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: ____________________ PHONE: __________ RELATION: ☐ SPOUSE ☐ PARENT/ GUARDIAN ☐ FRIEND

HOME PHONE: ____________________

WORK PHONE: ____________________ EMPLOYER: ____________________

CELL PHONE: ____________________ EMPLOYER PHONE#: ____________________

BIRTH DATE: __________ SEX: MALE ○ FEMALE ○ (circle one) WORK ADDRESS: ____________________

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

Are you represented by an attorney for this injury? ○ YES ○ NO

If YES, please list the name of your attorney: ______________

EMPLOYER AT DATE OF INJURY: ____________________

EMPLOYER ADDRESS ____________________

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

AUTORIZACIÓN PARA EL TRATAMIENTO DEL PACIENTE NO INTERNADO

Me han informado del tratamiento considerado necesario y que el tratamiento y los procedimientos serán realizados por terapistas físicos, terapistas ocupacionales, chiropractors, amaestradores atléticos, ayudantes físicas de la terapia, y fisiólogos del ejercicio empleados por Spine & Sport. La autorización es concedida para tal tratamiento y procedimientos.

Certifico que la información dada por mí está correcta y acepto la responsabilidad completa de todas las cargas. Asigno y autorizo por este medio el pago directamente a la clínica arriba nombrada de todas las ventajas de seguro. Si mi política actual prohíbe el pago directo a la espina dorsal y al deporte, mando y ordeno por este medio a la espina dorsal y al deporte para mandarme la cuenta directamente para los pagos del seguro hechos a mí. Entiendo que soy responsable de cualquier deuda después del pago del seguro, incluyendo todos los costos incurridos en recoger cualquier deuda si la cuenta llega a ser delincuente, por ejemplo costos de la corte, los honorarios del ' s del abogado y/o las comisiones o las cargas de agencia de colección.

AUTORIZACIÓN MÉDICA DE LOS EXPEDIENTES

Spine & Sport se autoriza por este medio para lanzar la información pertinente a mi tratamiento a cualquier doctor, asegurador, portador de la remuneración, abogado o agencia del bienestar implicada con mi caso.

PACIENTES DE MEDICARE

Certifico que la información dada por mí en solicitar el pago bajo título XVII del acto de la Seguridad Social está correcta. Autorizo cualquier sostenedor de la información médica u otra sobre mí para lanzar a la administración de Seguridad Social o sus intermediarios o portadores cualquier información necesitada para este o las demandas relacionadas de Seguro de enfermedad. Solicito que el pago de ventajas autorizadas esté hecho en mi favor.

Autorizo al clínico que trata a iniciar una queja a la comisión del seguro por cualquier razón en mi favor. Una fotocopia de esta asignación será considerada tan eficaz y válida como una original.

________________________ ________________________ ____________

Firma paciente | Testigo | Fecha

Como el padre o el responsable legal, yo he leído, entiendo, y convino con todos los artículos indicados arriba y autorizó por este medio a Spine & Sport para administrar el tratamiento físico de la medicina según lo prescrito a ______________________.

Nombre paciente

________________________ ____________________ ____________

Nombre del padre/del guarda | Firma del padre/ del guarda | Fecha

Estimado Paciente,

Este es un aviso de reglas para pacientes de compensacion al empleado (worker's compensation). Todo paciente cuyos gastos son pagados por compensacion al empleado, deben asistir a todas sus citas medicas o relacionadas con su recuperacion. Nuestra oficina debe comunicarle al agente de aseguranza de compensacion al empleado si el paciente no asiste a dos o mas citas en el periodo de un mes.

El no asistir a sus citas puede causar que no autorizen otras citas o procedimientos. En caso de que tenga que cancelar su cita, favor de avisar a nuestra oficina con 24 horas de anticipacion.

Al aplicar esta regla tomamos en consideracion que pueden surgir emergencias o enfermedades. Gracias por su cooperacion.

Yo, ______________________________, e leido y entiendo este aviso de regularizaciones de compensacion al empleado.

____

Firma del Paciente Fecha

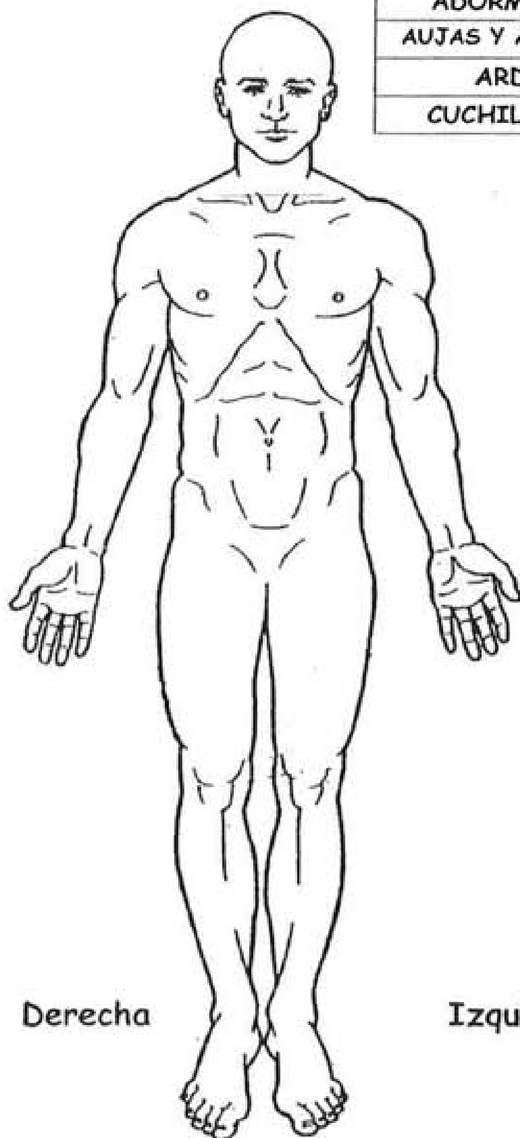
____

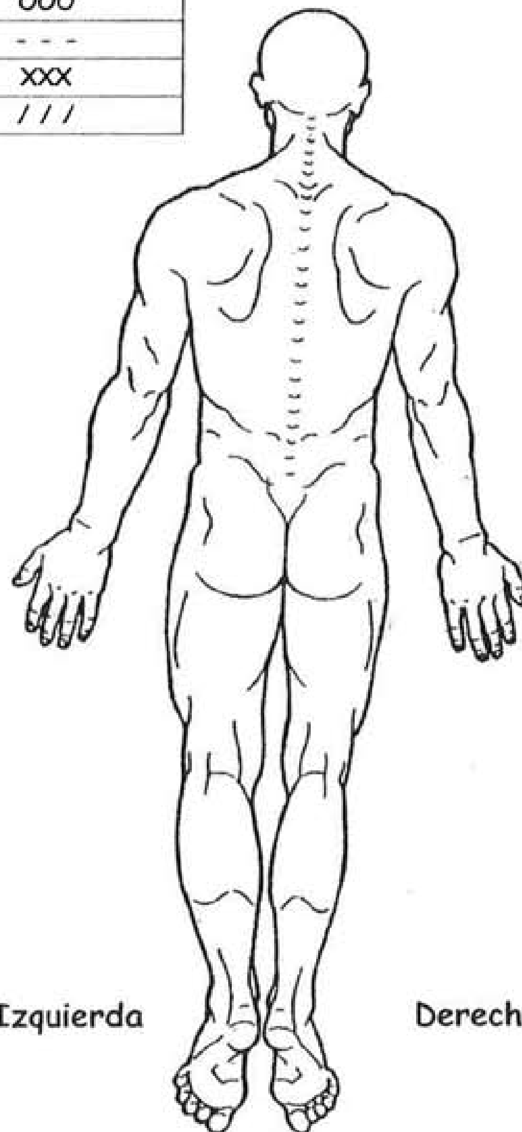
Firma del Terapista Fecha

DONDE TIENE SU DOLOR?

Marque las áreas de su cuerpo donde sienta las siguientes sensaciones:

CLAVES	
DOLOR	AAA
ADORMECIDO	OOO
AUJAS Y ALFILERES	- - -
ARDOR	XXX
CUCHILLASOS	/ / /





POR FAVOR DE MARCAR CON UNA "X" EL GRADO DE DOLOR EN ESTE MOMENTO:

____

NO DOLOR — DOLOR INRESISTIBLE

DESDE SU CIRUGIA/PROCEDIMIENTO, ESTA USTED: ☐ Mejor ☐ Peor ☐ Igual

NOMBRE DEL PACIENTE:____________________ FECHA____________________

Historia Medica del Paciente

Nombre:______________________ ID#:______________________ Fecha:______________

Edad:________ Estatura:__________ Peso:________ Sexo:_ Masculino: ◯ _____ Femenino ◯

En caso de emergencia llamar a :

Nombre:______________________________ Telefono:________________

Relacion:______________________________

1) Problemas que deben ser tratados hoy:______________________________________

Ha tenido tratamiento por este problema? (◯) Si (◯) No Cuando:______________________

Describa el tipo de tratamiento:____

Ha tenido cirugia por este problema? (◯) Si (◯) No

Si la respuesta es si, indique la fecha y el tipo de cirugia:______________________

2) Tiene alguna otra condicion que sea causada por el ejercicio?:______________________

3) Mencione los nombres de su doctor primario, internista, cardiologo, que ha visto o esta viendo:

Nombre:______________________ Nombre:______________________

Telefono:______________________ Telefono:______________________

4) Esta usted embarazada? (◯) Si (◯) No

5) Necesita asistencia con lo siguiente:

Transportacion	Si ◯	No ◯	Al Comer	Si ◯	No ◯
Mandados	Si ◯	No ◯	Cuidado Personal	Si ◯	No ◯
Labores domesticos	Si ◯	No ◯	Otro________	Si ◯	No ◯

6) Su dolor o desabilite ha causado alguno de estos problemas:

Problemas Finandieros	Si ◯	No ◯	Problemas Familiares	Si ◯	No ◯
Problemas Emocionales	Si ◯	No ◯	Otro___________	Si ◯	No ◯

7) Ha tenido o tiene actualmente lo siguiente:

			Osteoporosis	Si ◯	No ◯
Mareos o desmayos	SI ◯	No ◯	Enfermedades cardiacas	Si ◯	No ◯
Dolor de pecho/corazon	Si ◯	No ◯	Diabetes	Si ◯	No ◯
Valvula/aparato (corazon)	Si ◯	No ◯	Inchazon en los tobillos	Si ◯	No ◯
Dolor de cabeza	SI ◯	No ◯	Problemas del rinon	Si ◯	No ◯
Enfermedad de nervios	Si ◯	No ◯	Problemas de tiroides	Si ◯	No ◯
Alergias	Si ◯	No ◯	Hernia	Si ◯	No ◯
Convulciones	Si ◯	No ◯	Implantes de metal	Si ◯	No ◯
Problemas de balance	Si ◯	No ◯	Problemas de la vista	Si ◯	No ◯
Problemas de oido	Si ◯	No ◯	Presion alta	Si ◯	No ◯
Colesterol elevado	Si ◯	No ◯	Presion baja	Si ◯	No ◯
Cancer	Si ◯	No ◯	Tuberculosis	Si ◯	No ◯
			Hepatitis	Si ◯	No ◯

8) Favor de circular una respuesta si no sabe deje sin circular:

Cigarrillos (por dia)	Nunca ◯	1-5 ◯	10-20 ◯	30-40 ◯	>50 ◯
Bebidas alcohlicas (por semana)	Nunca ◯	1-5 ◯	10-20 ◯	>20 ◯	
Ejercicio Cardiovascular (por semana)	Nunca ◯	Ocasionalmente/ Recreativo ◯	3+ veces por semana por lo menos 15 minutos ◯		

9) Condicion Respiratoria: Normal ◯ Moderada ◯ Severo (dificultad al respirar al hacer esfuerzo minimo) ◯

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 ____________

Lien Claimant: Spine & Sport — Address: 3444 Kearny Villa Road, Suite 200, San Diego, CA 92123

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 ____________ Signature of Attorney for Lien Claimant — Date ____________

By ____________ 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