



DATE

First Name:	Last Name:	Date Of Birth:
☎ Home Phone:	☎ Mobile Phone:	☎ Work Phone:
@ E-Mail:	Preferred Communication: (Circle) H ☎ M ☎ W ☎ E@	
Street Address:	Apt/Suite :	
City:	ZipCode:	State:

SSN:	Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male	Preferred Language: <input type="checkbox"/> English <input type="checkbox"/> Other _____
Race & Ethnicity: <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> Black or African American <input type="checkbox"/> White <input type="checkbox"/> Other		Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Separated
Emergency Contact Name:	☎ Phone:	☎ Relationship:

Primary Care Provider Name:	Phone:
Street Address:	Apt/Suite #:
City:	ZipCode: State:

Employer/Company Name:	☎ Phone:
Street Address:	Apt/Suite #:
City:	ZipCode: State:
Job Title/Position:	Currently Working: <input type="checkbox"/> Yes <input type="checkbox"/> No ⇨ Date Stopped Working:

Insurance Detail

Primary Insurance Coverage

Insurance Company	Policyholder Name:
Insurance ID #:	Group Number:
Plan Name:	☎ Phone Number:
Street Address:	Suite/Unit #:
City:	ZipCode: State:
(Office Use) Policy Effective Date(s):	Payer ID:
Co-Pay \$:	Co-Insurance %: Deductible:

Secondary Insurance Coverage

Insurance Company Name:	Policyholder Name:
Insurance ID #:	Group Number:
Plan Name:	☎ Phone Number:
Street Address:	Suite/Unit #:
City:	ZipCode: State:
(Office Use) Policy Effective Date(s):	Payer ID:
Co-Pay \$:	Co-Insurance %: Deductible:

Financially Responsible Party

<input type="checkbox"/> Self		<input type="checkbox"/> Other (If Other Please Complete Section Below)	
First Name:	Last Name:	Date Of Birth:	
Home Phone:	Mobile Phone:	Work Phone:	
@ E-Mail:		Relationship With Patient:	
Street Address:		Apt/Suite #:	
City:	ZipCode:	State:	

Medical Detail

Reason For Your Visit

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<input type="checkbox"/> Wellness & Health Maintenance			
<input type="checkbox"/> Injury, Pain Complaint, or Ailment		Date Of Injury (When Did Your Pain Start?)	
<input type="checkbox"/> Accident	<input type="checkbox"/> Automobile Related Accident <input type="checkbox"/> Other Type Of Accident	Date Of Accident:	State: Where Accident Occurred
Please Provide Brief Details Of Your Injuries & Pain:			

Referring Provider

<input type="checkbox"/> I Was Referred By My Primary Care Physician (Same Doctor Listed On First Page)	
<input type="checkbox"/> I Was Referred By Another Doctor (Please Fill Out Doctor Info Below)	
Referring Provider Name:	Phone:
Street Address:	Apt/Suite #: @ E-Mail:
City:	ZipCode: State:

Representative Details (If You Are Being Represented By An Attorney For An Accident Please Provide Info)

Referring Provider Name:	Phone:
Street Address:	Apt/Suite #: @ E-Mail:
City:	ZipCode: ZipCode:

Medical History

Lifestyle

DATE

Are You A Smoker?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If Yes ⇨ How Often? _____ / Day / Week
Do You Drink Alcohol?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If Yes ⇨ How Often? _____ / Day / Week
Do You Exercise?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If Yes ⇨ How Often? _____ / Day / Week

Have You Ever Been Hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No	Have You Had Any Surgeries? <input type="checkbox"/> Yes <input type="checkbox"/> No
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If Yes, Please List Dates/Details:

Do You Have Any Allergies? Yes No ⇨ Do You Require Medical Treatment For Your Allergies? Yes No

If Yes, Please Provide Details:

Do You Take Any Medications? Yes No

Please List All Medications & Dosage (How Much & How Often?)

Please Provide Any Other Medical Information You Feel The Doctor Needs To Know About

Patient Signature

Date

Patient Name _____

Date _____

Spouse

First Name _____ Middle Initial _____ Last Name _____

Home Phone (_____) _____ - _____ Work Phone (_____) _____ - _____

Date of Birth ____/____/____

Emergency Contact

Contact Name _____ Relationship to Patient _____

Home Phone (_____) _____ - _____ Cell Phone (_____) _____ - _____

How did you hear about our office?

Medical Conditions: (Check all that apply to you)

- Arthritis Cancer Diabetes Heart Disease
- Hypertension Psychiatric Illness Skin Disorder Stroke
- Other _____ Fibromyalgia Asthma Osteoporosis

Surgeries: (Check all that apply to you)

- Appendectomy Cardiovascular procedure Cervical spine Hysterectomy
- Joint Replacement Prostate Lumbar spine Gall Bladder
- Brain Shoulder Thoracic spine Knee
- Carpal Tunnel Gastro-intestinal Uro-genital Hernia Breast Augmentation
- Other _____

Allergies: (Check all that apply to you)

- Mold Seasonal Milk or Lactose Animal Chemical _____
- Sulfites Wheat/Glutens Other

Social History: (Check all that apply to you)

- Caffeine use: occasional often never
- Drink Water: <64 oz/day >64 oz/day never
- Sleep: <8 hours/night >=8 hours/night Insomnia

Family History: (Check all that apply)

- Arthritis: Parent Sibling Cancer: Parent Sibling
- Diabetes: Parent Sibling Heart Disease Parent Sibling
- Hypertension Parent Sibling Stroke Parent Sibling
- Thyroid Parent Sibling Other _____

Occupational Activities: (Check one that best describes your job description)

- Administration Business Owner Clerical/Secretary
- Computer User Heavy Equipment operator Daycare/Childcare
- Construction Health Care Food Service Industry
- Medium Manual Labor Manufacturing Home Services Heavy Manual Labor
- Other _____
- Light Manual Labor Executive/Legal Housekeeper

Signature of patient or responsible party _____

Date _____

I acknowledge that any gift certificates/cards that I may present in this office is not redeemable for cash. I also acknowledge that if I wish to receive any additional services that are not described on the gift card, I am responsible for payment for those services. Any discounted or free services described on the gift certificate are only applicable on the day that the gift certificate is presented.

Review of Systems – (Check box if you have had trouble with any of the following)

Cardiovascular	Past	Present	No	Respiratory	Past	Present	No	Allergic/Immunologic	Past	Present	No
Poor Circulation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hives	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Immune Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Aortic Aneurism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Short Breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Allergy Shots	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cold/Flu	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cortisone Use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pace Maker	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ear, Nose and Throat	Past	Present	No
Jaw Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eyes	Past	Present	No	Difficulty Swallowing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Irregular Heartbeat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Swelling of legs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sore Throat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Genitourinary	Past	Present	No	Blurred Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nosebleeds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric	Past	Present	No	Sinus Infections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Burning Urination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Gums	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Frequent Urination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood in Urine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gastrointestinal	Past	Present	No
Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lower Side Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gall Bladder Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Endocrine	Past	Present	No	Bowel Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neurologic	Past	Present	No		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Liver Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Head Injury	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hair Loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Brain Aneurysm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Menopausal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nausea/Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Numbness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	PMS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bloody Stools	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Severe Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Poor Appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pinched Nerves	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hematologic	Past	Present	No		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Parkinson's	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Musculoskeletal	Past	Present	No
Carpal Tunnel	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gout	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vertigo	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Blood Clots	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Joint Stiffness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Constitutional	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bruising	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Muscle Weakness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Past	Present	No	Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fever, Chills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Broken Bones	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Weight Loss/Gain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sweating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Joints Replaced	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Low Energy Level	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Varicose Vein	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neck Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty Sleeping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Low Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Upper Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Signature of patient or responsible party

Date

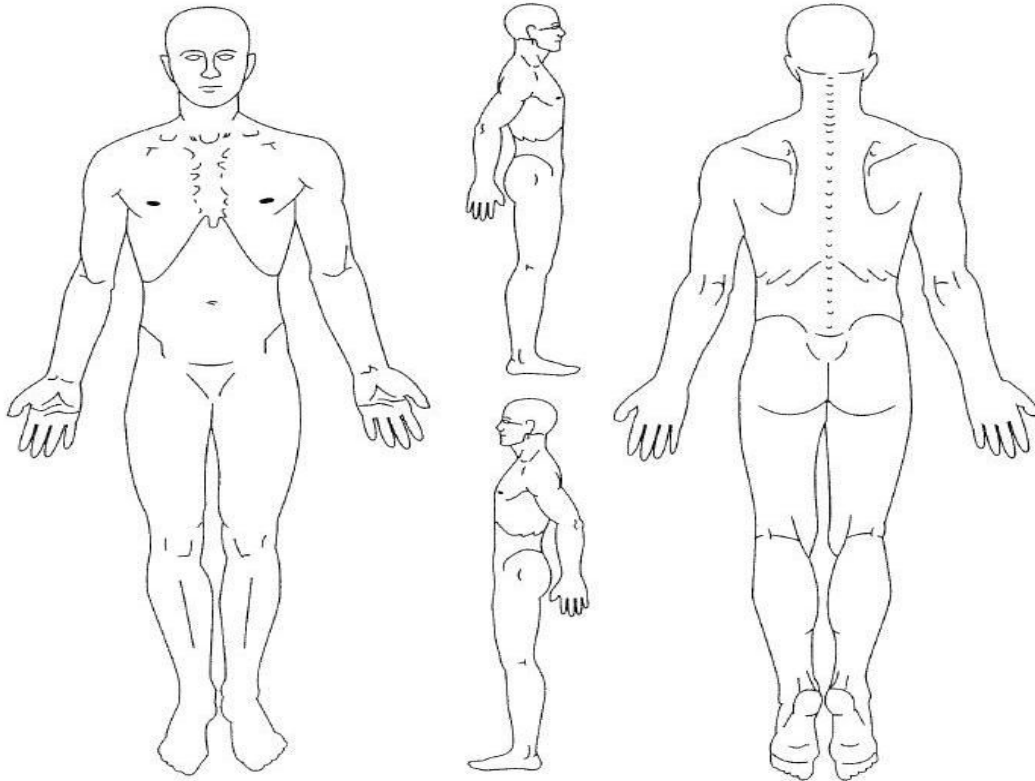
How are your symptoms changing? Getting better Not changing Getting worse

Are You Pregnant? (Check) Yes No

At this time, to the best of my knowledge, I am not pregnant, and I consent to radiographic pictures if necessary.

By using the key below, indicate on the body diagram where you are experiencing the following symptoms:

N=Numbness B=Burning S=Sharp T=Tingling
A=Dull Ache



Average Pain Intensity:

Last 24 hours: no pain 0 1 2 3 4 5 6 7 8 9 10 worst pain

Past week: no pain 0 1 2 3 4 5 6 7 8 9 10 worst pain

Does anything improve your pain? Yes No

If Yes, please list: _____

When did your symptoms begin? _____

Are your symptoms a result of: Motor Vehicle Accident Work related Accident Other _____

How did your symptoms begin? _____

How often do you experience your symptoms?

Constantly Frequently Occasionally Intermittently
(76-100% of the day) (51-75% of the day) (26-50% of the day) (0-25% of the day)

What describes the nature of your symptoms?

Sharp Ache Numb Shooting
Burning Tingling Throbbing
Other _____

Signature of patient or responsible party _____ Date _____

How often do you experience your symptoms?

- Constantly (76-100% of the day)
- Frequently (51-75% of the day)
- Occasionally (26-50% of the day)
- Intermittently (0-25% of the day)

How long have you had this condition? ____ years ____ months ____ days

Have you had this condition in the past? _____

Is this condition interfering with your work sleep daily routine

Other: Please describe: _____

Since your last visit, have you had any:

- Injuries (Falls, Accidents)
- Activities (Pain Caused by too much Gardening)
- Conditions (New Medications, New Diagnosis, New Health Problems)

Please describe: _____

Have you have any: Surgeries Chiropractic Care Medical Care Physical Therapy Please list name of provider and condition: _____

For Women Only: To your knowledge, are you pregnant? Yes No

Stressors:

Because accumulation of stress affects our health and ability to heal, please list your top three stresses (you have ever had) in each category:

1. Physical stress (falls, accidents, work postures, etc.)
 - a. _____
 - b. _____
 - c. _____

2. Bio-chemical Stress (smoke, unhealthy foods, missed meals, don't drink enough water, drugs, alcohol, etc.)
 - a. _____
 - b. _____
 - c. _____

3. Psychological or mental/emotional stress (work, relationships, finances, self esteem, etc.)
 - a. _____
 - b. _____
 - c. _____

On a scale of 1-10, please grade your present levels of stress:

Work: _____ Home: _____ Play: _____

On a scale of 1-10, please describe your: (1 being very poor and 10 being excellent)

Eating Habits: _____ Exercise Habits: _____ Sleep: _____

General Health: _____ Mind set: _____

Medication List: Please list Dosage:

Prescriptions	Over the Counter (Tylenol)

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowledgement*

I, _____, have received and had the opportunity to review a copy of Goldsboro Spine Center's Notice of Privacy Practices. I understand that the Notice describes the uses and disclosures of my protected health information and informs me of my rights with respect to my protected health information.

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify) :

Signature: _____

Date: _____

Patient Name _____ Date _____

PAYMENT POLICY

Thank you for choosing Goldsboro Spine Center as your chiropractic provider. We are committed to providing you with quality and affordable health care. Due to some of the questions our patients have regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask any questions you may have, and sign in the space provided below. A copy will be provided to you upon request.

1. **INSURANCE.** We participate in most insurance plans, including Medicare. If you are not insured by a plan we participate with, payment in full is expected at each visit. If you are insured by a plan we do participate with, but do not have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility, please contact your insurance company with any questions you may have regarding your coverage. If your insurance company requires a referral it is your responsibility to provide us with a referral dated the day of your first visit from your primary care physician prior to your first visit. We are only able to provide a summary of your chiropractic benefits.
2. **CO-PAYMENT AND DEDUCTIBLES.** All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help is in upholding the law by paying your co-payment at each visit.
3. **PROOF OF INSURANCE.** All patients must complete out patient information form before seeing the provider. We must obtain a copy of your most current insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.
4. **CLAIM SUBMISSION.** We will submit your claims and assist you in any way we reasonably can to help get your claim paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance pays your claim. Your insurance benefits are a contract between you and your insurance company; we are not party to that contract.
5. **COVERAGE CHANGES.** If your insurance coverage changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 90 days, the balance will automatically be billed to you.

6. MISSED APPOINTMENT. Our policy is to charge \$25.00 after one missed appointment not cancelled 24 hours in advance. The charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regular scheduled appointment.
7. RETURNED CHECK. There will be a \$25.00 returned fee for any returned checks.
8. X-RAYS. X-rays remain property of this office and cannot be released.
9. REACTIVATION FEE. There will be a \$35.00 fee for any established patient who has been inactive (has not visited the office for 3 months).

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.

I have read and understood the payment policy and agree to abide by its guidelines. In order to maximize your treatment at Goldsboro Spine Center, group therapy is required as part of the treatment process. Disclosure of Private Health Information is required in order to carry out this procedure. A signature below states that you release the use of the information under HIPAA guidelines. A signature will also authorize consent to release your health information to your insurance company, which allows them to make any contributions to your care directly to Goldsboro Spine Center, and gives us limited power of attorney to endorse any check made out to you for services rendered by our office to you on your behalf.

Patient Name _____ Date _____

ASSIGNMENT OF BENEFITS / ERISA AUTHORIZED REPRESENTATIVE FORM

FINANCIAL RESPONSIBILITY

I have requested professional services from Goldsboro Spine Center, 605 N. Spence Avenue Goldsboro, NC 27534 (“Provider”) on behalf of myself and/or my dependents, and understand that by making this request, I am responsible for all charges incurred during the course of said services. I understand that all fees for said services are due and payable on the date services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement unless other arrangements have been made in advance.

Assignment of Insurance Benefits

I hereby assign all applicable health insurance benefits to which I and/or my dependents are entitled to Provider. I certify that the health insurance information that I provided to Provider is accurate as of the date set forth below and that I am responsible for keeping it updated.

I hereby authorize Provider to submit claims, on my and/or my dependent’s behalf, to the benefit plan (or its administrator) listed on the current insurance card I provided to Provider, in good faith. I also hereby instruct my benefit plan (or its administrator) to pay Provider directly for services rendered to me or my dependents. To the extent that my current policy prohibits direct payment to Provider, I hereby instruct and direct my benefit plan (or its administrator) to provide documentation stating such non- assignment to myself and Provider upon request. Upon proof of such non-assignment, I instruct my benefit plan (or its administrator) to make out the check to me and mail it directly to Provider. I am fully aware that having health insurance does not absolve me of my responsibility to ensure that my bills for professional services from Provider are paid in full. I also understand that I am responsible for all amounts not covered by my health insurance, including co-payments, co-insurance, and deductibles. Authorization to Release Information

I hereby authorize Provider to: (1) release any information necessary to my health benefit plan (or its administrator) regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims. This order will remain in effect until revoked by me in writing.

Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient

Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. Record charges are as follows: \$.75 pages 1-25, \$.50 pages 26-100, \$.25 pages 100+. If you request an alternative format, we will charge a cost- based fee for providing your health information in that format. If you prefer, we will prepare a summary

or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before September 12, 2016. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Dr. Wayne Wagner

Telephone: (919)751-0555

Fax: (919)751-3001

Email: DrWagner@goldsborospinecenter.com

Address: 605 N. Spence Avenue Goldsboro, NC 27534

INFORMED CONSENT TO TREATMENT

I hereby request and consent to the performance of chiropractic treatments (also known as chiropractic adjustments or chiropractic manipulative treatments) and any other associated procedures: physical therapy by Dr. Wayne Wagner and/or other assistants and/or licensed practitioners.

I understand, as with any health care procedures, that there are certain complications, which may arise during chiropractic treatments. Those complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, Horners' syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to complications including stroke.

I do not expect the doctor to be able to anticipate all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure(s) which the doctor feels at the time, based upon the facts then known, that are in my best interest.

- All physical, occupational and rehab requests, consultations and progress notes.
- All disability, Medicaid or Medicare records including claim forms and record of denial of benefits.
- All billing records including all statements, insurance claim forms, itemized bills, and records of billing to third party payers and payment or denial of benefits for the period ____ to ____.

I understand the information to be released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), and alcohol and drug abuse. I authorize the release or disclosure of this type of information.

This protected health information is disclosed for the following purposes (Why do they need this letter?): _____

This authorization is given in compliance with the federal consent requirements for release of alcohol or substance abuse records of 42 CFR 2.31, the restrictions of which have been specifically considered and expressly waived. You are authorized to release the above records to the following representatives of defendants in the above-entitled matter who have agreed to pay reasonable charges made by you to supply copies of such records (Who is the office that this is going to?):

Name of Representative

Representative Capacity (e.g. attorney, records requestor, agent, etc.)

Street Address

City, State and Zip Code

I understand the following: See CFR §164.508(c)(2)(i-iii)

- a. I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization.
- b. The information released in response to this authorization may be re-disclosed to other parties.
- c. My treatment or payment for my treatment cannot be conditioned on the signing of this authorization.

Any facsimile, copy or photocopy of the authorization shall authorize you to release the records requested herein. This authorization shall be in force and effect until two years from date of execution at which time this authorization expires.

Records Deposit: _____
Payment Method: _____
Staff Initial: _____

It is the patient's responsibility to pay this fee before letter/information is released. Records Fee: 75 cents each page for the first 25 pages, 50 cents each page for pages 26 to 100, 25 cents each page for pages 101 and more.

At least 72 hours are needed to prepare these requests for you.

Signature of Patient or Legally Authorized Representative
(See 45CFR § 164.508(c)(1)(vi))

Date

Name and Relationship of Legally Authorized Representative to Patient
(See 45CFR §164.508(c)(1)(iv))

Witness Signature

Date

Office Policies for Personal Injury Patients

This office will accept as a new patient based on our clinical examination and belief that chiropractic care will be effective for the treatment of our injuries. Your responsibility to this office will be to follow the doctor's recommendations and to provide the appropriate financial information so that payment for services can be received. Patient's need to bring the following:

1. Copy of the police report and/or a copy of the exchange slip.
2. Copy of the personal automobile policy to verify Medical Payments covered by your Automobile Insurance.
3. Name of individual and insurance company of the party that's liable. Please include the policy number.
4. Name and telephone number of attorney if an attorney has been retained.

Following the completion of your treatment in this office, your bill will be forwarded to the responsible party. Please note that this account is still your responsibility.

Election to Pursue Liability Claim and NOT Health Insurance Claim

To Whom It May Concern

The staff of Goldsboro Spine Center has advised me that cost of my treatment for injuries sustained in an automobile accident that occurred on (DATE)

may be covered in whole or part by both my own health insurance and by the liability insurance of the party at fault.

The clinic staff has informed me that if I file on my own health insurance, I will be responsible for paying deductibles and co-payments and that any such payments will be due as treatment is received. The staff has also informed me that if my health insurance makes any payments towards the cost of treatment and I successfully pursue a claim against the liable party, I may be required to reimburse my health insurer for any sums it has paid either to me or to my treating physicians.

I have decided that I do not wish to file any claim on my health insurance. I hereby direct and authorize the clinic to send bills and treatment records only to my attorney, or to the liability insurance carrier, or to my own automobile insurer for the purpose of receiving payment under my Medical Payments, Uninsured or Under-Insured Motorist coverage, if applicable.

I understand that the clinic will rely on my decision and render treatment based on the assumption that payment will be received from sources other than my health insurance. I will not be expected to pay deductibles and co-payments and third party

payers will be billed at the clinic's usual rates rather than at discounted rates that may apply to in-network providers.

I understand that if for any reason, my liability claim is ultimately denied, compromised or litigated unsuccessfully, I will remain personally liable.

NOTICE OF DOCTOR'S LIEN

I do hereby authorize Dr. Wayne Wagner to furnish you, my attorney, with a full report of his examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I was recently involved.

I hereby authorize and direct you, my attorney, to pay directly to said doctor such sums as may be due and owing him for medical service rendered me both by reason of this accident and by reason of any other bills that are due to his office and to withhold such sums from any settlement, judgement or verdict as may be necessary to adequately protect said doctor. And I hereby further give a lien of my case to said doctor against any and all proceeds of my settlement, judgement or verdict which may be paid to you, my doctor, or myself, as a result of the injuries for which I have been treated or injuries in connection therewith.

I agree never to rescind this document and that a rescission will not be honored by my attorney. I hereby instruct that in the event another attorney is substituted in this matter, the new attorney honor this lien as inherent to the settlement and enforceable upon the case as if it were executed by him.

I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by him for service rendered me and that this agreement is made solely for said doctor's additional protection and in consideration of him awaiting payment.

And I further understand that such payment is not contingent on any settlement, judgement or verdict by which I may eventually recover said fee.

Please acknowledge this letter by signing below and returning to the doctor's office. I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment but may declare the entire balance due and payable.

Patient Name (Print): _____

Signature of Patient: _____

Date: _____

The undersigned being attorney of record for the above patient does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgement or verdict as may be necessary to adequately protect said doctor above named. Attorney further agrees that in the event this lien is litigated that the prevailing party will be awarded attorney fees and costs.

Attorney Name (print) _____

Attorney Signature _____

Date _____