Advanced SPINE REHAB & Athletics

Patient Information:

Full Name: _____ Sex: M F

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

Address: _____

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:** _____

Auto Accident Information

Patient Name _____ Date of Accident: _____
Auto Insurance: _____ Attorney Name: _____

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

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 □ Back □ 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

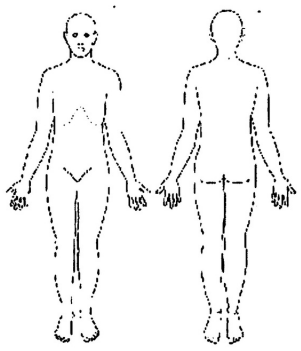
Patient Condition and Health History

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 Name: _____

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:** _____

GUARANTEE OF MEDICAL AND/OR HEALTH BILLS FROM SPECIFIC CLAIM FUNDS AND FIRST PARTY ASSIGNMENT

This Assignment, made effective on the _____day of_____, 20_____, by and between_____("Patient") and Advanced Spine, Rehab & Athletics and its officers, agents, members, shareholders, subsidiaries, assigns, employees, and directors (collectively referred to as "Clinic"); 9315 Columbia Rd SW, Etna Ohio 43062.

Witnesseth:

WHEREAS,_____insurance company insures Patient through a contractual right of uninsured/underinsured-motorist coverage and/or medical-payment coverage and/or health-insurance coverage and/or any other contractual right between Patient and insurance company ("First Party Insurance");

WHEREAS, Patient was involved in an accident on or about_____in which he/she was injured and for which he/she has a claim against another person(s) and/or liability insurance carrier(s) (including, but not limited to, "First Party Insurance" or "Third Party Insurance") for causing his/her injuries and/or damages (hereinafter referred to as "Claim");

WHEREAS, to the best of Patient's knowledge, the person(s) who caused the Claim is/are insured by _____insurance company(ies);

WHEREAS, Patient is entering into this Assignment and Guarantee of Payment voluntarily and without duress;

WHEREAS, Patient acknowledges that he/she has the right and opportunity to seek independent legal counsel to review this Assignment prior to execution;_____(Patient's initials)

WHEREAS, Patient seeks to have the Clinic provide medical care, treatment, and services as a result of Patient's Claim;

WHEREAS, Clinic agrees to provide medical care, treatment, and services to Patient for the injuries Patient sustained in the accident referred to above; and,

WHEREAS, Patient and Clinic desire to enter into this Assignment and Guarantee of Payment in accordance with the terms contained herein.

NOW, THEREFORE, in consideration of the mutual promises and covenants contained herein, and for other good and valuable consideration, the receipt of which is hereby acknowledged, it is agreed as follows:

1. **Patient hereby personally GUARANTEES payment of the Clinic's fees incurred by Patient to the Clinic for all treatment and other services rendered by the Clinic arising out of the Claim and/or from any proceeds and/or specific funds from Patient's Claim, including, but not limited to, third-party settlement(s), judgment(s), or verdict(s), and/or any first-party benefits, including but not limited to med-pay or other contractual proceeds. Patient affirms that this guarantee constitutes a lawful interest pursuant to Ohio Rule of Professional Conduct 1.15(D).**

   I have read and agree to the above guarantee to claim funds: _____
   (Signature of Patient)

2. **Patient hereby ASSIGNS, without any right to later revoke, a part of any proceeds from his/her Claim equal to the fees incurred by Patient to the Clinic for all treatment and other services rendered by the Clinic. Patient is <u>not</u> assigning any legal cause of action in the Claim above, but only contractual proceeds. Patient also assigns to the Clinic his/her right to enforce the obligation of any insurance company to pay med pay or other contractual proceeds for any treatment Patient receives in exchange for this assignment of first-party insurance benefits, including med-pay benefits. Prior to settlement or other disposition of the Claim, Patient understands and permits Clinic to pursue payment from any**

insurance company that insures Patient through a contractual right of uninsured/underinsured-motorist coverage and/or medical-payment coverage and/or health-insurance coverage and/or any other contractual right between Patient and insurance company, including medical-payments coverage in an automobile liability policy. Patient also assigns, without any right to later revoke, a part of any available medical-payments coverage equal to fees incurred by Patient to Clinic for all treatment and other services rendered by Clinic.

I have read and agree to the above assignment of claim funds:_____

(Signature of Patient)

3. **Patient directs the First Party Insurance Company to include the Clinic's name on all first party insurance contractual draft and/or check payments, including med pay payments. Further, Patient directs the First Party Insurance Company, including medical-payments carrier, to send all med pay payments to the Clinic at 9315 Columbia Rd SW, Etna Ohio 43062. Further, Patient authorizes and permits First Party Insurance Company, including Patient's applicable med-pay insurance, to disclose to Clinic the terms and amount of insurance proceeds available, including applicable med-pay coverage, under the subject first party insurance contractual policy.**

4. This Assignment and Guarantee and related documents, which Patient has signed in connection with it, state the entire agreement and Patient's complete understanding regarding the Clinic's fees. Patient has not relied on any statements by the Clinic or other information before making this Assignment. Patient understands that he/she remains responsible to Clinic for any Clinic fees not paid out of Patient's First Party Insurance Claim(s).

5. Patient understands that it is Patient's responsibility during treatment to remain aware of his/her cumulative account balance for services rendered. Patient has received a schedule of treatment fees for the Clinic; if Patient has not received a schedule of treatment fees prior to signing this Assignment and Guarantee of Payments, Patient agrees to immediately request one in writing.

6. Patient understands that this is an express contract to pay for the services rendered by the Clinic. Patient agrees to pay his/her account balance in full and/or direct its payment from the Claim proceeds. If Patient disputes his/her account balance or treatment rendered, Patient agrees that his/her remedy will be to resolve the dispute with a separate action from the Claim.

NOTICE: PATIENT HEREBY NOTIFIES AND DIRECTS ANY AND ALL FIRST PARTY INSURANCE COMPANIES, THIRD-PARTY ADMINISTRATORS, ATTORNEYS, OTHER PERSONS, AND/OR OTHER ENTITIES WHO HOLD OR LATER MAY HOLD ANY PROCEEDS FROM PATIENT'S CLAIM THAT CLINIC NOW HAS A LAWFUL INTEREST (AS THAT TERM IS USED AND APPLIED IN RULE 1.15(d) OF THE OHIO RULES OF ATTORNEY PROFESSIONAL CONDUCT) IN SAID PROCEEDS BY WAY OF THIS WRITTEN AGREEMENT GUARANTEEING PAYMENT FROM THE SPECIFIC FUNDS DESCRIBED ABOVE, AND PATIENT HEREBY DIRECTS YOU TO PROMPTLY DELIVER AND PAY THE CLINIC THE MONIES COLLECTED FROM THE FIRST-PARTY INSURANCE AND/OR THIRD PARTY SETTLEMENT(S), JUDGMENT(S), AND/OR VERDICT(S), EQUAL TO THE FEES INCURRED BY THE PATIENT FOR CARE AND TREATMENT, UNLESS THE CLINIC EXPRESSLY CONFIRMS PRIOR PAYMENT OF IT IN WRITING.

7. Ohio law governs this Assignment. Jurisdiction shall be in Ohio, and venue shall lie in the county, which the Clinic is located, unless otherwise required by applicable law. As a result of this Assignment and Guarantee of Payment from the specific funds and/or property referenced above, Rule 1.15 of the Ohio Rules of Professional Conduct applies to any and all funds held by the Patient's attorney related to Patient's Claim. If any of the provisions of this Assignment and/or Guarantee of Payment from the specific funds and/or property referenced above are deemed not binding by a court of competent jurisdiction, then it is agreed that the other remaining provisions of this entire agreement shall be construe as legal, valid, and/or enforceable.

8. Patient authorizes the Patient's applicable attorney to issue a letter of protection to the Clinic in order to

protect the Clinic's outstanding professional bills that remain unpaid after payments are received from the Patient's First Party Insurance Carrier and/or from any third-party settlement(s), judgment(s), or verdict(s) as additional consideration for the services provided by the Clinic and/or for the Clinic delaying collections of the services owed by the Patient.

9. **PATIENT ACKNOWLEDGES AND UNDERSTANDS THAT HE/SHE HAS NOW GIVEN AWAY A PART OF ANY PROCEEDS FROM HIS/HER CLAIM FOR WHICH THE CLINIC NOW HAS A LAWFUL INTEREST. IF PATIENT RECEIVES ANY PROCEEDS FROM HIS/HER CLAIM UNDER THIS ASSIGNMENT, PATIENT AGREES TO IMMEDIATELY DETERMINE IF THE CLINIC HAS BEEN SEPARATELY PAID IN FULL. UNLESS THE CLINIC EXPRESSLY CONFIRMS FULL PAYMENT IN WRITING, PATIENT ACKNOWLEDGES AND UNDERSTANDS THAT ANY USE BY PATIENT OF THESE PROCEEDS CONSTITUTES A TAKING OR CONVERTING MONEY THAT IS THE PROPERTY OF THE CLINIC.**

10. EVEN THOUGH THE CLINIC FIRST REQUESTED THAT PATIENT IS ONLY PERSONALLY GUARANTEEING PAYMENT FROM SPECIFIC FUNDS FROM THE PATIENT'S CLAIM, PATIENT FURTHER AGREES, NOTWITHSTANDING ANY CLAIM PAYMENTS, PATIENT UNEQUIVOCALLY **PERSONALLY GUARANTEES** PAYMENT TO CLINIC REGARDLESS OF THE OUTCOME OF ANY LEGAL ACTION, CLAIM, AND/OR FINAL DETERMINATION. PATIENT INSTRUCTS AND/OR WILL INSTRUCT HIS/HER ATTORNEY AND/OR INSURANCE COMPANY TO RELEASE ANY AND ALL INSURANCE FUNDS TO FULFILL PATIENT'S OBLIGATIONS TO THE CLINIC.

_____

Signature of Patient

IN WITNESS WHEREOF, the parties hereto have caused this Assignment and Guarantee of Payment from the specific funds described above to be executed and effective as of the date first written above.

PATIENT

Print Name: _____ Signed: _____

Signature of Parent/Legal Guardian: _____ Date : _____

ADVANCED SPINE, REHAB & ATHLETICS

Employee Name: _____ Signed: _____

Title: _____ Date: _____