DOTHAN SPINE & SPECIALTY

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Confidential Patient Information

Patient's Name: _____ Today's Date: ____/____/____
Last First (Legal) Initial

Home Phone: _____ Cell Phone: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

E-Mail: _____ Male Female

Date of Birth: ____/____/____ Age: _____ Social Security #: _____ - _____ - _____

Occupation: _____ Hours/Week: _____ Employer: _____ Business Phone: _____

Spouse's Name: _____ Employer: _____ Business Phone: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Concurrent Health Care

Family Physician: _____ City: _____ State: _____ Phone: _____

How were you referred to us? _____

Insurance Information:

Do you have health insurance? Yes No Company Name: _____

Is Today's Visit Due To a: Work Related Injury: Yes No **Auto Accident:** Yes No **Date Of Injury:**_____

(If yes to either questions above, please check with receptionist as additional information is required.)

Person Responsible for Account: _____ Phone: _____

Address:_____ City: _____ State: _____ Zip: _____

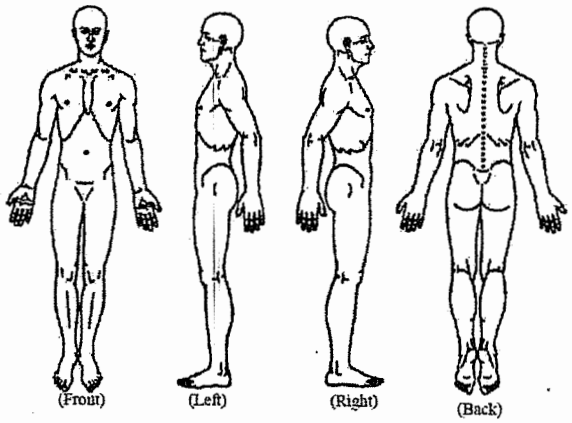
Please complete this brief health questionnaire.

Date of Onset: _____ Was the Onset: Gradual Sudden Since onset, has it gotten: Worse Better

Chief complaint: _____

Secondary or related complaint (if any) : _____

PLEASE MARK WHERE YOUR PAIN IS LOCATED:



SEVERITY OF PAIN:

Circle the number which represents the intensity of your pain.

Current Pain Level 0 1 2 3 4 5 6 7 8 9 10
no pain unbearable

Best Pain Level 0 1 2 3 4 5 6 7 8 9 10
no pain unbearable

Worst Pain Level 0 1 2 3 4 5 6 7 8 9 10
no pain unbearable

Continued on next page

Please read and Sign the below form before examination and treatment.

INFORMED CONSENT:

Medical doctors, chiropractic doctors and physical therapists that perform procedures are required by law to obtain your informed consent before beginning treatment.

I _____, Do hereby give my consent to the performance of conservative noninvasive treatment to the joints and soft tissues. I understand that the procedures may consist of manipulations/adjustments involving movement of the joints and soft tissues. Physical therapy and exercises may also be used. Although spinal and extremity manipulation/adjustment is considered to be one of the safest, most effective forms of therapy for musculoskeletal problems, I am aware that there are possible risks and complications associated with these procedures. Some risks and complications associated with therapy are as follows:

Soreness/Bruising: I am aware that like exercise it is common to experience muscle soreness and occasionally bruising in the first few treatments.
Dizziness: Temporary symptoms like dizziness and nausea can occur but are relatively rare.
Fractures/Joint Injury: I further understand that in isolated cases underlying physical defects, deformities or pathologies like weak bones from osteoporosis may render the patient susceptible to injury. When osteoporosis, degenerative disc, or other abnormality is detected, this office will proceed with extra caution.
Stroke: Although strokes happen with some frequency in our world, strokes from chiropractic adjustments are rare. I am aware that nerve or brain damage including stroke is reported to occur once in a million to once in ten million treatments. Once in a million is about the same chance as getting hit by lightning. Once in ten million is about the same chance as a normal dose of aspirin or Tylenol causing death.
Physical Therapy Burns: Some of the therapies used in this office generate heat and may rarely cause a burn. Despite precautions, if a burn is obtained, there will be a temporary increase in pain and possible blistering. This should be reported to the doctor. Tests have been or will be performed on me to minimize the risk of any complication from treatment and I freely assume these risks.

TREATMENT RESULTS

I also understand that there are beneficial effects associated with these treatment procedures including decreased pain, improved mobility and function, and reduced muscle spasm. However, I appreciate there is no certainty that I will achieve these benefits. I realize that the practice of medicine, including chiropractic and physical therapy, is not an exact science and I acknowledge that no guarantee has been made to me regarding the outcome of these procedures. I agree to the performance of these procedures by my doctor and such other person of the doctor's choosing.

ALTERNATIVE TREATMENTS AVAILABLE

Reasonable alternatives to these procedures have been explained to me including, rest, home applications of therapy, prescription or over-the counter medications, exercises and possible surgery.
Medications: Medication can be used to reduce pain or inflammation. I am aware that long-term use or overuse of medication is always a cause for concern. Drugs may mask pathology, produce inadequate or short-term relief, undesirable side effects, physical or psychological dependence, and may have to be continued indefinitely. Some medications may involve serious risks.
Rest/Exercise: It has been explained to me that simple rest is not likely to reverse pathology, although it may temporarily reduce inflammation and pain. The same is true of ice, heat or other home therapy. Prolonged bed rest contributes to weakened bones and joint stiffness. Exercises are of limited value but are not corrective of injured nerve and joint tissues.
Surgery: Surgery may be necessary for joint instability or serious disc rupture. Surgical risks may include unsuccessful outcome, complications, pain or reaction to anesthesia, and prolonged recovery.
Non-treatment: I understand the potential risks of refusing or neglecting care may include increased pain, scar/adhesion formation, restricted motion, possible nerve damage, increased inflammation, and worsening pathology. The aforementioned may complicate treatment making future recovery and rehabilitation more difficult and lengthy.

I have read or had read to me the above explanation of treatment. Any questions I have had regarding these procedures have been answered to my satisfaction PRIOR TO MY SIGNING THIS CONSENT FORM. I have made my decision voluntarily and freely.

_____ Signature of Patient Date: _____

_____ Signature of Parent or Guardian (if a minor) Date: _____

_____ Signature of Witness Date: _____

Continued from previous page

Describe what caused the pain: _____

Describe the quality of the complaint/pain: sharp dull/ache throbbing tingling/numbness other: _____

Does any of the following make the pain worse: lifting bending pushing pulling cough sneeze bowel movement driving riding sitting walking running standing other: _____

Describe if pain is in a single spot or does it spread out: radiating dull deep ache pin point burning sharp stabbing tingling numb other: _____

Does any of the following make it better: rest laying down sitting walking exercise other: _____

How often are you aware of the pain: intermittent (less than 25% of time when awake) occasional (25-50% of time when awake) frequent (50-75% of time when awake) constant (75-100% of time when awake)

Does it interfere with your daily activities: minimal (annoyance, no impairment) slight (tolerated, some impairment) moderate (marked impairment) marked (precludes any activity)

Have you detected any possible relationship of your current complaint with any of the following?
Muscle Weakness Bowel/Bladder problems Digestion Cardiac/Respiratory Other: _____

Have you tried any self-treatment or taken any medication (over the counter or prescription): Yes No
If yes, explain; _____ Results: _____

Past Health and Social History:

1. Is this the first time you have experienced this problem? Yes No If no, When: _____
2. Was treatment provided? Yes No If yes, By whom: _____ Outcome: _____
3. Have you **ever** had any **major illnesses, injuries, broken bones, hospitalizations, or surgeries?** If Yes, please list below:

Date	Injury / Fracture / Illness	Treatment	Results

4. What is your approximate height? _____ What is your approximate weight.? _____
5. Do you regularly exercise? Yes No If yes, how many hours a week and what activities: _____
6. Do you drink alcohol? None light moderate heavy How many glasses per week? _____
7. Check any conditions you have had:

AIDS/HIV	Deafness	Heart Disease	Osteoporosis	Thyroid Problems
Allergies	Diabetes	Herniated Disc	Poor Circulation	TMJ
Anxiety/Depression	Digestion Problems	High blood pressure	Prostrate Problems	Venereal disease
Arm/shoulder pain	Earache	Insomnia	Rheumatoid	Vertigo/Dizziness
Arthritis	Ear ringing	Irregular Cycle	Arthritis	Other:
Asthma	Epilepsy	Kidney Problems	Sciatica	_____
Bladder Problems	Headaches	Leg Pain	Shingles	_____
Cancer	Headache –	Low back pain	Sinus Infections	_____
Chronic Fatigue	Migraine	Neck Pain	Stroke	

Office Use Only _____

ASSIGNMENT OF BENEFITS:
Your signature is necessary for us to process any insurance claims and to ensure payment of services rendered. I authorize release of all medical information necessary to process my insurance, workman's compensation or personal injury claims or that is pertinent to my medical care. assign all medical benefits to which I am entitled to the above named physician or clinic. This agreement will remain in effect until all money owed to the above named physician or clinic is paid in full. In addition to the above, I hereby waive the stature of limitations on collection and/or recovery in this state of Alabama.

CANCELLATION AND NO-SHOW POLICY:
We take this subject very seriously as this can make a difference between responding to treatment or not. **We require a 24 hour notice in the event of a cancellation. THERE IS A $20 CHARGE FOR CANCELLATION OR NO-SHOW WITHOUT PROPER NOTICE.** For worker's compensation and personal injury cases, documentation of any missed appointment is forwarded to your case manager and/or primary physician. This charge will not be covered by your insurance, worker's compensation or personal injury cases, and **IS YOUR RESPONSIBILITY.**

STATEMENT OF FINANCIAL LIABILITY:
I understand that I am fully responsible for the payment of this account, and hereby assume and guarantee prompt payment of all expenses incurred. I understand that I am responsible for payment of office charges AT THE TIME OF SERVICE. I understand that unless otherwise indicated below, I hereby request and authorize DSS to bill my insurance policy/policies for all services provided to me. I authorize payment to DSS for all such services. I acknowledge that the fees charged by DSS are considered to fall within the "usual, customary and reasonable" range by most insurance companies. Since your policy is an agreement between you and your insurer, DSS will not enter into any dispute between you and your insurance company. When you begin treatment with DSS, our billing department will call your insurance company to verify that you do have valid insurance coverage. However, that verification is only a confirmation of a valid policy and not a guarantee of coverage. DSS recommends that each patient call and verify their own insurance coverage and benefits by calling member service with their insurance.

ALTERNATE BILLING / PAYMENT INSTRUCTIONS:
❑ By checking the box to the left, I hereby direct DSS TO NOT bill my insurance company for services provided to me and instead I agree to pay all fees for services furnished to me. I further understand and agree that I will be required to provide a down payment prior to receiving the services based on my estimated financial responsibility. DSS does offer a medical discount plan (ChiroHealth USA) for patients that wish to become a member to receive discounted services.

PERMISSION TO RELEASE MEDICAL INFORMATION:
(HIPPA ACKNOWLEDGEMENT)
I authorize DSS to release information from my medical record or from the person for whom I am legally responsible, to my/their insurance company, other third party payers or their reviewing agencies, as reasonably necessary to expedite claim processing. This authorization is valid for every visit to DSS until written notice revoking it is provided. I release DSS of all responsibility or liability for loss of confidentiality through access and/or copies of records release, or other information disclosed in compliance with this authorization.

I have read all of the above and understand/agree to all provisions therein regarding responsibility for payments and release of information.

_____ Signature of Patient Date _____

_____ Signature of Parent or Guardian (if a minor) Date _____

_____ Signature of Witness Date _____