SPINE&SPORT
"An Active Approach to Spinal & Extremity Injuries"

OFFICE USE ONLY:
DATE OF REFERRAL:_____
DIAGNOSIS:_____
EVAL DATE:_____

PATIENT REGISTRATION

NAME: SSN:

ADDRESS: DRIVERS LICENSE #:

CITY: In an emergency, who should we contact?

STATE: ZIP: NAME:

EMAIL: ☐ SPOUSE ☐ PARENT/ GUARDIAN

PHONE: RELATION: ☐ FRIEND

HOME PHONE:

WORK PHONE: EMPLOYER:

CELL PHONE: EMPLOYER PHONE#:

BIRTH DATE: SEX: MALE ◯ FEMALE ◯ WORK ADDRESS:
(circle one)

REFERRING PHYSICIAN:

Please describe your injury/condition (circle one):

◯ WORK-RELATED ◯ AUTO ACCIDENT ◯ PERSONAL INJURY LIEN ◯ NONE OF THESE

DATE OF INJURY: _____ or ☐ No injury date **EMPLOYER AT DATE OF INJURY:**

Are you represented by an attorney for this injury? ◯ YES ◯ NO **EMPLOYER ADDRESS**

If YES, please list the name of your attorney: **EMPLOYER PHONE**

Please give us all pertinent information regarding your insurance coverage for this case, If you have more than one carrier, please give us information for both carriers. Please show all numbers on your card(s). We will need copies of all applicable insurance cards, as well. Thank you for your assistance.

PRIMARY INSURANCE: _____ or ☐ DO NOT BILL INSURANCE

POLICY #: GROUP #:

TELEPHONE #:

INSURED NAME (As it appears on your insurance card):

SECONDARY INSURANCE: _____ or ☐ NO SECONDARY INSURANCE

POLICY #: GROUP #:

TELEPHONE #:

INSURED NAME (As it appears on your insurance card):

PLEASE READ THE OTHER SIDE AND SIGN YOUR NAME ♦ THANK YOU

Spine & Sport

AUTHORIZATION FOR OUTPATIENT TREATMENT

I have been informed of the treatment considered necessary and that the treatment and procedures will be performed by appropriately licensed physical therapists, occupational therapists, chiropractors, athletic trainers, physical therapy assistants, and exercise physiologists or other assistants employed by Spine & Sport. Authorization is herby granted for such treatment and procedures as prescribed by my physician, or directed under California "Direct Access".

I understand and acknowledge that as part of my treatment I will be engaging in physical exercises and using exercise equipment and as with all such physical activity there is an inherent risk of injury or complication to my existing condition. I am voluntarily participating in these physical activities and knowingly and freely assume all risks of injury, loss or damage on account of these activities. I understand that results are not guaranteed and that I have the right to discuss the purposes and risks associated with all recommended treatment procedures and activities with my therapist.

I certify that the information provided to Spine & Sport by me is correct, and I accept full responsibility for all charges*. I hereby assign and authorize payment directly to the above named clinic of all applicable insurance benefits. If my current policy prohibits direct payment to Spine & Sport, I hereby instruct and direct the Spine & Sport to bill me directly for the insurance payments made to me. I understand that I am responsible for any balance after insurance payment, including all costs incurred in collecting the balance if the account becomes delinquent, such as court costs, attorney's fees and/or collection agency commissions or charges.

*Patients with valid workers' compensation claims are not responsible for treatment charges.

MEDICAL RECORDS AUTHORIZATION

Spine & Sport is hereby authorized to release information pertinent to my treatment to any doctor, insurer, compensation carrier, attorney or other agency legally involved with my case (proof of relationship will be confirmed).

MEDICARE PATIENTS

I certify that the information provided to Spine & Sport by me in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or related Medicare claims. I request that payment of authorized benefits be made on my behalf.

I authorize Spine & Sport to initiate a complaint to the Insurance Commissioner for any reason on my behalf. A photocopy of this assignment shall be considered as effective and valid as an original.

Patient Signature	Witness	Date

FOR MINORS: As parent or legal guardian, I have read, understand, and agree with all items stated above and hereby authorized Spine & Sport to administer physical medicine treatment as prescribed to _____.
Patient Name

Parent/Guardian Name	Parent/Guardian Signature	Date

Spine & Sport

Dear Patient,

This letter is a notice of regulations regarding worker's compensation patients. All patients whose expenses are being covered by worker's compensation are required to keep all scheduled medical appointments. Our office is required to notify the worker's compensation carrier any time a patient misses two or more visits in a one-month period.

Please be advised, missed appointments may affect the authorization of future visits or procedures. In the event that it is necessary to re-schedule your appointment, please notify our office 24 hours in advance.

Emergencies and illnesses are taken into consideration when applying this regulation. Thank you for your cooperation and understanding.

I, _____, have read and understand the above statement regarding worker's compensation regulations.

_____

Patient Signature Date:

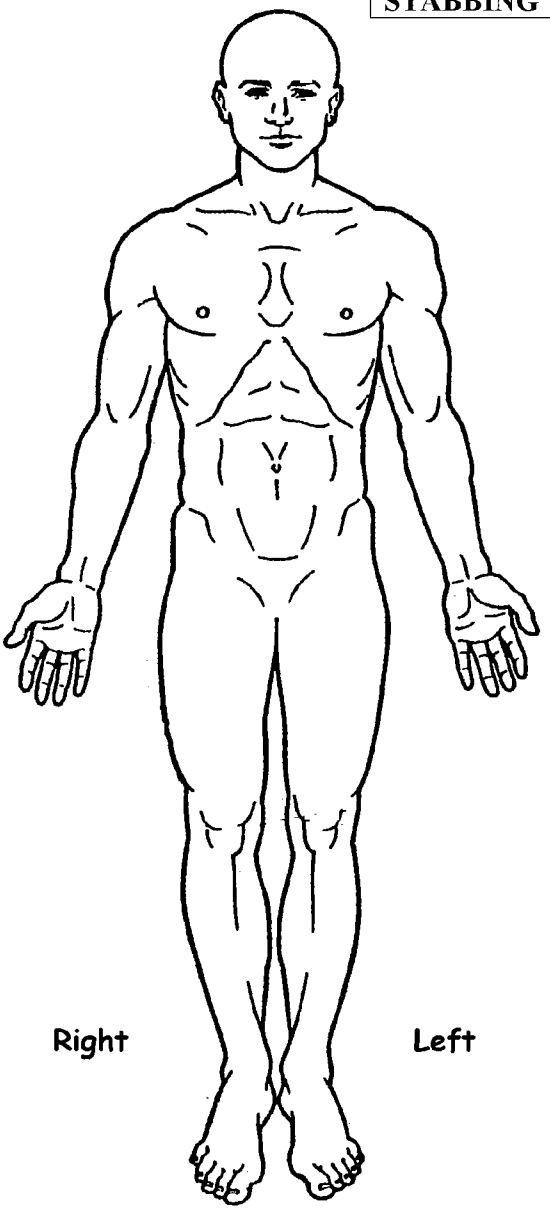
_____

Therapist Signature Date:

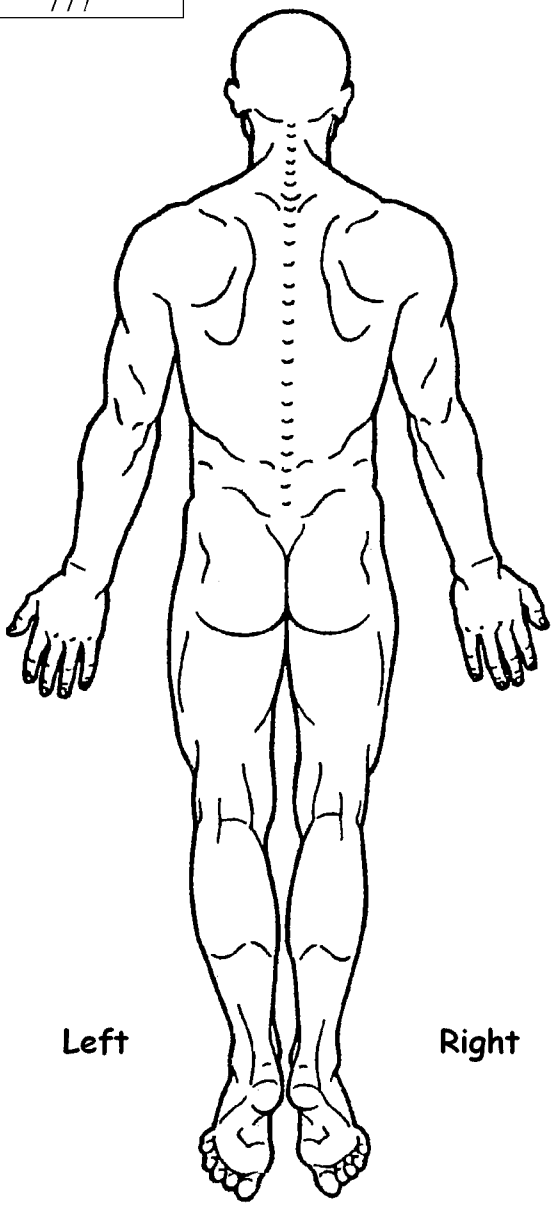
WHERE IS YOUR PAIN NOW?

Mark the areas on your body where you feel these sensations:

KEY	
ACHE	AAA
NUMBNESS	OOO
PINS & NEEDLES	- - -
BURNING	XXX
STABBING	///



Right Left



Left Right

PLEASE MARK WITH AN "X" ON THE LINE BELOW THE DEGREE OF PAIN NOW:

NO PAIN WORST PAIN

SINCE YOUR SURGERY/PROCEDURE, ARE YOU NOW: ☐Better ☐Worse ☐Same

PATIENT NAME: _____ DATE: _____

Patient Medical History and Health Risk Profile

Patient Name: _____ Date: _____

Age: _____ Height: _____ Weight: _____ Gender: ( ) Male ( ) Female

Emergency contact:

Name: _____ Phone: _____

Relationship: _____

1) Problems to be treated today: _____

Have you had treatment for this problem before? ( ) Yes ( ) No When: _____

Please describe the type of treatment: _____

Have you had surgery associated with this problem? ( ) Yes ( ) No

If so, please list date and type: _____

2) Do you have any other condition that is aggravated by exercise? _____

3) Please list the names of any primary care physician / internist / cardiologist that you are seeing, or have seen in the past:

Name: _____ Name: _____

Phone: _____ Phone: _____

4) Are you currently pregnant? ( ) Yes ( ) No

5) Do you need assistance with any of the following:

Transportation	Yes ( )	No ( )	Meals	Yes ( )	No ( )
Shopping/Errands	Yes ( )	No ( )	Personal Care	Yes ( )	No ( )
Domestic chores	Yes ( )	No ( )	Other_____	Yes ( )	No ( )

6) Has your illness / disability caused any of the following:

Financial Problems	Yes ( )	No ( )	Family Problems	Yes ( )	No ( )
Emotional Problems	Yes ( )	No ( )	Other_____	Yes ( )	No ( )

7) Do you have or have you had any of the following:

			Osteoporosis	Yes ( )	No ( )
Feel faint or dizzy	Yes ( )	No ( )	Known heart disease	Yes ( )	No ( )
Frequent pain in heart or chest	Yes ( )	No ( )	Diabetes	Yes ( )	No ( )
Pacemaker	Yes ( )	No ( )	Swollen ankles	Yes ( )	No ( )
Headaches	Yes ( )	No ( )	Kidney problems	Yes ( )	No ( )
Nervous disorders	Yes ( )	No ( )	Heat sensitivity	Yes ( )	No ( )
Allergies	Yes ( )	No ( )	Hernia	Yes ( )	No ( )
Seizures	Yes ( )	No ( )	Metal implants	Yes ( )	No ( )
Balance problems	Yes ( )	No ( )	Vision problems	Yes ( )	No ( )
Hearing Problems	Yes ( )	No ( )	High blood pressure	Yes ( )	No ( )
High cholesterol	Yes ( )	No ( )	Low blood pressure	Yes ( )	No ( )
Cancer	Yes ( )	No ( )	Tuberculosis	Yes ( )	No ( )
			Hepatitis	Yes ( )	No ( )

8) Please circle the closest answer or leave item blank if you do not know:

Cigarettes (per day)	Never ( )	1-5 ( ) 10-20 ( )	30-40 ( )	>50 ( )
Alcoholic drinks (per week)	Never ( )	1-5 ( ) 10-20 ( )	>20 ( )	
Cardiovascular Fitness (per week)	None ( )	Occasional/ Recreational ( )	3+ days/week for at least 15 minutes ( )	

9) Respiratory Status: Normal ( ) Moderate ( ) Severe (shortness of breath with mild exertion) ( )

For office use only: I have reviewed the Health Risk Profile and the following is appropriate:

- ❑ Contact MD with CV Screening Request Form or request results of exercise test within last 2 years;
- ❑ Further cardiovascular screening is not necessary at this time.

Clinician Signature:

PATIENT FINANCIAL RESPONSIBILITY POLICY NOTICE

We would like to make the billing and payment process for services as simple as possible. Please read the following information regarding the financial policies of this office.

It is customary to pay for services at the time they are rendered. For your convenience, payments may be made by cash, check credit card. If you have medical insurance coverage, a determination of your eligibility will be made, followed by a discussion of your benefits as they pertain to your treatment.

_____1. **PRIVATE INSURANCE**: Professional services rendered to you (or your dependents) by Spine & Sport are your sole financial responsibility. Spine & Sport will bill your insurance as a courtesy, but you are ultimately responsible for payment for your treatment. You are financially responsible for any and all balances not paid by your insurance (i.e. deductible, co-pay, coinsurance, denied charges, and fees reduced by usual & customary charges). You are required to pay your reported co-payment on the day of your visit. Any other unpaid balance due will be reflected in your monthly billing statement. Please pay close attention to statements received from your insurance company as they may report balances due prior to receiving a statement from our office. Any unpaid charges on an account for 90 days are subject to collections action.

_____2. **WORKER'S COMPENSATION**: If you were injured during the course of your employment, please notify the front office so that you may complete the appropriate paperwork. Coverage will be verified with your employer and we will bill the worker's compensation carrier directly.

_____3. **PERSONAL INJURY/NO ATTORNEY**: If you were in an accident and you do not have an attorney, you are expected to make consistent payments as you receive treatment. You will be reimbursed for any overpayments should your case settle in your favor and payment is received by another party. You are responsible for your entire treatment cost, regardless of settlement circumstances or amounts. Please ask the front desk for available payment options.

_____4. **PERSONAL INJURY/ATTORNEY**: If you were in an accident and are represented by an attorney, we must have a lien on file signed by you and your attorney. This will allow you to receive treatment without payment until your case settles. You are ultimately responsible for your entire treatment cost, regardless of settlement circumstances or amounts.

_____5. **CASH**: If you do not have insurance, you will be expected to pay for treatment at the time of service. A discount will be extended if payment is made at the time of service or in advance.

Please direct any additional questions to the business office.

I, THE UNDERSIGNED, HAVE READ THE ABOVE INFORMATION AND UNDERSTAND MY FINANCIAL OBLIGATION TO SPINE & SPORT.

_____ _____

Patient (or Guardian) Signature Date

_____ _____

Witness Signature Date

Spine & Sport

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Clinic Name _____ **Clinic Address** _____

Phone #: _____ **Fax:** _____ _____

Patient Name _____ Date: _____

Address _____ SS#: _____

_____ DOB: _____

Receive Records From:

_____

_____

_____

Release Records To:

_____

_____

_____

Please send a copy of my records as indicated for date(s) of Treatment: _____

_____ ☐ Operative Records _____ ☐ Lab Reports _____ ☐ H&P _____ ☐ X-ray Reports
_____ ☐ Prenatal Records _____ ☐ Discharge Sum _____ ☐ Discharge Sum _____ ☐ Other

Purpose for releasing medical information _____

_____ _____

SIGNATURE OF PATIENT, PARENT OR LEGAL GUARDIAN

WITNESS

_____

DATE

I understand that my express consent is required to release any health information relating to testing, diagnosis and/or treatment of alcohol or drug related medical problems, and this special consent also will apply to HIV/AIDS related diagnoses, sexually transmitted diseases and psychiatric disorders/mental health. This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (42 C.F.R. Part 2) prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains or as otherwise permitted by such regulations. This authorization can be revoked but not retroactive to the release of information made in good faith.

_____ _____

SIGNATURE OF PATIENT

WITNESS

_____

DATE

Permission to FAX records for medical emergency? ☐ Yes ☐ No

This authorization expires ninety (90) days from the date of this signature.

REV 1208

Spine & Sport

HIPAA NOTICE

April 14, 2003

Dear Spine & Sport Patient:

As you may know, the federal government has enacted a new "privacy rule" designed to protect the privacy of your health information. This law applies to physicians, hospitals, other health care providers and health plans. As of April 14, 2003, under this privacy rule we are required to provide you with a copy of our Notice of Privacy Practices which summarizes how we may legally use your health information and also our duty to protect your health information.

Please acknowledge your receipt of the Spine & Sport Notice of Privacy Practices by signing the attached Acknowledgment form. We understand the importance of privacy and are committed to maintaining the confidentiality of your medical records.

Please let the Clinic Director know if you have any questions about our Spine & Sport Notice of Privacy Practices.

Spine & Sport

ACKNOWLEDGMENT OF RECEIPT OF SPINE & SPORT NOTICE OF PRIVACY PRACTICES

By signing this document, I acknowledge that I have received a copy of Spine & Sport Notice of Privacy Practices.

Print Patient Name: _____

_____ Date: _____

Signature of Patient or Legal Representative

If signed by legal representative, please describe relationship to patient:

_____

STATE OF CALIFORNIA
DEPARTMENT OF INDUSTRIAL RELATIONS

WORKERS' COMPENSATION APPEALS BOARD

NOTICE AND REQUEST FOR ALLOWANCE OF LIEN ID OR CASE NO: _____

(Print or type names and addresses; include ZIP codes)

Injured Worker's Name	Date of Birth	Social Security Number
Address		Date of Claimed Injury
Attorney for Injured Worker	Attorney's Address	
Employer	Employer's Address	
Insurance Carrier or, if Self-Insured, Certificate Name	Address Where Claim is Administered	
Adjusting Agency, if Agency Administered	Attorney for Employer/Carrier	
Spine & Sport Lien Claimant	3444 Kearny Villa Road, Suite 200, San Diego, CA 92123 Address	
Attorney for Lien Claimant	Address	

The lien claimant hereby requests the Workers' Compensation Appeals Board to determine and allow as a lien the sum of $_____ against any amount now due or which may hereafter become payable as compensation to the above named worker on account of the above claimed injury.

This request and claim for lien is for (please check appropriate box):

- ☐ The reasonable expense incurred by or on behalf of said worker for medical treatment to cure or relieve from the effects of said injury; or
- ☐ The reasonable medical expense incurred to prove a contested claim; or
- ☐ The reasonable value of living expenses of said worker or of his or her dependents, subsequent to the injury, or
- ☐ The reasonable living expense of the spouse or minor children, or both, of said worker, subsequent to the date of injury, where such worker has deserted or is neglecting his or her family; or
- ☐ The reasonable fee for interpreter's services performed on
- ☐ _____

NOTE: ITEMIZED STATEMENT JUSTIFYING THE LIEN MUST BE ATTACHED

FOR INJURIES OCCURING ON OR AFTER JANUARY 1, 1990, FOR WHICH THE LIEN CLAIMANT DOES NOT HAVE A WCAB IDENTIFICATION NUMBER, the lien claimant declares under penalty of perjury that:

- ☐ a copy of the original completed Employee's Claim for Workers' Compensation Benefits (DWC Form 1) is attached, or
- ☐ the lien claimant does not have a copy of the claim form, but made the following efforts to secure one:

_____

_____

- ☐ A copy of the lien claim and supporting documents was served by mail or delivered to each of the above-named parties.

By _____ _____ By _____ _____
Signature of Attorney for Lien Claimant Date Signature of Lien Claimant Date

EMPLOYEE'S CONSENT TO ALLOWANCE OF LIEN

I consent to the requested allowance of a lien against my compensation

_____ _____
Signature of Attorney for Injured Worker Signature of Injured Worker