SPINE CENTER
MYRTLE BEACH

Legal Name: _____ Preferred Name:_____

Date of Birth:_____ Gender Identity:_____ Sex at birth:_____

Address: _____ City_____State_____Zip_____

Social Security Number:_____ Preferred Language:_____

Cell Phone:_____ Home phone:_____ Work Phone: _____

Email:_____

Employment Status: _____ Employer: _____ Occupation:_____

Name of Significant Other: _____ Marital status: ☐ Married ☐ Single ☐ Other

Emergency Contact Name:_____ Phone Number: _____

Race (mark one): ☐ American Indian ☐ Alaska Native ☐ Asian ☐ Black or African American
☐ Native Hawaiian ☐ White or Caucasian ☐ Pacific Islander ☐ Decline to answer ☐ Other

Ethnicity (Mark one): ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline to answer ☐ Other

Name of Insurance Company:_____ Relationship to cardholder: _____

Cardholder's Name: _____ DOB:_____ SS#:_____

Cardholders Place of Employment: _____

**In order of importance, please fist the complaints/reason you are seeing the Doctor today:

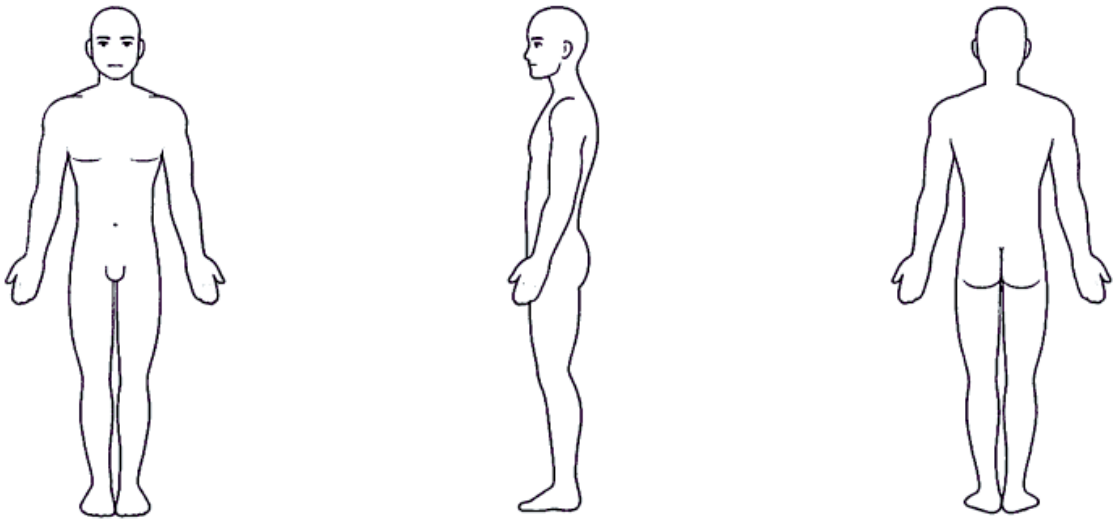
1._____ How long? _____

2._____ How long? _____

3._____ How long? _____

Please mark the areas of complaint on the illustration below using the following symbols:

P = Pain N = Numbness B = Burning A = Ache T = Tenderness S = Spasm R = Radiation (where to?)



Is this due to an accident?_____ Date of Accident:_____

Do you have an attorney?_____ Name:_____

(*** IF DUE TO ACCIDENT LET THE RECEPTIONIST KNOW IMMEDIATELY****)

Have you ever had pain like this before? ☐ Yes ☐ No If so, when?_____

Does the pain radiate anywhere (up, down, left., or right - be specific)? _____

What is the pain like (when it is at it's worst) on a scale of 1 to 10, with 10 being the worst:_____

Describe the pain (Mark all that apply): ☐ Throbbing ☐ Stabbing ☐ Burning Numb ☐ Dull Ache ☐ Other

Patient Name:_____ Signature:_____ Date:_____

If a minor, Guardian's name: _____ Guardian's signature:_____

When does the pain bother you? (Mark all that apply) ☐ Night ☐ Day ☐ Constant ☐ Occasionally ☐ Daily ☐ Weekly

Has the pain cause you to miss any work or school ? ☐ Yes ☐ No If yes, how much?_____

When did the pain begin?_____ What were you doing at the time? _____

Have you seen any other Doctors for this pain? ☐ Yes ☐ No If yes, whom?_____

How long ago did you see him/her? _____ What was the progress? (Mark one) ☐ Same ☐ Better ☐ Worse

What treatments have you received already for this pain?_____

What have you tried to make the pain feel better? (Mark all that apply)

☐ Resting ☐ Working ☐ Twisting ☐ Adjustments ☐ Bending ☐ Running ☐ Walking ☐ Eating
☐ Sitting ☐ Stretching ☐ Exercising ☐ Sleeping ☐ Tylenol/Aleve/Ibuprofen ☐ Medications
☐ Massage ☐ Lying down ☐ Heat ☐ Ice ☐ Standing ☐ Other:_____

Does anything make the pain feel worse (Mark all that apply):

☐ Bending ☐ Exercising ☐ Running ☐ Twisting ☐ Carrying ☐ Gardening ☐ Working
☐ Chewing ☐ Lifting ☐ Sleeping ☐ Walking ☐ Cleaning ☐ Lying down ☐ Sneezing
☐ Cooking ☐ Typing ☐ Medications ☐ Standing ☐ Coughing ☐ Pulling ☐ Turning
☐ Stretching ☐ Driving ☐ Pushing ☐ Sitting ☐ Other: _____

Is there anything else you would like the doctor to know about your condition(s)? (please write it in the space below)

_____

_____

_____

_____

Who is your Primary Care Physician (PCP)?_____When did you last see him/her? _____

PCP Address:_____ PCP Phone:_____

Personal Habits: Smoker? ☐ Yes ☐ No If yes, how much/how often? _____ Start date: _____

Alcohol? ☐ Yes ☐ No If yes, how much/how often? _____

Exercise? ☐ Yes ☐ No If yes, how much/what type? _____

Are you currently pregnant? ☐ Yes ☐ No Date of last menstrual cycle? _____

If you are pregnant, please notify the doctors and staff during your consultation.*

Please list all of your allergies (Medication, Food, Environmental, etc.):

_____

_____

Please list all the over-the-counter medicine you are taking and the dosage (vitamins, Tylenol, A/Eve, allergy medicine, etc.):

_____

_____

Please list all of the prescription medication you are taking and the dosage and frequency:

_____

_____

Please list any surgeries or hospitalizations and when they occurred:

_____

_____

How did you hear of our office? _____

I attest that the information that I filled out is accurate to the best of my knowledge, and I agree to have this office and physician examine me for further evaluation. This may include consultation, examination, and x-rays (if necessary). If the patient is a minor, I attest that I am legally allowed to provide this consent.

Patient Name:_____ Signature:_____ Date:_____

If a minor, Guardian's name: _____ Guardian's signature:_____

Personal & family health history

Please fill out as completely as possible and be specific where indicated
put "X" where applicable and indicate which family member and if they are living (L) or deceased (D)

Condition	Self	Mother / father	Sibling(s)	Children	Aunt / Uncle	Grandparent
1. Alcoholism						
2. Alzheimer's						
3. Allergies						
4. Anemia						
5. Arthritis (Type)						
6. Asthma						
7. Autoimmune (Type)						
8. Back Pain						
9. Bleeding Disorder						
10. Blood Clots						
11. Bowel Disease (Type)						
12. Cancer (Type)						
13. Carpal Tunnel						
14. Chemotherapy						
15. Depression						
16. Diabetes (Type)						
17. Drug Allergies (Type)						
18. Emphysema						
19. Epilepsy						
20. Fatigue						
21. Heart Disease (Type)						
22. Hepatitis						
23. High Blood Pressure						
24. HIV/AIDS						
25. Kidney Disease (Type)						
26. Lupus						
27. Migraines						
28. Multiple Sclerosis						
29. Neck Pain						
30. Obesity						
31. Osteoporosis						
32. Pacemaker						
33. Parkinson's Disease						
34. Psychiatric Care						
35. Radiation						
36. Rheumatic Fever						
37. Seizures						
38. Scoliosis						
39. Stroke						
40. Thyroid Disorder						
41. Ulcers (Type)						

Please list any current diagnosis or illness you have, who diagnosed you, and when:

Patient Name:_____ Signature:_____ Date:_____

Checklist: Review of systems.

If you have experienced any of the symptoms in the past (6+ months ago) and would like the doctor to know about them, please Mark the symptom and write when you experienced them.

**Please mark all that apply in each bolded section that you are currently having or have had in the past 6 months. **

General

- ☐ Weight loss or gain
- ☐ Fatigue
- ☐ Fever or chills
- ☐ Weakness
- ☐ Trouble sleeping

Skin

- ☐ Rashes
- ☐ Lumps
- ☐ Itching
- ☐ Dryness
- ☐ Color changes
- ☐ Hair and nail changes

Eyes

- ☐ Vision
- ☐ Glasses or contacts
- ☐ Pain
- ☐ Redness
- ☐ Blurry or double vision
- ☐ Flashing lights
- ☐ Specks
- ☐ Glaucoma
- ☐ Cataracts Last eye exam (Date)_____

Throat

- ☐ Teeth
- ☐ Gums
- ☐ Bleeding
- ☐ Dentures
- ☐ Sore tongue
- ☐ Dry mouth
- ☐ Sore throat
- ☐ Hoarseness
- ☐ Thrush
- ☐ Non-healing sores
- ☐ Last dental exam (Date)_____

Ears

- ☐ Decreased hearing
- ☐ Ringing in ears (tinnitus)
- ☐ Earache
- ☐ Drainage

Neck

- ☐ Lumps
- ☐ Swollen glands
- ☐ Pain
- ☐ Stiffness

Nose

- ☐ Stuffiness Discharge
- ☐ Itching
- ☐ Hay fever
- ☐ Nosebleeds
- ☐ Sinus pain

Head

- ☐ Headache
- ☐ Head injury

Breasts

- ☐ Lumps
- ☐ Pain
- ☐ Discharge
- ☐ Self-exams
- ☐ Breast-feeding

Urinary

- ☐ Frequency
- ☐ Urgency
- ☐ Burning or pain
- ☐ Blood in urine (hematuria)
- ☐ Incontinence
- ☐ Change in urinary
- ☐ strength

Patient Name:_____ Signature:_____ Date:_____

If a minor, Guardian's name: _____ Guardian's signature:_____

Respiratory

- ☐ Cough (dry, wet, productive)
- ☐ Sputum
  color_____
  amount_____
- ☐ Coughing up blood (hemoptysis)
- ☐ Shortness of breath (dyspnea)
- ☐ Wheezing
- ☐ Painful breathing

Male Genital

- ☐ Pain with sex
- ☐ Hernia
- ☐ Penile discharge
- ☐ Sores
- ☐ Masses or pain
- ☐ Erectile dysfunction
- ☐ STD's (what/when)

  _____

Female Genital

- ☐ Pain with sex
- ☐ Vaginal dryness
- ☐ Hot flashes
- ☐ Vaginal discharge
- ☐ Itching or rash
- ☐ STD's (what/when)
- ☐ _____

Cardiovascular

- ☐ Tightness
- ☐ Chest pain or discomfort
- ☐ Palpitations
- ☐ Shortness of breath with activity (Dyspnea)
- ☐ Difficulty breathing lying down (Orthopnea)
- ☐ Swelling (Edema)
- ☐ Sudden awakening from sleep with Shortness of breath (Paroxysmal Nocturnal Dyspnea)

Vascular

- ☐ Calf pain with walking (Claudication)
- ☐ Leg cramping

Musculoskeletal

- ☐ Muscle or joint pain
- ☐ Stiffness
- ☐ Back pain
- ☐ Redness of joints
- ☐ Swelling of joints
- ☐ Trauma

Neurologic

- ☐ Dizziness
- ☐ Fainting Seizures
- ☐ Weakness
- ☐ Numbness
- ☐ Tingling
- ☐ Tremor

Gastrointestinal

- ☐ Swallowing difficulties
- ☐ Heartburn
- ☐ Change in appetite
- ☐ Nausea
- ☐ Change in bowel habits
- ☐ Rectal bleeding
- ☐ Constipation
- ☐ Diarrhea
- ☐ Yellow eyes or skin (jaundice)

Respiratory

- ☐ Ease of bleeding
- ☐ Ease of bruising

Endocrine

- ☐ Head or cold intolerance
- ☐ Sweating
- ☐ Frequent urination (polyuria)
- ☐ Thirst (Polydypsia)
- ☐ Change in appetite (polyphagia)

Psychiatric

- ☐ Nervousness
- ☐ Depression care
- ☐ Memory loss

Patient Name:_____ Signature:_____ Date:_____

If a minor, Guardian's name: _____ Guardian's signature:_____

OFFICE POLICIES

- Following today's consultation, if the doctor feels that you can benefit from care, he or she will make specific recommendations for examination procedures in order to fully understand your condition. At the completion of your examination, you will be scheduled for a separate appointment for the doctor to review these findings with you and make recommendations for treatment (if appropriate). We are committed to providing you with the best care possible in a caring environment, and we have financial policies consistent with that goal.

- In an effort to maintain compliance with various state and federal regulations, managed care agreements, and preferred provider agreements, as well as billing and coding guidelines, we have adopted the following financial policy: our clinic has established a single fee schedule that applies to all patients for each service provided. You may be entitled to a network or contractual discount under the following circumstances: if we are a participating provider in your health plan; if you are covered by a state or federal program with a mandated fee schedule; if you are a member of DMPO that we may join (patients who are uninsured or underinsured with limited benefits will be entitled to network discounts similar to our insured patients); if you are eligible and choose a pre-payment or auto debit payment plan. As part of our compliance plan, our office will be unable to extend any type of discount other than those listed above.

- You are expected to pay for your treatment at the time service is rendered, unless other arrangements have been made in advance. Details of available payment options will be discussed with you when the doctor goes over your specific recommendation for care during your report of findings. This will typically be scheduled on our next business day. You are responsible for any and all expenses incurred in the collection of any overdue account. We reserve the right to charge a delinquency charge of 1.5% per month up to 18% per year, and there will be a $35 returned check fee on any check payments that are returned.

- We reserve the right to charge a $25 fee for missed appointments without prior notification, and we request 24-hour notice if you are going to miss an appointment.

- Verification of your insurance benefits is not a guarantee of payment. You will be responsible for any unpaid balances. If we submit your insurance claims, the amount due will be based on our best estimate according to the information provided to us by your insurance company. If claims process differently than expected, we will update your amount due according to the information provided in your insurance company's explanation of benefits (EOB). All payments are due at the time of service or by another previously agreed-upon arrangement. You will be refunded any overpayments (if applicable).

- Finances and patient health information will not be discussed over the telephone; if you have a question, you may address it at your next scheduled appointment. If you do not have an appointment, you can schedule a consultation with the proper department to handle your question.

- We advise that you follow the treatment recommendations given by the doctor(s). There are multiple providers in the clinic, and in order to maximize your treatment at Myrtle Beach Spine Center, PA, group therapy is part of the treatment process. Disclosure of private health information, in a limited manner, to staff members that are actively involved in your treatment is required to carry out this procedure. A signature below states that you release the use of that information under HIPAA guidelines.

- A signature below will authorize your consent to release your health information to your insurance company (if applicable, and we are filing your health insurance for you), which allows them to make contributions to your care directly to Myrtle Beach Spine Center, Pa, and gives us limited power of attorney to endorse any check made out to you for services rendered by our doctors to you or on your behalf.

INITIAL : _____

- X-rays remain the property of this office and will only be duplicated in a digital format (sent via HIPAA-secure email) or printed on paper when the proper x-ray request forms have been filled out. Letters or forms requested by the patient will be subject to a $35 administration fee due at the time of request. Medical record copies will be assessed at a fee of: pages 1–30, $.65 per page; pages 31–50, plus S/H costs. All record requests must have the proper request form filled out prior to the release of any medical records.

- Myrtle Beach Spine Center, PA, staff will treat all patients and visitors in a welcoming manner that is free from discrimination based on age, race, color, creed, ethnicity, religion, national origin, marital status, sex, sexual orientation, gender identity or expression, disability, veteran or military status, or any other basis prohibited by federal, state, or local law. We will treat all of our practice members with respect and expect the same courtesy to be extended to our staff. (Full versions of. Privacy Policy, Non-Discrimination Policy, and Financial Policy documents are available upon request for review.

- It is the policy of this office to remind patients of their appointments. We may do this by telephone, email, USPS, or by any means convenient to the practice and/or requested by you. We may send you other communications informing you of changes to office policy, schedule changes, promotions, office closures, or new technology that you might find valuable. You may opt in or out of the text messages and/or emails directly from the message itself or by letting the receptionist know. MBSC utilizes a number of vendors in the conduct of business. These vendors may have access "indirectly to protected health information (PHI), but they have all agreed to abide by the confidential rules of HIPAA (in writing in the form of a Business Associate Agreement).

- Any gift certificate that you may present in this office is not redeemable for cash. If you wish to receive any additional services that are not described on the gift certificate, you are responsible for paying for those services. Any discounted or free services described on a gift certificate are only applicable on the day that the gift certificate is presented to the office. Gift certificates can only be redeemed for the services described on the certificate. ("NOTE: If you are filing your health insurance for your treatment, you cannot use a gift certificate for payment towards any covered services; see gift certificates for specific limitations.")

- Pictures and videos are periodically taken during patient hours. In the event that you are in the background (meaning you are not directly identifiable) of one of these images, you give consent to Myrtle Beach Spine Center, PA, to use that video or picture without further authorization. In the event that you agree to or would like to be a featured subject, there will be a separate consent form presented for your agreement.

- Your confidential information will not be used for the purpose of marketing or advertising products, goods, or services.

- We agree to provide patients with access to their records in accordance with state and federal laws.

- You have the right to request restrictions in the use of your PHI and to request changes in certain policies used within the office concerning your PHI. We will do the best we can to accommodate your request; however, we are not obligated to alter internal policies to confirm your request.

- Please be courteous to other patients' office experiences. We discourage cell phone usage during treatment. If you must take a call, please step outside. If you are watching videos or playing games, please use your headsets so as not to disturb those around you.

- Please refer to our website, **www.MyrtleBeachSpineCenter.com**, to learn more about additional services in our office, patient education, health tips and videos, and more.

Patient Name:_____ Signature:_____ Date:_____

If a minor, Guardian's name: _____ Guardian's signature:_____

SPINE CENTER
MYRTLE BEACH

CONSENT FOR USE OR DISCLOSURE OF HEALTH INFORMATION SERVICE AGREEMENT AND ACKNOWLEDGEMENT

- Myrtle Beach Spine Center, PA (MBSC) is very concerned with protecting your privacy. While the law requires MBSC to give you this disclosure, please understand that we have and always will respect the privacy of your health information. This office conforms to the current HIPAA guidelines, and you may request a copy of our HIPAA and privacy policies. There are several circumstances in which we may have to use or disclose your health care information: i.e., another health care provider or hospital if it is necessary to refer you for the diagnosis, assessment, or treatment of your health condition; another party that may be responsible for the payment of your services; within our practice for quality control or other operational purposes.

- If there is anyone who you would like to authorize to receive disclosure of your health information, you must provide their name, relationship, and contact information in writing BEFORE we can release any information or speak to them on your behalf. You have the right to request that we do not disclose your health care information to specific individuals or organizations. If you would like to place any specific restrictions on the use or disclosure of your health information, please let us know in writing. We will not be able to honor your request if we have already released your health information before we receive written notice from you. If you were required to give your authorization for a condition while obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

- I hereby authorize Myrtle Beach Spine Center, PA, to release and permit the examination or copying of any of my medical records, x-rays, lab reports, and the results of all tests of any type or character to such persons or companies as the doctor deems appropriate (i.e., health insurance, insurance adjustor, attorney, etc.) for treatment of my condition and payment for my care.

RECORDS RELEASE, ASSIGNMENT OF BENEFITS, LIMITED POWER OF ATTORNEY ONLY FOR THIS CASE, AND PAYMENT AGREEMENT

- I authorize medical payments to be made directly to Myrtle Beach Spine Center, PA (hereinafter listed as MBSC). I further assign to MBSC a lien in the amount of my bill for health care services against the proceeds of any insurance policy or health care plan and against any claims which I may have against any other party whose negligence may have caused my injuries or who may be legally responsible for my injuries, illnesses, or health care costs. I direct payments to be made directly to MBSC on my behalf (assignment of benefits to Myrtle Beach Spine Center, PA). I agree to cooperate with the doctor in collecting any such amounts, including appearing in court if necessary.

- I understand that I am fully responsible for any and all charges that are brought on behalf of the care received at MBSC, regardless of any medical insurance coverage. I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that MBSC will prepare any necessary reports and forms to assist me in making collections for the insurance company and that any amount authorized to be paid directly to MBSC will be credited to my account upon receipt.

- I understand and agree that all services rendered 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 to me will be immediately due and payable.

- While MBSC will do the submission of claims on my behalf, the insurance company may send payments directly to me instead of MBSC. MBSC will do their best to inform me when to expect those payments and paperwork from the insurance company. MBSC also asks that I bring in any and all paperwork attached to the check from my insurance company so that we can apply those payments appropriately. In the event that I receive payment directly, at a time when there is still a balance due to the MBSC, I agree to deliver such monies immediately upon receipt to be applied to my bill.

Patient Name:_____ Signature:_____ Date:_____

If a minor, Guardian's name: _____ Guardian's signature:_____

SPINE CENTER
MYRTLE BEACH

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 Myrtle Beach Spine Center, PA, 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.

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 on this office. Use or disclosure of protected information in violation of an agreed-upon restriction will be a violation of 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.

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

Print Patient's Full Name :_____

Patient or Legally Authorized Individual Signature : _____ Date: _____

INFORMED CONSENT FORM

Analysis/Examination/Treatment

- As a part of the analysis, examination, and treatment, you are consenting to the following procedures (if/when clinically necessary): examination, palpation, vital signs, orthopedic testing, basic neurologic testing, range of motion testing, muscle strength testing, postural analysis, radiographic studies, ultrasound, cold laser, spinal decompression, manual traction, hot/cold therapy, electrical stimulation, mechanical traction, neuromuscular re-education, therapeutic exercises, and trigger point therapy.
- Note: Only the procedures that are clinically indicated for your condition will be performed. The doctor will recommend and discuss each procedure as applicable.

The material risks inherent in treatment and the probability of those risks occurring:

As with any healthcare procedure, there are certain complications that may arise during manipulation and therapy. These complications include, but are not limited to: fractures, disc injuries, dislocations, muscle strains, cervical myelopathy, costovertebral strains and separations, and burns. These complications are generally described as rare. Fractures are rare occurrences and generally result from some underlying weakness of the bone, which we check for during the taking of your history, examination, and X-ray (if needed). Some types of manipulation of the neck have been associated with injuries to the arteries in the neck, leading to or contributing to serious complications, including stroke. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. Some patients will feel some stiffness and soreness following the first few days of treatment. We will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to our attention, it is your responsibility to inform us.

The availability and nature of other treatment options

Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics, and rest
- Medical care and prescription drugs such as anti-inflammatory drugs, muscle relaxants, and painkillers
- Hospitalization
- Surgery

If you chose to use one of the above-noted "other treatment" options, you should be aware that there are risks and benefits to such options, and you may wish to discuss these with your primary medical physician.

The risks and dangers of leaving conditions untreated

Conditions left untreated may allow the formation of adhesions and reduce mobility, which may set up a pain reaction, further reducing mobility. Your condition may continue to deteriorate or worsen. Over time, this process may complicate treatment, making it more difficult and less effective the longer it is postponed.

I have read the above explanation of the chiropractic adjustment and related treatment. I have discussed it with the doctor and have had my questions answered to my satisfaction. By signing below, I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to the above-mentioned treatment(s).

Patient Name:_____ Signature:_____ Date:_____

If a minor, Guardian's name: _____ Guardian's signature:_____