Integrated Spinal Solutions Patient Information

Patient Name:	**Today's Date:**
Address:	Home Telephone:
City/State/Zip:	Work Telephone:
Birth Date: Age:	Cellular Telephone:
Height: Weight:	Employer's Name:
Social Security Number:	Employer's Address:
Email:	
Marital Status: Single Married Divorced Widowed	Primary MD Name & Address

How were you referred to our office?	__ Location	__ Our Web Site	__ Other:_____
	__ Provider Manual	__ Yellow Pages	__ Spinal Talk at: _____
	__ Internet Search	__ Radio / TV	__ Existing Patient:_____

Emergency Contact Information

Nearest Adult Relative:	Relation to Patient:
Address:	Phone #:

Insurance Information

Does your insurance cover Chiropractic treatment?	☐ Yes ☐ No If yes, we need a copy of your card
If yes, indicate Insurance Company Name.	Carrier Name:
	Address:
If you are being seen for a work related or car accident injury we need the Claim Number and the Claims Adjusters Name.	Telephone Number:
	I.D. Number:
	Group Number:
Are you the insured person or a dependent?	☐ Insured ☐ Dependent (wife/husband/child)
If you are the insured persons dependent (spouse or child), we need the insured persons name, date of birth, social security number, name of the insured employers business and the address of the business.	Name of Insured Person:
	Social Security Number:
	Insured Date of Birth:
	Name of Insured Company
	Insured Company Address:

As a courtesy, our office will provide insurance billing services for you if you so desire. Please remember that you are ultimately responsible for any charges incurred in this office. It is your responsibility to pay any deductible amount, co-pay and or any other balances not paid by your insurance carrier (except for contracted discounts). Your signature on this document indicates that you agree to pay for any outstanding bills incurred in this office.

IN ORDER TO KEEP OUR OFFICE OVERHEAD DOWN AND KEEP OUR PATIENT FEES REASONABLE, WE REQUIRE PAYMENT AT THE CONCLUSION OF EACH TREATMENT FOR CASH PATIENTS AND THE CO-PAYMENT FOR INSURANCE PATIENTS.

Patient Signature (Parent or responsible party):_____ Date: _____

Patient Name:

Patient History Integrated Spinal Solutions, pc

(775) 828-9665 (775) 829-8686
Fax: (775) 828-7605

How long have you been experiencing your complaint?	☐ 1 day	☐ 2 days	☐ 1 week	☐ weeks	☐ month	☐ months	☐ years

Cause:

☐ Car Accident ☐ At home ☐ Work related ☐ Other
☐ Fall ☐ Athletic injury ☐ After surgery

Have you ever had a similar injury or complaint in the past?

☐ Yes : _____

_____

_____

☐ No

Prior Treatment:

☐ ER Visits ☐ Physical Therapy ☐ Surgeries ☐ Other:

Prior Imaging:

☐ X-rays ☐ CT Scan ☐ MRI ☐ EMG

Imaging Center:

Quality of Pain:

☐ Local ☐ Electrical shock ☐ Ache ☐ Stabbing
☐ Radiates ☐ Sharp ☐ Tingle ☐ Throbbing
☐ Radiates to legs ☐ Dull ☐ Cramping
☐ Radiates to arms ☐ Burning ☐ Stinging

Feels worse with:

☐ Standing ☐ Lay Down ☐ Walk down hill ☐ Lifting
☐ Sitting ☐ Walk up hill ☐ Bending ☐ Other:

Feels better with:

☐ Standing ☐ Lay Right ☐ Bend Forward ☐ Other:
☐ Sitting ☐ Lay Left ☐ Change positions

Medical History:

	Me	Family		Me	Family		Me	Family
☐ Heart Disease	☐	☐	☐ Trauma	☐	☐	☐ Lung Disease	☐	☐
☐ Diabetes	☐	☐	☐ Nerve Disease	☐	☐	☐ Seizures	☐	☐
☐ High Blood Pressure	☐	☐	☐ Psychiatric Disorders	☐	☐	☐ Arthritis	☐	☐
☐ Ulcers	☐	☐	☐ Depression	☐	☐	☐ Toxin Exposure	☐	☐

List <u>All</u> Past

☐	Work related Injuries:	
☐	Car Accidents:	
☐	Hospitalization:	
☐	Surgeries: Broken Bones: Fractures:	

Patient Name:	
Have you recently experienced…	☐ Other Joint Pain ☐ Tightness ☐ Numbness ☐ Balance Loss ☐ Lack of Coordination ☐ Depressed Mood ☐ Loss of Appetite ☐ Recent Weight Gain ☐ Irritability ☐ Blood or dark urine ☐ Fatigue ☐ Sleeplessness ☐ Decreased Energy ☐ Nausea ☐ Vomiting ☐ Fevers ☐ Chills ☐ Recent Weight Loss ☐ Anxiety ☐ Shortness of Breath ☐ Chest Pain ☐ Sweating ☐ Vision Changes ☐ Hearing Changes ☐ Dizziness ☐ Headaches ☐ Night Pain ☐ New Lump on Body ☐ Painful Bowel Movement ☐ Painful urination
Bowel or Bladder Dysfunction present?	☐ No ☐ Yes: _____

Please complete the form below.

Mark all symptoms you currently have:	**Side**	**Severity** 0 = No pain 10 = Most Severe Pain Ever	**Frequency** 0% = Absent 100% = Constant
Orthopedic & Musculoskeletal Symptoms			
☐ "Clunk" sound with neck movements			
☐ Neck pain……	☐ Right ☐ Left	0 1 2 3 4 5 6 7 8 9 10	0%----------50%---------- 100%
☐ Upper back pain……..	☐ Right ☐ Left	0 1 2 3 4 5 6 7 8 9 10	0%----------50%---------- 100%
☐ Low back pain……	☐ Right ☐ Left	0 1 2 3 4 5 6 7 8 9 10	0%----------50%---------- 100%
☐ Shoulder pain…….	☐ Right ☐ Left	0 1 2 3 4 5 6 7 8 9 10	0%----------50%---------- 100%
☐ Upper arm pain……..	☐ Right ☐ Left	0 1 2 3 4 5 6 7 8 9 10	0%----------50%---------- 100%
☐ Elbow pain……	☐ Right ☐ Left	0 1 2 3 4 5 6 7 8 9 10	0%----------50%---------- 100%
☐ Forearm pain……...	☐ Right ☐ Left	0 1 2 3 4 5 6 7 8 9 10	0%----------50%---------- 100%
☐ Wrist pain……	☐ Right ☐ Left	0 1 2 3 4 5 6 7 8 9 10	0%----------50%---------- 100%
☐ Hand pain……	☐ Right ☐ Left	0 1 2 3 4 5 6 7 8 9 10	0%----------50%---------- 100%
☐ Hip pain……..	☐ Right ☐ Left	0 1 2 3 4 5 6 7 8 9 10	0%----------50%---------- 100%
☐ Upper leg pain……	☐ Right ☐ Left	0 1 2 3 4 5 6 7 8 9 10	0%----------50%---------- 100%
☐ Knee pain……	☐ Right ☐ Left	0 1 2 3 4 5 6 7 8 9 10	0%----------50%---------- 100%
☐ Lower leg pain……	☐ Right ☐ Left	0 1 2 3 4 5 6 7 8 9 10	0%----------50%---------- 100%
☐ Ankle pain……...	☐ Right ☐ Left	0 1 2 3 4 5 6 7 8 9 10	0%----------50%---------- 100%
☐ Foot pain…….	☐ Right ☐ Left	0 1 2 3 4 5 6 7 8 9 10	0%----------50%---------- 100%
☐ Jaw pain……..	☐ Right ☐ Left	0 1 2 3 4 5 6 7 8 9 10	0%----------50%---------- 100%
☐ Clicking in jaw	☐ Right ☐ Left	0 1 2 3 4 5 6 7 8 9 10	0%----------50%---------- 100%
☐ Pain when chewing			
☐ Face pain			
☐ Chest pain			
☐ Stomach pain			
☐ Bowel or bladder dysfunction?	☐ No ☐ Yes		
☐ Bruise to _____			
☐ Scrape to _____			
☐ Other Symptom _____			
☐ Other Symptom _____		_____ **0 = Absent** **10 = Severe**	
Neurological Symptoms			
☐ Numb/Tingling Arm / Hand……	☐ Right ☐ Left	0 1 2 3 4 5 6 7 8 9 10	
☐ Numb/Tingling Leg /Foot……...	☐ Right ☐ Left	0 1 2 3 4 5 6 7 8 9 10	
☐ Weakness Arm / Hand……	☐ Right ☐ Left	0 1 2 3 4 5 6 7 8 9 10	
☐ Weakness Leg / Foot……...	☐ Right ☐ Left	0 1 2 3 4 5 6 7 8 9 10	_____ Mark how frequently you experience **Headaches.**
Other Symptoms:			
☐ Stiffness or limited movement in joint(s)			
☐ Headaches……..	……	0 1 2 3 4 5 6 7 8 9 10	_____ X / Day _____ X / Week _____ X / Month
☐ Muscle Spasms / Sore muscles			
☐ Dizziness, lightheaded, woozy feeling			
☐ Visual disturbances or vision change			
☐ Sleep changes / disruption of patterns			
☐ Pain radiates from one place to another			
☐ Anxiety or nervous when driving			
☐ Irregular heart beat or uneven pulse			
☐ Feeling depressed about things			
☐ I am taking medications			

INTEGRATED SPINAL SOLUTIONS, PC
TERMS OF ACCEPTANCE

Agreement to Financial Policy

I have agreed to pay charges at the time of service. I understand that I may pay by check, cash, or credit card. I understand Emergency and after hour visits will be subject to additional charges. I agree to be charged a **missed appointment fee of $10** if I miss an appointment without giving at least 4 hours advanced notice. I understand that as the parent or guardian, I am responsible for full payment of child's care. I further understand that for unaccompanied minors, payment in full is still required at time of service. If I have insurance coverage I hereby assign directly to Integrated Spinal Solutions, PC all medical benefits, if any, payable to me if any services rendered. I also understand that there is a 1.5% monthly interest charge on any unpaid balance over one (1) month old. It is at the discretion of the doctor to collect or waive said fee and will depend upon the payment history of the account. By signing below, I agree that should my account be referred to a collection agency or an attorney for collections, I will be directly responsible for paying all reasonable attorney's fees, other legal fees and/or any and all collection expenses.

Patient Accepts Responsibility for Insurance Reimbursements and Approvals

I accept responsibility to know my policy limits and requirements. I further accept responsibility to seek pre-authorization, bill and collect reimbursement from my insurance carrier if applicable. I understand that my insurance policy is a contract between the insurance carrier and myself. I further understand that Integrated Spinal Solutions, pc is in no way a guarantee of coverage or reimbursement from my insurance carrier. I further understand that my health insurance will be billed as a courtesy but that I am ultimately responsible for payment. I understand that some of perhaps all of the services that I receive may not be considered reasonable and necessary under the Medicare program and/or other insurance plans. I understand that insurance claims that are over 90 days old and unpaid, will become my responsibility. By my presence and continuation of appointments, I consent and elect care provided by Dr. Xavier Martinez and/or his staff.

Patient Will Truthfully and Fully Disclose Health Status and History

I hereby state that all information that I hereby give Integrated Spinal Solutions, pc and/or it's staff will be complete and truthful. I will not misrepresent my presence, nature, severity or cause of my injuries. I further state that I will fully disclose my health history and authorize the release of all past medical records to Integrated Spinal Solutions, pc. I present myself for health reasons only and it is not my intent to mislead, defraud or coerce this office or any third party or misrepresent myself in any manner.

Patient Consents to Care and Accepts Responsibility

I consent to recommendations and care by the Doctor(s) of Integrated Spinal Solutions, pc for myself (or my children if minors) including, but not limited to examinations, x-rays, chiropractic adjustments, rehabilitative and physical therapy. I understand that my care will be individualized to me and therefore may not be comparable to standards or guidelines used or required by insurance companies, professional associates, and/or consensus groups. I understand that my treatment will comply with the inherent risks. These risks, though rare, could occur ranging from minor aggravation of current condition to serious conditions such as cerebral vascular accident or death. I am signing this consent after having been fully informed to my satisfaction by the Doctor(s) of Integrated Spinal Solutions, pc and/or his staff of the risks and benefits of the care and the risks and benefits of not having the recommended treatment. I have been informed and fully understand that there are no guarantees of treatment success. By my presence and continuation of appointments, I consent and elect to care provided by Doctor(s) of Integrated Spinal Solutions, pc and/or his staff.

Medicare Limits and Responsibilities Advance Notice

The only charge for Chiropractic that is covered by Medicare is manual manipulation of the spine. I accept responsibility to know the current Medicare guidelines and limits for covered services. I accept responsibility to pay for all covered non-covered or denied services. I have been notified by my physician that he believes that in my case Medicare is likely to deny payment for some services. If Medicare denies payment, I agree to be personally and fully responsible for payment. I understand that I must pay for services at the time of treatment. I also understand that Integrated Spinal Solutions, pc will bill all charges directly to Medicare as required by law. I authorize the release of my records as necessary for Medicare Billing.

I have read, understand and agree to the provisions and terms of acceptance. This agreement shall become effective upon signing and be irrevocable for the full extent of my treatment by the doctor.

Patient Name (please print): _____

Patient Signature: _____ Date:_____

For Doctors Use: