ACTIVE SPINE AND SPORT P.C. 7400 HERITAGE VILLAGE PLAZA, GAINESVILLE, VA 20155 (703) 753-5599

PATIENT REGISTRATION FORM

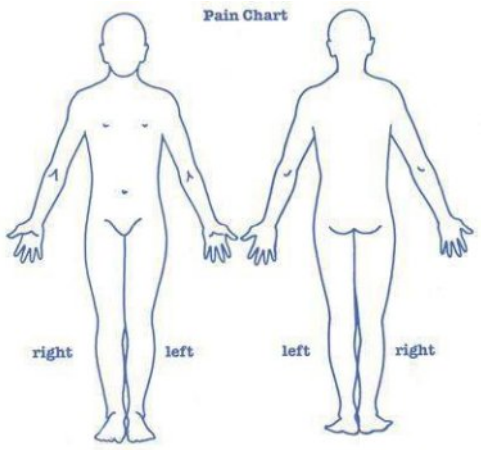
NAME			HOME #
ADDRESS			WORK #
CITY-STATE-ZIP		AGE	REFERRED BY
NAME YOU PREFER TO BE ADDRESSED AS	DATE OF BIRTH	SS #	PRIMARY CARE PHYSICIAN
E-MAIL ADDRESS (OPTIONAL) FOR OUR MONTHLY E-NEWSLETTER EXAMINING NOTEWORTHY HEALTH STUDIES			

PLEASE INDICATE PRIMARY COMPLAINT (E.G. HEADACHES, PAIN IN NECK, LOW BACK, FOOT ETC.)

_____

USE THE LETTERS LISTED BELOW TO INDICATE THE *TYPE* AND *LOCATION* OF YOUR PAIN AND SENSATIONS... (E.G. IF YOU HAVE A STABBING PAIN IN YOUR NECK, MARK AN "S" ON THE NECK WHERE THE PAIN IS)

KEY
A = ACHE
B = BURNING S
= STABBING N
= NUMBNESS
P = PINS & NEEDLES
O = OTHER



IS THIS PAIN RECURRENT? ◯YES ◯NO IF YES, HOW OFTEN DOES IT RECUR? _____

WHEN WAS THE FIRST TIME YOU EVER SUFFERED FROM THIS COMPLAINT? _____

WHEN DID THIS EPISODE BEGIN? _____

WHAT DO YOU THINK WAS THE CAUSE OF YOUR PAIN? (E.G. CAR ACCIDENT, OCCUPATION ETC.) _____

_____

WHAT DECREASES YOUR PAIN? (E.G. PAIN MEDICATION, ICE, HEAT, LAYING DOWN, STRETCHING ETC.)

_____

WHAT INCREASES YOUR PAIN? (E.G. SITTING TOO LONG, READING, WALKING, BENDING ETC.)

_____

HAVE YOU EXPERIENCED ANY NUMBNESS, PAIN, WEAKNESS OR TINGLING IN YOUR ARMS, HANDS, LEGS OR FEET?

◯ YES ◯ NO IF YES, WHERE? _____

PLEASE MARK A VERTICAL LINE (|) ON EACH LINE BELOW TO INDICATE THE SEVERITY OF YOUR PAIN AT IT'S WORST, BEST AND AVERAGE (0 = NO PAIN ... 10 = MOST SEVERE PAIN IMAGINABLE)

0 ——————————— 10 AT IT'S WORST

0 ——————————— 10 AT IT'S BEST

0 ——————————— 10 ON AVERAGE

PLEASE LIST ANY OTHER TREATMENT THAT YOU HAVE EVER RECEIVED FOR YOUR PRIMARY COMPLAINT:

DOCTOR'S NAME AND PHONE #	MRI / X-RAY RESULTS	TYPE OF TREATMENT GIVEN AND THE SUCCESS OF THE TREATMENT
DOCTOR'S NAME AND PHONE #	MRI / X-RAY RESULTS	TYPE OF TREATMENT GIVEN AND THE SUCCESS OF THE TREATMENT
DOCTOR'S NAME AND PHONE #	MRI / X-RAY RESULTS	TYPE OF TREATMENT GIVEN AND THE SUCCESS OF THE TREATMENT

HAVE YOU EVER RECEIVED TREATMENT FROM A CHIROPRACTOR? ○ YES ○ NO

HAVE YOU BEEN INVOLVED IN ANY RECENT TRAUMA (FALL, ACCIDENT ETC.) ○ YES ○ NO

IF YES, PLEASE DESCRIBE: _____

DO ANY OF THE FOLLOWING APPLY TO YOU:

	YES	NO		YES	NO
LOSS OF STRENGTH	○	○	UNEXPLAINED WEIGHT LOSS	○	○
LOSS OF BLADDER / BOWEL CONTROL	○	○	FEVER (OVER 101), CHILLS	○	○
USE OF PRESCRIPTION STEROIDS	○	○	IV DRUG USE	○	○
WORSE PAIN AT NIGHT OR WHEN LYING	○	○	NIGHT SWEATS	○	○

HAVE YOU EVER HAD:

○ ASTHMA	○ BLEEDING PROBLEMS	○ BLOOD CLOTS	○ CANCER
○ COPD	○ DEPRESSION	○ DIABETES	○ HEART DISEASE
○ HEPATITIS	○ HIGH BLOOD PRESSURE	○ HIGH CHOLESTEROL	○ HIV
○ KIDNEY DISEASE	○ LIVER DISEASE	○ LUNG DISEASE	○ MENTAL ILLNESS
○ OSTEOPOROSIS	○ STROKE	○ OTHER_____	

IS THERE A CHANCE YOU MAY BE PREGNANT? YES ○ NO ○

PLEASE LIST ANY MEDICATIONS YOUR ARE TAKING AND THE CONDITION THAT YOU ARE TAKING THEM FOR:

_____

_____

_____

I, THE UNDERSIGNED, WHOSE NAME APPEARS ABOVE, HEREBY CONSENT TO AND AUTHORIZE ALL DIAGNOSTIC AND THERAPEUTIC TREATMENTS CONSIDERED NECESSARY OR ADVISABLE IN THE JUDGEMENT OF THE ATTENDING PHYSICIAN.

I AUTHORIZE PAYMENT OF ANY MEDICAL BENEFITS FROM MY INSURANCE COMPANY TO BE PAID DIRECTLY TO ACTIVE SPINE AND SPORT P.C. (DBA) OR ARLINGTON NECK AND BACK CENTER P.C. FOR ANY SERVICE RENDERED TO ME

PATIENT SIGNATURE:

_____

DATE

_____

PATIENT CONSENT FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

TO CARRY OUT TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I, _____, HEREBY STATE THAT BY SIGNING THIS CONSENT, I ACKNOWLEDGE AND AGREE AS FOLLOWS:

1. A COPY OF ACTIVE SPINE AND SPORT (HEREAFTER REFERRED TO AS THE PRACTICE) PRIVACY NOTICE IS AVAILABLE AT ANY TIME. THE PRIVACY NOTICE INCLUDES A COMPLETE DESCRIPTION OF THE USES AND/OR DISCLOSURES OF MY PROTECTED HEALTH INFORMATION ("PHI") NECESSARY FOR THE PRACTICE TO PROVIDE TREATMENT TO ME, AND ALSO NECESSARY FOR THE PRACTICE TO OBTAIN PAYMENT FOR THAT TREATMENT AND TO CARRY OUT IS HEALTH CARE OPERATIONS. THE PRACTICE EXPLAINED TO ME THAT THE PRIVACY NOTICE WILL BE AVAILABLE TO ME IN THE FUTURE AT MY REQUEST. THE PRACTICE HAS FURTHER EXPLAINED MY RIGHT TO OBTAIN A COPY OF THE PRIVACY NOTICE PRIOR TO SIGNING THIS CONSENT, AND HAS ENCOURAGED ME TO READ THE PRIVACY NOTICE CAREFULLY PRIOR TO MY SIGNING THIS CONSENT.
2. THE PRACTICE RESERVES THE RIGHT TO CHANGE ITS PRIVACY PRACTICES THAT ARE DESCRIBED IN ITS PRIVACY NOTICE, IN ACCORDANCE WITH APPLICABLE LAW.
3. I UNDERSTAND THAT, AND CONSENT TO, THE FOLLOWING APPOINTMENT REMINDERS OR COMMUNICATIONS THAT WILL BE USED BY THE PRACTICE:
   A) A POSTCARD MAILED TO ME AT THE ADDRESS PROVIDED BY ME; AND
   B) TELEPHONING MY HOME AND LEAVING A MESSAGE ON MY ANSWERING MACHINE OR WITH THE INDIVIDUAL ANSWERING THE PHONE.
4. THE PRACTICE MAY USE AND/OR DISCLOSE MY PHI (WHICH INCLUDES INFORMATION ABOUT MY HEALTH OR CONDITION AND THE TREATMENT PROVIDED TO ME) IN ORDER FOR THE PRACTICE TO TREAT ME AND OBTAIN PAYMENT FOR THAT TREATMENT, AND AS NECESSARY FOR THE PRACTICE TO CONDUCT ITS SPECIFIC HEALTH CARE OPERATIONS.
5. I UNDERSTAND THAT I HAVE A RIGHT TO REQUEST THAT THE PRACTICE RESTRICT HOW MY PHI IS USED AND/OR DISCLOSED TO CARRY OUT TREATMENT, PAYMENT AND/OR HEALTH CARE OPERATIONS. HOWEVER, THE PRACTICE IS NOT REQUIRED TO AGREE TO ANY RESTRICTIONS THAT I HAVE REQUESTED. IF THE PRACTICE AGREES TO A REQUESTED RESTRICTION, THEN THE RESTRICTION IS BINDING ON THE PRACTICE.
6. I UNDERSTAND THAT THIS CONSENT IS VALID FOR *SEVEN YEARS*. I FURTHER UNDERSTAND THAT I HAVE THE RIGHT TO REVOKE THIS CONSENT, IN WRITING, AT ANY TIME FOR ALL *FUTURE* TRANSACTIONS, WITH THE UNDERSTANDING THAT ANY SUCH REVOCATION SHALL NOT APPLY TO THE EXTENT THAT THE PRACTICE HAS ALREADY TAKEN ACTION IN RELIANCE ON THIS CONSENT.
7. I UNDERSTAND THAT IF I REVOKE THIS CONSENT AT ANY TIME, THE PRACTICE HAS THE RIGHT TO REFUSE TO TREAT ME.
8. I UNDERSTAND THAT IF I DO NOT SIGN THIS CONSENT EVIDENCING MY CONSENT TO THE USES AND DISCLOSURES DESCRIBED TO ME ABOVE AND CONTAINED IN THE PRIVACY NOTICE, THEN THE PRACTICE WILL NOT TREAT ME.

I HAVE READ AND UNDERSTAND THE FOREGOING NOTICE, AND ALL OF MY QUESTIONS HAVE BEEN ANSWERED TO MY FULL SATISFACTION IN A WAY THAT I CAN UNDERSTAND.

_____ _____

NAME OF INDIVIDUAL (PRINTED) SIGNATURE OF INDIVIDUAL

_____ _____

SIGNATURE OF LEGAL REPRESENTATIVE* RELATIONSHIP

DATE SIGNED _____/_____/_____

*ATTORNEY-IN-FACT, GUARDIAN, PARENT IF A MINOR

Office Policy and Assignment of Payments

APPOINTMENTS:

PLEASE SHOW UP FOR YOUR APPOINTMENTS ON TIME. WE MAINTAIN AN EXCEPTIONAL RECORD FOR RUNNING ON TIME, AND EXPECT THE SAME FROM YOU. IF YOU ARE LATE, YOU ARE CAUSING THE DOCTOR TO RUN LATE, AND THEN THE NEXT PATIENT HAS TO WAIT. PLEASE SHOW RESPECT FOR OTHER PATIENTS

MISSED APPOINTMENTS:

IF YOU NEED TO CANCEL YOUR APPOINTMENT, PLEASE GIVE US AT LEAST 24 HOURS NOTICE.

AFTER THE FIRST "NO SHOW" YOU WILL BE GIVEN A PHONE CALL AND A REMINDER THAT THE OFFICE VISIT WAS MISSED.

AFTER THE SECOND AND SUBSEQUENT MISSED APPOINTMENTS A "MISSED APPOINTMENT" CHARGE OF $30.00 WILL BE SENT TO THE PATIENT. THIS CHARGE IS NOT BILLABLE TO THE INSURANCE COMPANY.

IN THE EVENT OF INCLEMENT WEATHER AND YOU DO NOT FEEL IT IS SAFE TO DRIVE HERE, PLEASE CALL US.

PAYMENT POLICY:

ANY REQUIRED PAYMENTS ARE EXPECTED AT THE TIME OF EACH VISIT. THERE IS A $30.00 RETURNED CHECK FEE.

IF THE INSURANCE COMPANY DOES NOT PAY IN FULL, ACCORDING TO THE TERMS OF THE PATIENT'S POLICY, THE PATIENT WILL BE RESPONSIBLE FOR ALL UNPAID CHARGES.

IT IS THE PATIENT'S RESPONSIBILITY TO KEEP TRACK OF THE DOLLAR AMOUNT LIMITS, NUMBER OF AUTHORIZED VISITS (IF NECESSARY), CHANGES FOR CO-PAYMENTS, DEDUCTIBLES, ETC. FOR THEIR INSURANCE POLICY.

ACTIVE SPINE AND SPORT P.C. WILL CALL TO VERIFY YOUR INSURANCE BENEFITS AT THE TIME OF YOUR INITIAL VISIT, HOWEVER, AS STATED BY YOUR INSURANCE COMPANY "THESE ARE AN ESTIMATE OF BENEFITS AND NOT A GUARANTEE OF PAYMENT".

I ACKNOWLEDGE THAT I AM ULTIMATELY RESPONSIBLE FOR PAYMENT OF MY BILL AND ANY SERVICE CHARGES THAT ARE INCURRED IN COLLECTING PAYMENT FOR MY BILL INCLUDING ATTORNEY FEES, INTEREST AND COURT COSTS IF APPLICABLE.

HMO/POS/PPO Referrals/Authorization:

If an insurance company requires a referral for the initial visit, this referral needs to be received by our office before the patient is seen. Obtaining this initial referral is the patient's sole responsibility and all charges incurred due to improper referral procurement will also be the patients responsibility.

If an insurance company requires an additional referral or authorization for further treatment, Active Spine and Sport P.C. will provide the patient with the necessary documentation, or we will fax it directly to the primary care doctor's office. However, it is ultimately the patient's responsibility to obtain the referral or authorization.

Copies of Records:

Active Spine and Sport P.C. reserves the right to charge an administrative fee of 25 cents per page for the copying and/or sending of clinical records. We also reserve the right to charge 25 dollars for the initial page and 10 dollars per page thereafter for any written reports, requests or forms pertaining to the patient's condition.

As a courtesy to our patients, we will submit medical claims to your primary and secondary insurance. In signing this form, you agree that we may bill your insurance company on your behalf, and you agree to ASSIGN PAYMENTS to Active Spine and Sport P.C.. This means that you give permission for the insurance payments to be made directly to us. If you do not agree to this, we require payment directly from you at the time of service, and we will then provide you with the necessary documentation to file your own insurance papers.

I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement of any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submission.

I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under the any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and claim and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with the doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and clinic's expense.

I HAVE READ THE ABOVE AGREEMENT. I UNDERSTAND AND AGREE TO ALL OF THE POINTS DISCUSSED ABOVE.

NAME (PRINTED): _____

NAME (SIGNED): _____ DATE: _____