Advanced SPINE REHAB & Athletics

Patient Information:

Full Name: _____ Sex: M F

Date of Birth: _____ Social Security #: _____ Marital Status: S M D W

Address: _____ City, State, Zip _____

Cell Phone: _____ Home or Work Phone: _____

Email Address: _____

Occupation: _____ Employer: _____

Emergency Contact:

Name: _____ Relationship: _____ Phone: _____

Health Insurance Information:

Primary Insurance: _____
Member ID #: _____ Group #: _____ Relationship to Insured: _____
Policyholder Name: _____ DOB: _____ SSN: _____

Secondary Insurance: _____
Member ID #: _____ Group #: _____ Relationship to Insured: _____
Policyholder Name: _____ DOB: _____ SSN: _____

Appointment Reminders:
As a convenience to our patients, we offer appointment reminders through emails and text messages. Would you like automatic reminders? □ Email □ Text - Cell Phone Provider: _____

Accident Information:
Is this visit due to an accident? □ Yes □ No Type? □ Auto □ Work □ Other Date of Accident: _____
Has the accident been reported? □ Yes □ No To Whom? _____

Whom may we thank for referring you to our office? _____

Patient/Guardian Signature: _____ **Date:** _____

Treatment of a Minor Child:
I authorize Advanced Spine Rehab and Athletics to examine and provide necessary treatment and adjustments to my minor child _____.

Parent/Guardian Signature _____ **Date:** _____

Work Injury Information

Patient Name _____ Claim No.: _____ Injury Date: _____
MCO Name: _____ Attorney Name: _____

Please describe the injury in detail (Use the back of this sheet if needed) _____

_____

_____

Please answer the following questions ONLY if you were injured in an automobile accident at work:

1. Were you the:

□ driver □ passenger □ a pedestrian □ on a bicycle □ on a motorcycle

2. Did you:

□ get hit by another vehicle □ at fault (you caused the accident) □ hit another vehicle, but are not at fault

3. From which side were you struck:

□ behind □ the front □ the driver's side □ the passenger side □ the passenger side front □ the driver's side front
□ the passenger side back □ the driver's side back

4. At the time of impact were you:

□ stopped □ moving/driving □ walking □ standing still □ running □ bicycling □ riding a motorcycle
□ crossing the street

5. If you were moving at the time of the accident, what was your approximate speed? _____

6. Was the involved party moving when the accident occurred? □ Yes □ No **If yes, what was their speed?** _____

7. Did you have your seat belt on at the time of the accident? □ Yes □ No

8. Was your head turned at the time of the accident? □ Yes □ No **If yes, were you looking:**

□ Forward □ looking to the right □ looking to the left □ looking behind you □ looking up □ looking down

9. Were you alone at the time of the accident? □ Yes □ No **If no, who was with you?** _____

10. What parts of your body hit other structures at the time of impact? (check all that apply)

□ Head □ Face □ Forehead □ Back of head □ Right TMJ □ Left TMJ □ Right Shoulder □ Left Shoulder □ Right Arm
□ Left Arm □ Right Elbow □ Left Elbow □ Right Wrist □ Left Wrist □ Right Hand □ Left Hand □ Right Leg
□ Right Knee □ Left Knee □ Right Ankle □ Left Ankle □ Right Foot □ Left Foot □ Other: _____

11. What structures did you hit? (check all that apply)

□ Steering Wheel □ Windshield □ Side Window □ Door □ Roof □ Dashboard □ Headrest □ Seat □ Floor
□ Side of Car □ Hood of Car □ Bumper □ Trunk □ The Pavement □ Tree □ Another Car □ Another Person
□ Another Object □ A Wall

12. How did you feel after the collision? (check all that apply)

□ Stunned □ Disoriented □ Lost Consciousness □ Tightness □ Felt Mild Discomfort □ Felt Moderate Discomfort
□ Felt Severe Discomfort □ Felt Intense Pain □ Frightened □ Felt a Popping and Ripping Sensation □ Went to Hospital

13. Who was cited for the accident? □ Me □ Other Driver

14. Have you had one or more of the following symptoms since your accident?

□ Cannot sleep due to the accident □ having trouble getting to sleep since the accident
□ Lost time from work due to the accident □ Have been depressed since the accident occurred

15. Have you been treated for injuries related to the accident already? □ Yes □ No
If yes, by whom? _____ **Did they perform any diagnostic testing?** □ Yes □ No

16. Have you lost wages or not been able to work due to the accident? □ Yes □ No

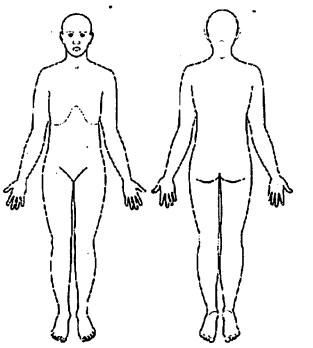
Patient Condition and Health History

Reason for your visit:

□ Neck Pain/Stiffness	□ Jaw Problems	□ Headaches/Migraines	□ Dizziness
□ Mid Back Pain/Stiffness	□ Shoulder Pain	□ Elbow Pain	□ Wrist/Hand Pain
□ Low Back Pain/Stiffness	□ Hip Pain	□ Knee Pain	□ Ankle/Foot Pain
□ Pins/Needles in Arms	□ Pins/Needles in Legs		

□ Other _____

Mark an "X" on the picture where you are experiencing symptoms:



When did your symptoms appear? _____

Is your condition/Symptoms: □ Getting Worse □ Getting Better □ Staying the Same

Do the symptoms interfere with: □ Daily Routine □ Recreation □ Sleep □ Work

What treatment have you already received for your condition? □ Physical Therapy □ Medications □ Chiropractic □ Surgery □ Other: _____

Have you had: □ X-Rays □ MRI/CT Scan □ Other: _____ When? _____

Are you currently Pregnant? □ Yes □ No If yes, when is your due date? _____

Dominant Hand? □ Right □ Left

Are you currently on any blood thinners? □ Yes □ No

Do your work activities mostly involve: □ Sitting □ Standing □ Light Labor □ Heavy Labor

Please check to indicate if you have ever had any of the following:

□ Aids/HIV	□ Chest Pain	□ Heart Disease	□ Mononucleosis	□ Sleeping Difficulties
□ Alcoholism	□ Chicken Pox	□ Hepatitis	□ Multiple Sclerosis	□ Stomach Problems
□ Allergies/Allergy Shots	□ Cold Feet	□ Hernia	□ Mumps	□ Stroke
□ Anemia	□ Constipation	□ Herniated Disc	□ Nervousness	□ Sudden Weight Loss
□ Anorexia	□ Depression	□ Herpes	□ Night Pain	□ Thyroid Disorder
□ Appendicitis	□ Diabetes	□ High Blood Pressure	□ Osteoporosis	□ Tonsillitis
□ Arthritis	□ Eczema	□ High Cholesterol	□ Parkinson's Disease	□ Tuberculosis
□ Asthma	□ Emphysema	□ Kidney Disease	□ Pinched Nerve	□ Tumors/Growths
□ Bleeding Disorders	□ Epilepsy	□ Light Bothers Eyes	□ Pneumonia	□ Typhoid Fever
□ Blurred Vision	□ Fainting	□ Liver Disease	□ Polio	□ Ulcers
□ Bowel/Bladder Changes	□ Fatigue	□ Loss of Memory	□ Prostate Problems	□ Unintentional Weight Loss
□ Breast Lump	□ Fractures	□ Loss of Smell	□ Prosthesis	□ Vaginal Infections
□ Bronchitis	□ Glaucoma/Cataracts	□ Loss of Taste	□ Rheumatoid Arthritis	□ Venereal Disease
□ Bulimia	□ Goiter	□ Measles	□ Rheumatic Fever	□ Other: _____
□ Cancer	□ Gonorrhea	□ Migraines	□ Scarlet Fever	_____
□ Chemical Dependency	□ Gout	□ Miscarriage	□ Shortness of Breath	_____

Contraindications: Certain procedures should be avoided if patients have certain conditions. Please answer the following:

Do you have a Pacemaker? □ Yes □ No

Do you suffer from blood clots? □ Yes □ No

Do you have a knee or hip replacement? □ Yes □ No

Do you have a local or systemic infection? □ Yes □ No

Family History (Indicate which family member and type):

□ Heart Disease _____

□ Diabetes _____

□ Cancer _____

□ Arthritis _____

□ Other _____

Medications/Supplements:

_____

_____

_____

Surgeries/Hospitalizations:

_____

_____

_____

Allergies:

_____

_____

_____

Exercise

□ None Activities: _____

□ Moderate _____

□ Daily _____

□ Heavy _____

Habits

□ Smoking Packs per Day _____

□ Alcohol Drinks per Week _____

□ Caffeine Cups per Day _____

□ Energy Drinks Drinks per Day _____

I certify that the above questions were answered accurately. I understand that providing incorrect information can be dangerous to my health.

Patient or Guardian Signature: _____ **Date:** _____

Consent to Treatment

I understand that Advanced Spine Rehab and Athletics will attempt to diagnose and treat any symptoms I am experiencing through diagnostic testing, chiropractic care, active/passive rehabilitation, physical therapy and/or massage therapy. I will be referred to an appropriate physician should there be a condition or symptom present that is out of the Doctor's scope of practice. I am also aware that any treatment provided is meant to help my condition, but in certain cases due to underlying physical defects, pathologies or deformities there may be an increase in the risk for injury. I am responsible to inform the doctor of any conditions (illnesses, deformities, etc.). I also clearly understand that if I do not follow the Doctor's specific recommendations that I will not receive the full benefit from the treatment and/or program.

Financial Policy

I understand that I am financially responsible and agree to ensure full payment for any and all fees incurred for any services/treatment provided to me regardless of any health insurance coverage that may provide payment on my behalf. Payment is due at the time of service unless other payment arrangements have been agreed upon by all parties. If I terminate my care prematurely, all fees incurred are immediately due and payable at that time and any discounts will not apply. I am aware that there will be a $20 fee charged for any returned checks.
*Insurance Patients: I understand and agree that health/accident insurance policies are an arrangement between the insurance carrier and myself. If this office chooses to bill any service to my health insurance carrier, it is strictly as a convenience to me. The office will provide any necessary reports or required information to my insurance carrier, but I am responsible for any unpaid balances due to denied claims.

Insurance Authorization and Assignment

I authorize Advanced Spine Rehab and Athletics to release any medical information necessary to process any insurance claims. Upon receipt of written request, I authorize any fiduciary or plan administrator, my attorney or insurer to release any and all insurance policies, settlement information or plan documents to Advanced Spine Rehab and Athletics and its representatives for the purpose of medical benefits and reimbursement. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions. I authorize the assignment of all insurance benefits to be directed to the Doctor and/or Physician for all services rendered.

I certify that I have read and fully understand this assignment and authorize this assignment to remain in effect until revoked by me in writing. A copy of this assignment is as valid as the original.

Name of Guarantor (person responsible for guaranteeing payment of all services) _____

Patient or Guardian Signature: _____ **Date:** _____

X-Ray Consent

I understand that the Doctor may recommend x-rays to accurately diagnose and analyze my condition. By signing below, I do hereby consent and will allow Advanced Spine Rehab and Athletics to take x-rays of my spine and/or extremities.

Females Only: I also hereby declare that to my knowledge, I am not pregnant. _____ (initial)

Patient or Guardian Signature: _____ **Date:** _____

Acknowledgement of Receipt of Notice of Privacy Practices

I hereby confirm that I have received a copy of Dr. Gina Infantino, D.C., M.S. and Dr. Christopher McDonough, D.C., M.S.'s **Notice of Privacy Practices.** I understand that it is my responsibility to familiarize myself with the contents of this Notice.

Patient or Guardian Signature: _____ **Date:** _____

Advanced SPINE REHAB & Athletics

Insurance Company Payment(s) Policy

I _____ have been advised that the doctors and therapists at Advanced Spine Rehab & Athletics, will bill my insurance company directly for my treatment. I have been further advised that the payment may be sent to me by my insurance company. By signing below, I affirm and attest that I am in no way entitled to this reimbursement for my treatment, and I understand that this money is intended to pay the above mentioned companies and physicians.
Accordingly, it is hereby understood and agreed to again that I have no right, implied or otherwise to said funds as they do not belong to me, and/or the insured party and are intended to pay for my medical care and procedure(s) performed with my informed consent.
Furthermore, in the event I receive a check or checks from the responsible insurance company as payment for my treatment/procedure(s) or the insured's procedure(s), I will immediately or within forty eight hours contact the appropriate party (the office or the billing department) about the check and return these funds to the appropriate party.
I understand that I am ultimately responsible for all medical bills if my insurance company fails to pay, and I will assist Advanced Spine, Rehab & Athletics with the collection of any funds.
In the event that a check or multiple checks are made payable to me or the insured and is received by Advanced Spine, Rehab & Athletics or its physicians, I hereby grant the facility and above provider(s) the express permission and limited power of attorney solely and exclusively for the purpose of endorsing said check(s), so that I do not need to return to the facility with the express intent to endorse the funds to the facility / provider(s).
If either party defaults in the performance of any of the terms, provisions, covenants and conditions and by reason thereof, the other party employs the services of an attorney to enforce performance of the covenants, or to perform any service based upon defaults, regardless of initiation of court proceedings, there in any of said events, the prevailing party shall be entitled to recover from the non-prevailing party all of the prevailing party's reasonable attorney's fees and all expenses and costs incurred by the prevailing party pertaining thereto (including costs and fees relating to any appeal) and in the enforcement of any remedy. By signing below, I agree that the sole and exclusive venue for any litigation arising from or related to this Lease shall be in the state courts in Licking County.

Patient Printed Name: _____

Signature: _____ **Date:** _____

Massage Cancellation Policy

I understand that if I am scheduled for a massage appointment that I must cancel at least 2 hours prior to my scheduled time. I also understand that if I do not give at least 2 hours notice and the office is not able to fill my massage time, that I will be responsible for a $25 cancellation fee.
I understand that if I am late for my massage that the time I missed will not be made up. If I am more than 10 minutes late and I do not call, the office may give my appointment to another patient.
I understand that if I fail to call or show up to my appointment and the office is not able to fill the appointment, I will be responsible for a $25 missed appointment fee.

I have read and fully understand the above.

Signature: _____ **Date:** _____

Ohio | Bureau of Workers' Compensation

First Report of an Injury, Occupational Disease or Death

By signing this form, I:

- **Elect to only receive compensation and/or benefits that are provided for in this claim under Ohio workers' compensation laws;**
- **Waive and release my right to receive compensation and benefits under the workers' compensation laws of another state for the injury or occupational disease, or death resulting from an injury or occupational disease, for which I am filing this claim;**
- **Agree that I have not and will not file a claim in another state for the injury or occupational disease or death resulting from an injury or occupational disease for which I am filing this claim;**
- **Confirm that I have not received compensation and/or benefits under the workers' compensation laws of another state for this claim, and that I will notify BWC immediately upon receiving any compensation or benefits from any source for this claim.**

WARNING:
Any person who obtains compensation from BWC or self-insuring employers by knowingly misrepresenting or concealing facts, making false statements or accepting compensation to which he or she is not entitled, is subject to felony criminal prosecution for fraud.
(R.C. 2913.48)

Injured worker and injury/disease/death info.

Last name, first name, middle initial		Social Security number	Marital status ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed	Date of birth
Home mailing address		Sex ☐ Male ☐ Female		Number of dependents
City	State / 9-digit ZIP code	Country if different from USA		Department name
Wage rate ☐ Hour ☐ Month ☐ Week $ _____ Per: ☐ Year ☐ Other _____		What days of the week do you usually work? ☐ Sun ☐ Mon ☐ Tues ☐ Wed ☐ Thur ☐ Fri ☐ Sat		Regular work hours From _____ To _____
Have you been offered or do you expect to receive payment or wages for this claim from anyone other than the Ohio Bureau of Workers' Compensation? ☐ Yes ☐ No If yes, please explain.				Occupation or job title

Employer name

Mailing address (number and street, city or town, state, ZIP code and county)

Location, if different from mailing address

Was the place of accident or exposure on employer's premises? ☐ Yes ☐ No
(If no, give accident location, street address, city, state and ZIP code)

Date of injury/disease	Time of injury _____ ☐ a.m. ☐ p.m.	If fatal, give date of death	Time employee began work _____ ☐ a.m. ☐ p.m.	Date last worked	Date returned to work
Date hired	State where hired		Date employer notified	State where supervised	

Description of accident (Describe the sequence of events that directly injured the employee, or caused the disease or death.)	Type of injury/disease and part(s) of body affected (For example: sprain of lower left back)

Benefit application release of information – I am applying for a claim under the Ohio Bureau of Workers' Compensation Act for work-related injuries that I did not inflict. I affirm that I elect to receive compensation and benefits under Ohio's workers' compensation laws for my claim, and I waive and release my right to file for and receive compensation and benefits under the laws of any other state for this claim. I request payment for compensation and/or medical benefits as allowable, and authorize direct payment to my medical providers. I permit and authorize any provider who attends, treats or examines me, the Ohio State Board of Pharmacy, the Ohio Department of Job and Family Services and the Ohio Rehabilitation Services Commission to release medical, psychological, psychiatric, pharmaceutical, vocational and social information. I understand this may include personally identifying information that is casually or historically related to my physical or mental injuries relevant to issues necessary for the administration of my claim to BWC, the Industrial Commission of Ohio, the employer in this claim, the employer's managed care organization and any authorized representatives. My previous or future BWC claims may affect decisions made in this claim. Proper administration of the present claim may require BWC to share claims information with the employers of record (or their authorized representatives) and/or my authorized representative for any and all such previous or future claims. The released claims information may include any record maintained in my claim files.

Injured worker signature	Date	E-mail address	Telephone number	Work number ( )

Treatment info.

Health-care provider name	Telephone number ( )	Fax number ( )	Initial treatment date
Street address	City / State		9-digit ZIP code

Diagnosis(es): Include ICD code(s)

Will the incident cause the injured worker to miss eight or more days of work? ☐ Yes ☐ No	Is the injury causally related to the industrial incident? ☐ Yes ☐ No

E code	11-digit BWC provider number	Date

Health-care provider signature

Employer info.

Employer policy number	Check if ☐ Employer is self-insuring ☐ Injured worker is owner/partner/member of firm			
Telephone number ( )	Fax number ( )	E-mail address	Federal ID number	Manual number

Was employee treated in an emergency room? ☐ Yes ☐ No	Was employee hospitalized overnight as an inpatient? ☐ Yes ☐ No

If treatment was given away from work site, provide the facility name, street address, city, state and ZIP code

☐ **Certification** - The employer certifies that the facts in this application are correct and valid.

☐ **Rejection** - The employer rejects the validity of this claim for the reason(s) listed below:

For self-insuring employers only

☐ **Clarification** - The employer clarifies and allows the claim for the condition(s) below:
☐ **Medical only** ☐ **Lost time**

Employer signature and title	Date	OSHA case number