



SPINE & SPORT REGISTRATION FORM

Date: / /

Referring Physician: _____

Primary Care Physician: _____

Date Last Seen: _____

Date last Seen: _____

PATIENT INFORMATION

Patient's First Name: _____ Middle Int.: _____

Mr. Ms.
 Mrs. Miss.

Marital Status (circle one)
Single / Mar / Div / Sep / Wid

Last: _____

Is this your legal name?

Yes No

If not, what is your legal name?

Social Security Number:

Birth date:

/ /

Age:

Sex:

M F

Home Phone:

()

Cell Phone:

()

Email Address:

Mailing Address:

City:

State:

Zip Code:

Preferred Contact Method

Mail Email

Occupation:

Employer:

Employer Phone Number:

()

Chose clinic because/ How did you hear about Spine & Sport: Social Media Advertisement: (Specify) _____

Family /Friend Insurance Plan Dr. Close to home/work Speaking Engagement Networking Event Mailing

Referred by: _____
Name

Auto Accident

Workers Compensation

INSURANCE INFORMATION

(Please Give Insurance Card & Picture ID to Receptionist)

RELEASE OF MEDICAL RECORDS

I am hereby authorizing Spine & Sport to request on my behalf, Medical Records and/ or Health Information from past/ current physicians. I understand that may revoke this authorization, in writing, at any time. Disclosure of my medical records by those receiving the above authorized information may be accomplished without my further written authorization. Without my written revocation, the authorization will automatically expire upon satisfaction of the need for disclosure.

Patient/ Guardian Signature _____ Relation to Patient: _____

Date: _____

IN CASE OF EMERGENCY

Name of local friend or relative (not living at the same address): _____

Relationship to patient: _____

Home Phone: ()

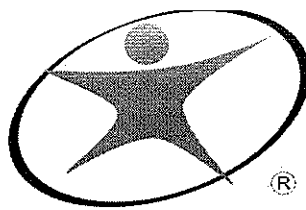
Work Phone: ()

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for all balances including all collection cost, attorney fees, and court cost should the account be in default. I also authorize Spine & Sport or the insurance company to release any information required to process my claims.

Patient/ Guardian Signature: _____ Date: _____

Relationship to Patient: _____

Date: _____



MEDICAL SCREENING FORM

Circle YES or NO...

Have you or any immediate family members ever been told you have ...

	<u>Self</u>	<u>Family</u>
Cancer?	yes...no	yes...no
Diabetes?.....	yes...no	yes...no
High blood pressure?.....	yes...no	yes...no
Heart disease?.....	yes...no	yes...no
High Cholesterol?.....	yes...no	yes...no
Angina/chest pain?.....	yes...no	yes...no
Stroke?.....	yes...no	yes...no
Osteoporosis.....	yes...no	yes...no
Osteoarthritis?	yes...no	yes...no
Rheumatoid arthritis?.....	yes...no	yes...no

In the past 3 months have you had or do you experience:

A change in <i>your</i> health?.....	yes...no
Nausea/Vomiting?	yes...no
Fever/chills/sweats?.....	yes...no
Unexplained weight change?.....	yes...no
Numbness or tingling?.....	yes...no
Changes in appetite?.....	yes...no
Difficulty swallowing?.....	yes...no
Changes in bowel or bladder function?.....	yes...no
Shortness of breath?.....	yes...no
Dizziness?.....	yes...no
Upper respiratory infection?	yes...no
Urinary tract infection?.....	yes...no

Circle YES or NO

Do you have a history of:

Allergies/Asthma?	yes...no
Headaches?.....	yes...no
Bronchitis?	yes...no
Kidney disease?.....	yes...no
Rheumatic fever?	yes...no
Ulcers?	yes...no
Sexually transmitted disease?.....	yes...no
Seizures?.....	yes...no

Are you currently:

Pregnant?.....	yes...no
Depressed?.....	yes...no
Under Stress?.....	yes...no

Are your symptoms: (check one)

- Getting worse The same Improving

How are you able to sleep at night? (check one)

- Fine Moderate difficulty Only with medication

Do you have a problem with?... (check all that apply)

- Hearing Vision
 Speech Communication
 Energy Focusing

Do you or have you in the past smoked tobacco?

Circle YES or NO

If yes, how many packs? _____

How many years? _____

When was your last use of tobacco _____

Do you drink alcoholic beverages?

Circle YES or NO

If yes, how many drinks do you routinely have per week?
_____ per week.

Date of last physical examination _____

List medications currently using: _____

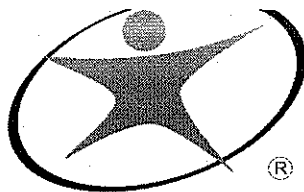
List any vitamins/supplements currently using: _____

What brand?: _____

**Would you like to talk with our AmeriSciences
Vitamin Product Specialist about
preventing or treating any of the following issues below
through vitamin supplementation?**

Please Check All That Apply:

- | | |
|---|---|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Children's Health | <input type="checkbox"/> Men's Health |
| <input type="checkbox"/> Vision | <input type="checkbox"/> Weight Loss |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Sleep Difficulty |
| <input type="checkbox"/> Memory & Focus | <input type="checkbox"/> Tiredness/ Fatigue |
| <input type="checkbox"/> Osteopenia/ Osteoporosis | <input type="checkbox"/> Women's Health |
| <input type="checkbox"/> Prenatal | |



MEDICAL SCREENING FORM

1.) Race:

- 1. Aleut/Eskimo
- 2. American Indian
- 3. Asian/Pacific Islander
- 4. Black
- 5. White
- 6. Other

2.) Ethnicity:

- 1. Hispanic or Latino
- 2. Not Hispanic or Latino

7.) With whom do you live? (Check all that apply)

- 1. Alone
- 2. Spouse/Significant Other
- 3. Child/Children
- 4. Other relative(s)
- 5. Group setting
- 6. Personal care attendant
- 7. Other: _____

3.) Education: (Please check one)

- 1. Less than high school
- 2. Some high school
- 3. High school graduate
- 4. Attended or graduated from technical school
- 5. Attended college, did not graduate
- 6. College graduate
- 7. Completed graduate school/advanced degree

8.) Where do you live?

- 1. Private home
- 2. Private apartment
- 3. Rented room
- 4. Board and care/assisted living/group home
- 5. Homeless (with or without shelter)
- 6. Long-term care facility (nursing home)
- 7. Hospice
- 8. Other

4.) Please check the combined annual income of everyone in your house: (necessary for Medicare patients only)

- 1. Less than \$10,000
- 2. \$10,001-\$14,999
- 3. \$15,000-\$24,999
- 4. \$25,000-\$34,999
- 5. \$35,000-\$49,999
- 6. \$50,000-\$74,999
- 7. \$75,000-\$99,999
- 8. \$100,000-\$149,999
- 9. \$150,000 or more

9) Have you received any in-home services this year beginning January 1st? If so, what? (for example: Oxygen tank delivery, a nurse coming to draw blood, previous Physical Therapy, or Speech Therapy)

5.) Employment/Work (Check all that apply)

- 1. Working full-time outside of home
- 2. Working part-time outside of home
- 3. Working full-time from home
- 4. Working part-time from home
- 5. Working with modification in job because of current illness/injury
- 6. Not working because of current illness/injury
- 7. Homemaker
- 8. Student
- 9. Retired
- 10. Unemployed

10.) What Physician wrote the referral for any services listed in #9 above?

11.) Have you received any Occupational, Speech, or Physical Therapy in the past one year? Yes No

If Yes:

Where _____

How Many Sessions: _____

12.) Have you received any previous out-patient Physical Therapy or Speech Therapy this calendar year beginning January 1st?

If Yes:

Where _____

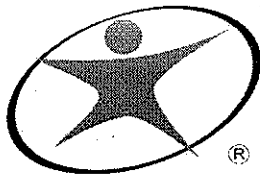
How Many Sessions: _____

6.) Do you use a: (Check all that apply)

- 1. Cane?
- 2. Walker, rolling walker, or rollator?
- 3. Manual wheelchair?
- 4. Motorized wheelchair?
- 5. Other: _____

13.) At the present time, would you say your health is:

Excellent Very Good Fair Poor



Where does it hurt? Mark all areas where you feel pain on the bodies below. Put the symbols below on the body to describe the pain. Example: S= Sharp

SHARP
SSSSS

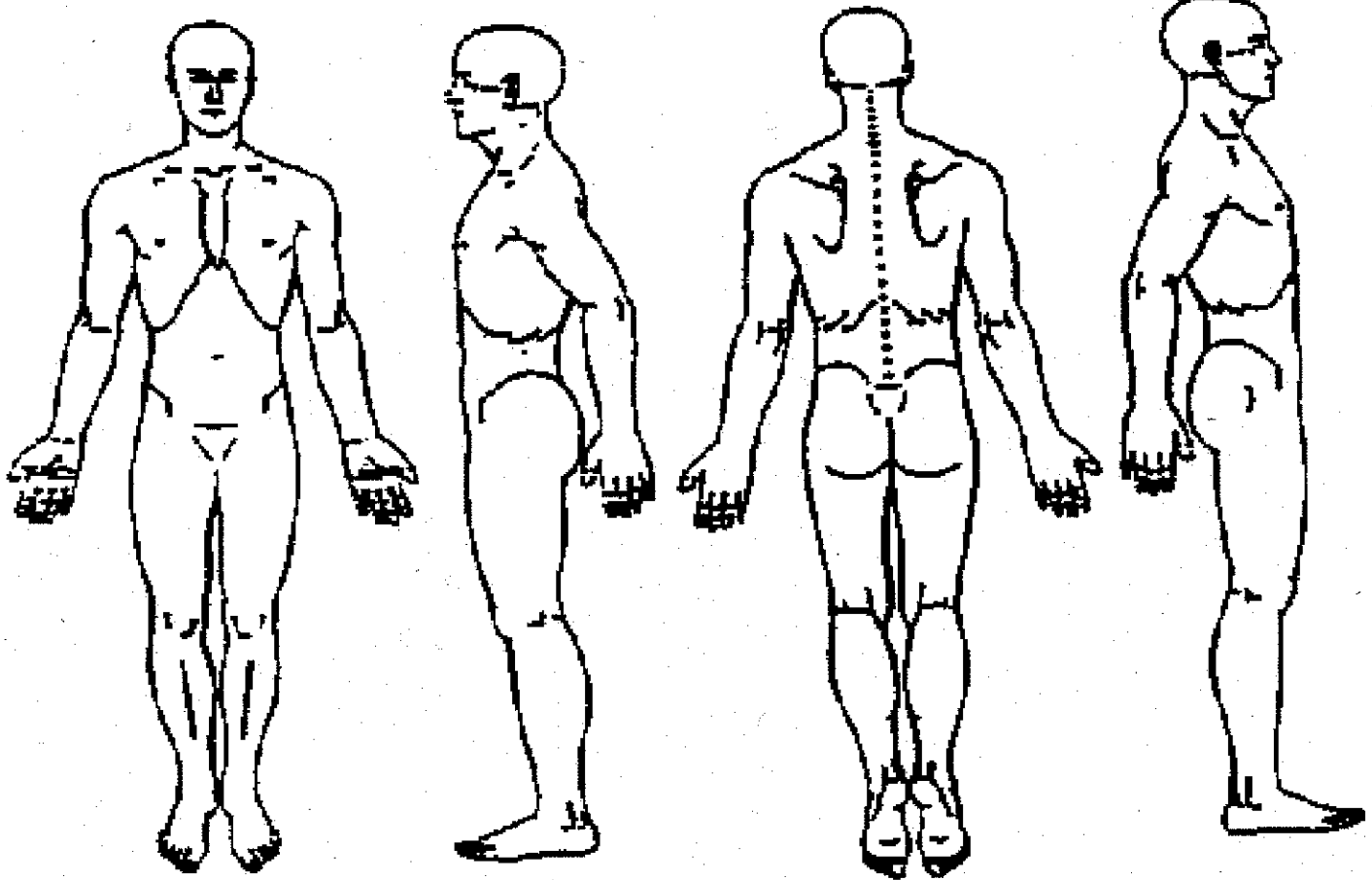
DULL
DDDD

BURNING
BBBBB

ELECTRICAL
EEEE

CRAMPING
CCCCC

OTHER
XXXX



Rate your pain at this moment on the scales below:

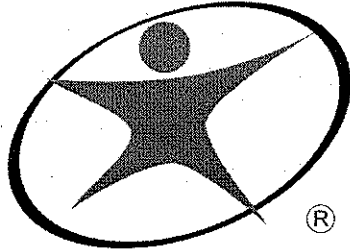
- 0= None
- 1-2= MINIMAL: Pain present but forgotten with activity
- 3-4= MILD: Annoying but does not interfere with activity
- 5-6= MODERATE: Pain requires changes of normal activity but is not disabling
- 7-8= SEVERE: Pain prevents normal duties
- 9-10= VERY SEVERE: Certain activities cause you to cry out in pain

Please mark below on a scale of one to ten the severity of your pain:

<p><u>NECK</u></p> <p>Rest: None 1 2 3 4 5 6 7 8 9 10 Severe</p> <p>Activity: None 1 2 3 4 5 6 7 8 9 10 Severe</p>	<p><u>MIDDLE OF BACK</u></p> <p>Rest: None 1 2 3 4 5 6 7 8 9 10 Severe</p> <p>Activity: None 1 2 3 4 5 6 7 8 9 10 Severe</p>	<p><u>LOW BACK</u></p> <p>Rest: None 1 2 3 4 5 6 7 8 9 10 Severe</p> <p>Activity: None 1 2 3 4 5 6 7 8 9 10 Severe</p>
<p><u>SHOULDER ARM WRIST OR HAND</u></p> <p>Rest: None 1 2 3 4 5 6 7 8 9 10 Severe</p> <p>Activity: None 1 2 3 4 5 6 7 8 9 10 Severe</p>	<p><u>HIP KNEE ANKLE OR FOOT</u></p> <p>Rest: None 1 2 3 4 5 6 7 8 9 10 Severe</p> <p>Activity: None 1 2 3 4 5 6 7 8 9 10 Severe</p>	<p><u>HEAD</u></p> <p>Rest: None 1 2 3 4 5 6 7 8 9 10 Severe</p> <p>Activity: None 1 2 3 4 5 6 7 8 9 10 Severe</p>

Date: _____

Signature: _____



SPINE & SPORT

www.spinesport.org

PAYMENT FOR SERVICE(S) RENDERED AGREEMENT

As a courtesy Spine & Sport verifies your insurance coverage through your insurance provider for billing purposes, it is your responsibility to know your insurance coverage for treatment; therefore you are responsible for any Co-Pay, Co-Insurance and/or Deductible per your policy. You are responsible for any charges incurred during treatment that your insurance provider does not cover for any reason.

If you are here by referral and the referral has not been received by Spine & Sport, you are responsible for contacting your referring physician to obtain the necessary paperwork.

Patient Signature

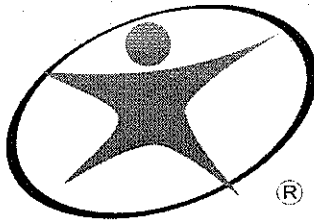
Date

PAYMENT FOR SERVICES(S) RENDERED AGREEMENT

Spine & Sport will file claims for all services rendered to you (unless specified to you by your Physical Therapist) using the insurance information that you have provided. It is ultimately your responsibility to be aware of any Co-Pay, Co-Insurance and/or Deductible that is due to Spine & Sport at the time of your treatment. If at any time you feel you are becoming financially unable to pay any Co-Pay, Co-Insurance and/or Deductible due to Spine & Sport for services, you may contact our Finance Department at (877) 826-1509 in order to set up a monthly payment plan.

Patient Signature

Date



Informed Consent for Treatment

I hereby voluntarily and of free will give consent and permission to Spine & Sport to administer physical therapy services. I am aware that a physician may refer me to Physical Therapy or that I may seek it out on my own because of the Direct Access in the state of Georgia. I understand that I will be evaluated by a licensed physical therapist. All assistants will work under the supervision of the physical therapist. I understand the nature of my condition, that certain risks may be involved, and there are no guarantees for treatment success. In the event of a change in medical status, I understand that my treatment may be modified or stopped. I reserve the right to withdraw at any time.

Signature: _____

Acknowledgement of Receipt of Privacy Notice

I have received a copy of Spine & Sports Notice of Privacy Practices, explaining how my Protected Health Information (PHI) may be used and shared as permitted by law. I understand the contents of the notice and I request the following restriction(s) concerning the use of my protected PHI:

Further, I permit a copy of this permission to be used in place of the original.

Signature: _____ **Date:** _____

If not signed by patient, please indicate relationship to patient (ex. Spouse)

Relationship: _____

Witnessed by: _____ **Date:** _____

For Internal Use Only:

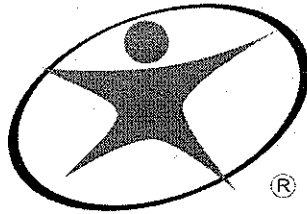
If patient's representative refuses to sign acknowledgement of notice, please document date and time the notice was presented to patient and sign below.

Date: _____ **Time:** _____

Person presenting document: _____

Title: _____

Corporate Office
135 Goshen Rd. Ext
Suite 206
Rincon, GA 31326
(877) 826-1509
Fax: (912) 826-9767



SPINE & SPORT
www.spinesport.org

Effingham
135 Goshen Rd. Ext
Suite 206
Rincon, GA 31326
(912) 826-3797
Fax: (912) 826-9767

Islands
119 Charlotte Rd.
Suite G
Savannah, GA 31410
(912) 898-7714
Fax: (912) 898-7715

Richmond Hill
1203 Gandy Dancer
Richmond Hill, GA 31324
(912) 459-2230
Fax: (912) 459-2240

Downtown
22 West Oglethorpe Ave.
Savannah, GA 31401
(912) 443-1400
Fax: (912) 443-1772

Hinesville
740 General Stewart Way
Suite 109
Hinesville, GA 31313
(912) 368-1078
Fax: (912) 368-1080

Patient Notice of Privacy Practices Effective April 13, 2006

Introduction

At Spine & Sport, we are committed to treating and protecting health information about you. This Patient Notice of Privacy describes the health information we collect and shows how and when we use or share that information. This notice is effective April 13, 2006 and applies to all protected health information as defined by federal laws.

Your personal medical information is called Protected Health Information or "PHI".

Understanding Your Health Record/Information

Each time you visit Spine & Sport, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnosis, treatment, and a plan for future care or treatment. This information is often referred to as your health or medical record.

Your Rights

Although your health record is the physical property of Spine & Sport, the information belongs to you. You have the right to:

- Obtain a per copy of this notice of privacy practices upon request
- Inspect and copy your health record
- Make changes in your health record
- Obtain a list of who your PHI was shared with
- Request communication of your PHI in certain places (for example, you may want us to call you at work instead of home)
- Request a restriction on certain uses and sharing of your information
- Revoke your permission for use or sharing of your PHI except to the extent that action has already been taken

The Health and Wellness Experts

Our Responsibilities

Spine & sport is required to:

- Maintain the privacy of your PHI
- Provide you with this notice as to our legal duties and privacy practices with respect to PHI we collect and maintain about you
- Abide by 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 PHI by alternative locations

We reserve the right to change our practices and to make the new provisions effective for all PHIs we maintain.

We will not use or share your PHI without permission, except as described in this notice. We will also discontinue the use of the Patient Notice of Privacy Practices and share your PHI after we have received notice in writing that you have revoked your permission.

Use and Sharing of PHI for Treatment, Payment and Health Operations

The law allows us to use your PHI without your permission for treatment, payment and business operations. The following are some examples: patient billing, third party billing, quality of care and improved services, other specialty care, caregiver/family member notification/communication, research, organ and tissue donation, marketing, fundraising, Food and Drug Administration (FDA), Workers Compensation, law enforcement, and public health.

Federal law makes provision for your PHI to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

For more information or to report a problem:

If you have any questions and would like additional information, you may contact the practice's Privacy Officer at 912-826-3797.

If you believe your privacy rights have been violated, you can file a complaint with the practice's Privacy Officer or the Office of Civil Rights, U.S. Department of Health and Human Resources. There will be no retaliation for filing a complaint with either the Privacy Officer or the Office for Civil Rights. The address for the OCR is listed below:

*Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue S.W.
Room 509F, HHH Building
Washington, DC 20201*