, etc.

Front **Back**



Past Health History

Have you been in an accident or had a major injury prior to today? Y N

Tell us about it: _____

_____

Are you pregnant? Y N Please list in detail any previous hospitalizations

_____

Circle if you have or had: Sickle Cell Diabetes HIV Cancer Osteoporosis Epilepsy Rheumatoid _____

CONSENT FOR TREATMENT:

I, _____ (Print Name), 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. Complications to chiropractic care may include rib fracture and stroke, however, specific tests designed to minimize these risks are employed and do minimize these outcomes. 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 or receive 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.

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.

Parent / Guardian Signature

Name Printed: _____ Date: _____

Name Signed: _____ Date: _____

Witness

Name Signed: _____ Date: _____

Assignment of Benefits

Today's Date: _____

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—P.O. 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 manner, any balance 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: _____ Date: _____

Name Signed: _____ Date: _____

Witness

Name Printed: _____ Date: _____

Name Signed: _____ Date: _____

Today's Date: _____

Date of Injury: _____ **Policy / Claim #** _____

Contract for Services including the LIEN AGREEMENT and

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 or guardian name clearly) _____ here forth known as "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 interest of the Phenix City Spine & Joint Center, LLC.

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.

If there is an attorney representing me, this lien against me is to be enforced against the third party insurance company for direct payment or payment through the attorney at the discretion of the clinic. If the clinic at it's discretion does allow payment from the attorney, the patient is bound personally and jointly with the attorney, if retained, or other noted counsel responsible for the total amounts due to said office. The attorney is only 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.

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. The clinic may perfect an AL lien or obtain a letter of protection from any attorney representing me in this case.

Patient Name—PRINTED: _____

Signed: _____ Date: _____

Witness Name—PRINTED: _____

Signed: _____ Date: _____

Attorney Name - (firm or individual): _____

Signed: _____ Date: _____

If another attorney is involved:

Attorney Name - (firm or individual): _____

Signed: _____ Date: _____

Insurance Company: _____

Adjuster Name: _____

Signed by Representative: _____ Date: _____

Today's Date: _____

HIPAA PRIVACY Statement for the PHENIX CITY SPINE & JOINT CENTER

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 date 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 the right to:

- ◊ Request a restriction on certain uses and disclosures of your information as provided by CFR 164.522
- ◊ 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:

- ◊ 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

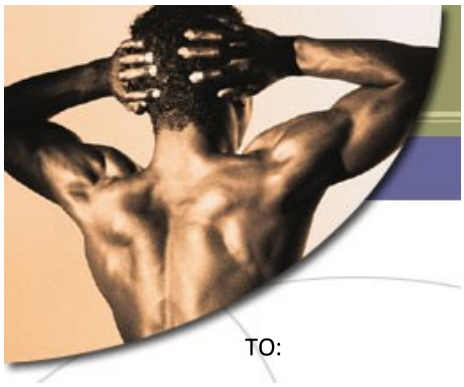
We reserve the right to change our practices and make new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you have supplied to us.

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

For more information, questions, or to report a problem, you may contact our HIPAA Privacy Officer at (412) 446-9100. If you believe your privacy rights have been violated, you may file a complaint with our HIPAA Privacy Officer. There will be no retaliation for filing a complaint.

I have read the HIPAA PRIVACY STATEMENT and Understand: _____ Initial

(HIPAA stands for the "health insurance portability and accountability act")



Phenix City Spine & Joint Center

Stephen B. Cooper, DC

3700 South Railroad St. Suite B

Phenix City, AL 36867 **334.298.7700 office / 334.298.7071 fax**

TO:

_____

_____

_____

This is a formal request for medical records, x-ray's, MRI's, Lab Tests and reports be sent to Phenix City Spine and Joint Center to the above address or faxed to: 334-298-7071 regarding the patient:

Patient Name (printed)

_____

Social Security Number Birth date

_____ _____

Please send records by this date: _____

Patients Signature for Release:

_____ _____

Patient Signature Today's Date (request expires 30 days from this date)

If you have any questions, please call us at 334-298-7700. We appreciate your promptness for this request.

Thank You,

Phenix City Spine & Joint Center

Dr. Stephen B. Cooper

Accident Form

PERSONALfMEDICAL INFORMATION

DISCLOSURE AGREEMENT

I,_____ , hereby authorize Phenix City Spine & Joint Center, LLC, its agents/employees, as well as its counsel, Richard L. Cross, Jr., Cross Law Firm, its agents/employees to investigate the existence of insurance coverage relating to that injury sustained on _____and being more specifically identified as follows:

_____

_____

I understand that Phenix City Spine & Joint Center, LLC will need to reveal the minimal amount of information it deems necessary to Cross Law Firm to cause this investigation. Generally, this will be limited to wreck report and existence of injury associated with such applicable insurance coverage.

I understand Cross Law Firm and/or Phenix City Spine & Joint Center LLC, may need to disclose some or all of the information authorized herein to applicable insurance company and/or purported tort feasor/applicable third party (as is deemed by Phenix City Spine & Joint LLC/Cross Law Firm to be necessary to ascertain existence of applicable insurance coverage).

I hereby authorize Phenix City Spine & Joint LLC and Cross Law Firm to make all such necessary disclosures, as they deem necessary to ascertain existence of insurance coverage. I agree to hold Phenix City Spine & Joint Center LLC its agents/employees and Cross Law Firm, including its agents/employees as well as associated medical/legal professionals for any loss I may suffer as a result.

I have been advised of my opportunity to discuss/have this authorization reviewed by independent counsel before executing the same. I have either obtained independent legal counsel's opinion and agree to this Authorization or hereby waive my right to the same and agree to this Authorization. 1have read and understood the terms and ramifications outlined herein. I voluntarily accept the same.

I understand Cross Law Firm does not represent me in this Authorization or action authorized herein. Cross Law Firm and associated legal professionals are counsel of Phenix City Spine & Joint LLC and will be acting in Phenix City Spine & Joint's best interest. Benefit to me is and shall be deemed incidental to any action taken by Cross Law Firm seeking coverage or serving Phenix City Spine & Joint. I understand that I am solely responsible for my debt to Phenix City Spine & Joint for services/treatment rendered and shall pay/cause payment of the same.

Signed this __ day of _____ , 20__

_____ Witness

_____ Patient

_____ Witness

_____ Print Name

_____ Guardian (if applicable)

_____ Print Name

Sworn to and subscribed before me
this the ___ day of _____ 20__ .
Notary Public
My commission expires _____.

Accident Form