Physicians Plus Spine and Rehab Center

In order to provide you the best possible wellness care, please complete all pages of this form during your first appointment. All pages are required. All information is strictly CONFIDENTIAL.

HOW DID YOU HEAR ABOUT US?

Referring new patients to our office is the highest compliment we can receive. Please take a moment to let us know ALL the ways you heard about our office. Put a check next to each source and then CIRCLE the main reason you selected this office.

Thank you!

Patient Name:_____

___ Physician referral (Please list name below)

___ Internet

___ Family Member/Sibling

___ Office Incentive (contest/free consultation flyer)

___ Insurance company

___ Direct mailings

___ Newspaper

___ Other:_____

Please list the names of whom referred you to us (if applicable so we may thank them properly):

_____

_____

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Patient Data

First Name: _____ M.I.: ____ Last Name: _____

Nickname/Preferred Name:_____ Date _____

Patient Information

Address: _____ City: _____ State: _____ Zip: _____
Cell #:_____ Home #:_____ Work #:_____
E-mail: _____ Preferred Contact: ☐Text ☐Email ☐Phone Call
DOB:____/_____/_____ Age: _____ Social Security #:_____/_____/_____ Gender:_____
Primary Care Physician: _____ Phone #: _____
Occupation: _____ Employer:_____
Marital Status: _____ Spouse's Name? _____ Children?: ☐ Yes ☐ No How Many:_____
Emergency Contact:*(Name, Relationship, Phone #)*_____

Insurance Information

Do you have Insurance? ❑ Yes ❑ No
Type of Insurance: ❑ Medicare ❑Medicaid ❑ Commercial ❑ VA ❑ Other: _____
Primary Insurance Carrier: _____ Phone: _____
ID#_____ Group #_____
Name of Policy Holder: _____ Relationship to Patient: _____
Is patient covered by another insurance? ❑ Yes ❑ No
Secondary Insurance Carrier: _____ ID#_____

ASSIGNMENT/AUTHORIZATION/RELEASE:
I certify that I, and/or my dependents, have insurance with the above named insurance company(s) and assign directly to Physicians Plus Spine and Rehab Center all benefits, if any, otherwise payable to me for services rendered. I authorize the use of my signature on all insurance submissions. I understand that copays, coinsurance, and deductibles are payable at the time of each visit and that I am financially responsible for all charges whether or not paid by insurance. The above named provider's office may use my health care information and may disclose such information to the above named insurance company(s) and their agents for the purpose of obtaining payment for services and determining benefits payable for related services.

❑ **Private Pay/Cash:** By checking this box, I acknowledge that I **do not** have insurance and understand that I am financially responsible for all services at the time they are rendered. **Name of person responsible for payment on this account:**
_____

Patient/Guardian Signature: _____ Date: _____

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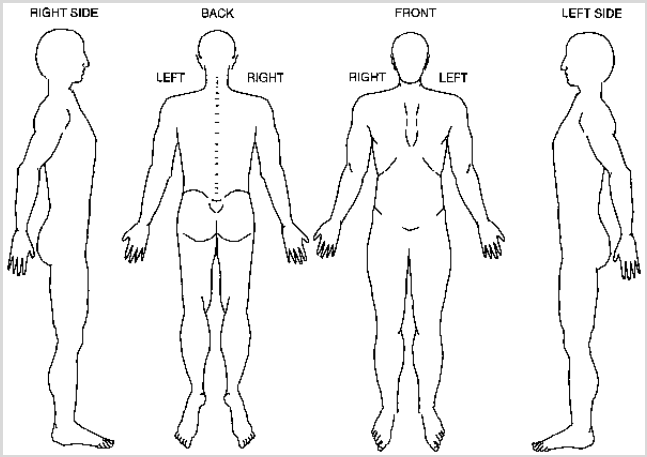
PLEASE DESCRIBE SYMPTOMS BELOW: (START AT THE TOP OF YOUR BODY AND WORK YOUR WAY DOWN, I.E HEADACHE, NECK PAIN, ETC.)

SYMPTOM 1_____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time:
  0 1 2 3 4 5 6 7 8 9 10
- What caused your symptoms and when did they begin?
  _____
- What makes the symptoms worse?
  Bending neck forward, Bending neck backward, tilting head to the left, tilting head to the right, turning head to the left, turning head to the right, bending forward at the waist, bending backward at the waist, tilting left at the waist, tilting right at the waist, twisting left at the waist, twisting right at the waist, sitting, standing, getting up from sitting, lifting, driving, walking, running, sleeping, any movement, other (please describe) _____
- What makes the symptoms better?
  Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing,
  Other_____
- Describe the quality of symptoms (circle all that apply)
  Sharp, Dull, Achy, Burning, Throbbing, Piercing, Stabbing, Deep, Nagging, Shooting, Stinging,
  Other_____
- Does the symptom radiate to another part of your body (circle one): YES NO
- If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (circle one)
  Morning Afternoon Evening Night Unaffected by time of day

CURRENT COMPLAINTS: INDICATE ALL AREAS OF COMPLAINT ON THE DIAGRAM PROVIDED:



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SYMPTOM 2_____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time:
  0 1 2 3 4 5 6 7 8 9 10
- What caused your symptoms and when did they begin? _____
- What makes the symptoms worse?
  Bending neck forward, Bending neck backward, tilting head to the left, tilting head to the right, turning head to the left, turning head to the right, bending forward at the waist, bending backward at the waist, tilting left at the waist, tilting right at the waist, twisting left at the waist, twisting right at the waist, sitting, standing, getting up from sitting, lifting, driving, walking, running, sleeping, any movement, other (please describe) _____
- What makes the symptoms better?
  Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other_____
- Describe the quality of symptoms (circle all that apply)
  Sharp, Dull, Achy, Burning, Throbbing, Piercing, Stabbing, Deep, Nagging, Shooting, Stinging,
  Other_____
- Does the symptom radiate to another part of your body (circle one): YES NO?
- If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (circle one)
  Morning Afternoon Evening Night Unaffected by time of day

SYMPTOM 3_____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time:
  0 1 2 3 4 5 6 7 8 9 10
- What caused your symptoms and when did they begin? _____
- What makes the symptoms worse?
  Bending neck forward, Bending neck backward, tilting head to the left, tilting head to the right, turning head to the left, turning head to the right, bending forward at the waist, bending backward at the waist, tilting left at the waist, tilting right at the waist, twisting left at the waist, twisting right at the waist, sitting, standing, getting up from sitting, lifting, driving, walking, running, sleeping, any movement, other (please describe) _____
- What makes the symptoms better?
  Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other_____
- Describe the quality of symptoms (circle all that apply)
  Sharp, Dull, Achy, Burning, Throbbing, Piercing, Stabbing, Deep, Nagging, Shooting, Stinging,
  Other_____
- Does the symptom radiate to another part of your body (circle one): YES NO
- If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (circle one) Morning Afternoon Evening Night Unaffected by time of day

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Name of Current PCP: **Date of Last Physical Exam:**

CURRENT MEDICATIONS:	**ALLERGIES:**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	
_____	

Surgeries | Date & Type of Surgery

_____

_____

_____

Social and Occupational History:

a. **Job description** _____
b. **Work schedule** _____
c. **Recreational activities/Hobbies**_____
d. **Lifestyle: Exercise ___days/week Alcohol ___/week Tobacco: ___ packs/day/week**
   - **None/Other**_____

PREGNANCY WAIVER- (Male patients please skip this section)

I hereby acknowledge that Physicians Plus Spine and Rehab Center has informed me prior to being x-rayed of the advisability of risk and the probable consequences of receiving x-rays during pregnancy. I have stated on my own that I was not pregnant at the time and do hereby release and hold harmless from any legal action or responsibility caused by the use of this procedure.

Printed Name of Patient _____

Signature of Patient/Authorized Representative of Patient _____

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REVIEW OF SYSTEMS (Please circle all that apply)

Pulmonary (lung-related)
- Asthma/difficulty breathing
- COPD
- Emphysema
- None/Other: _____

Cardiovascular (heart-related)
- Heart surgeries
- Congestive Heart Failure
- Murmurs or valvar disease
- Heart attacks
- Heart Disease/problems
- Hypertension (high blood pressure)
- Pacemaker
- Angina/chest pain
- Irregular heartbeat
- None/Other _____

Neurological (nerve-related)
- Visual changes/loss of vision
- One-sided weakness of face or body
- History of seizures
- Stroke/TIAS
- Headaches
- Memory loss
- Tremors
- Vertigo
- None/Other:_____

Endocrine (glandular/hormonal)
- Thyroid disease
- Hormone replacement therapy
- Injectable steroid replacements
- Diabetes- TYPE_____
- None/Other_____

Renal (kidney-related)
- Renal Calculi/Stones
- Hematuria (blood in the urine)
- Incontinence (can't control)
- Bladder infections
- Difficulty urinating
- Kidney Disease
- Dialysis

Gastroenterological (stomach-related)
- Nausea
- Difficulty swallowing
- Ulcerative disease
- Frequent abdominal pain
- Hiatal hernia none
- Gastroesophageal reflux/heartburn
- Constipation
- Pancreatic disease
- Irritable bowel/colitis
- Hepatitis or liver disease
- Bloody or black tarry stools
- Vomiting Blood
- None/Other:_____

Dermatological (skin-related)
- Significant burns
- Significant rashes
- Skin grafts
- Psoriatic Disorder
- None/Other_____

Musculoskeletal (bone/muscle-related)
- Rheumatoid arthritis
- Gout
- Osteoarthritis
- Spinal fractures
- Spinal surgeries
- Arthritis (unknown type)
- Metal Implants
- None/Other: _____

Psychological
- Psychiatric diagnosis
- Depression
- Suicidal ideations
- Bipolar disorder
- Homicidal ideations
- Schizophrenia
- Psychiatric hospitalizations
- None/Other_____

Cancer

Are you currently in remission or currently have a diagnosis of having Cancer? If so, please explain:_____

_____

_____

_____

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AUTHORIZATION FOR COMMUNICATION

❒ I authorize communication between Physicians Plus Spine and Rehab Center staff and the person(s) listed below on my behalf regarding my information including medical records, billing, and/or scheduling. *(This communication may be sent by email if requested.)*

- ❒ Family Member: _____
- ❒ Other: _____
- ❒ Physician's Office: _____

❒ I authorize Physicians Plus Spine and Rehab Center to *leave voicemail and/or text message reminders* about scheduling and/or billing at the number indicated on these forms and/or at _____.

❒ I **DO NOT** authorize the release of information to anyone. *(I understand by doing this no one can talk on my behalf and no information will be release to any one including other doctor's office or attorney's office.)*

❒ I **DO NOT** authorize Physicians Plus Spine and Rehab Center to leave voicemail and/or text message reminders about scheduling and/or billing.

By signing below, I authorize Physicians Plus Spine and Rehab Center to communicate by mail or email with myself and/or those I have given authorization. I know that I am under no obligation to authorize Physicians Plus Spine and Rehab Center to send emails and/or text messages. I understand that releasing medical information or communicating by email and/or text messages is not a secure format of communication. There is some risk that individually identifiable health information or other sensitive or confidential information contained in email communication may be misdirected, disclosed to or intercepted by unauthorized third parties. Information included in email and/or text messages communication may include your first name, date/time of appointments, name of physician, and physician phone number, or other pertinent information. This ***Authorization for Communication*** will remain in effect until terminated by me in writing.
By signing below, I accept and understand the risk explained above.

Acknowledgment of Privacy Practices

Our practice is committed to protecting privacy and confidentiality. With my consent, Physicians Plus Spine and Rehab Center, may use and disclose Protected Health Information (PHI) about me or my dependent to perform treatment, payment and healthcare operations (TPO). Please refer to Notice of Privacy Practices of Physicians Plus Spine and Rehab Center for a complete description of such uses and disclosures. I acknowledge that a copy of said Notice of Privacy Practices was offered to me.

Date: _____ Date: _____

_____ _____

Patient's Name Name of Parent or Guardian (if a minor)

_____ _____

Signature Signature of Parent or Guardian (if a minor)

Physicians Plus Spine and Rehab Center

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HIPPA Authorization

Patient Name:_____ DOB:_____

THE FOLLOWING PHI IS TO BE RELEASED: (PATIENT OR PATIENT REPRESENTATIVE MUST CHECK ONE BOX FOR EACH ITEM):

Yes	No	Items Requested	Yes	No	Items Requested
❒	❒	Physician Notes	❒	❒	All Medical Records on file
❒	❒	X-Ray Reports	❒	❒	Lab Results
❒	❒	MRI Scans	❒	❒	Claims/Billing Information
❒	❒	CT Scans	❒	❒	Other: _____

REVIEW OF PROCEDURES AND SELECTION OF INSPECTION OR COPYING OF MEDICAL RECORDS:

Your request to inspect or copy your PHI will be reviewed by the Medical Records Clerk of Physicians Plus Spine and Rehab Center who will determine if the information requested can be made available to you. We may legally prohibit from making certain information available to patients or the patients' representatives, including: Psychotherapy Notes, information related to legal proceedings, information that federal or state laws prevent us from disclosing, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, and information that was obtained under a promise of confidentiality.

- **Inspection of Medical Records:** We will complete our review of your request and will arrange for you to inspect your records at our Bear office within **a minimum of 14 business days** of your request.
- **Copying of Medical Records:** We will complete our review of your request and within the limitations of the law, we will make every effort to accommodate your request. **If we deny your request**, in whole or in part, you may request that we review that decision. It will take a **minimum of 14 business days** before your records will be copied. We will call you when your records are ready to be picked up at the Bear office.

Indicate the reason why you want your medical records copied: _____

Provide full name and address if you want your records mailed to your doctor: _____

I understand that my PHI may be redisclosed by the person or entity receiving my PHI from Physicians Plus Spine and Rehab Center, and that it then may no longer be protected by federal privacy regulations. State law may or may not prohibit such redisclosure by the person or entity receiving my PHI from Physicians Plus Spine and Rehab Center I voluntarily sign this authorization, and I understand that my health care will not be affected if I do not sign this form. I understand that I have the right to receive a copy of this authorization. I also understand that I may revoke or modify this authorization at any time by notifying Physicians Plus Spine and Rehab Center in writing. I understand that my revocation or modification of this authorization will not affect any actions taken by Physicians Plus Spine and Rehab Center in reliance on this authorization before Physicians Plus Spine and Rehab Center receives my request for revocation or modification. I must sign and date my written request and send it to the following address: Medical Records Department, Physicians Plus Spine and Rehab Center, 1701 Pulaski Highway, Bear, DE 19701.

The authorization will expire on (date no more than one year in advance): _____

Signature of Patient/Guardian:_____Date:_____

If you are signing as the patient's representative, print your name: _____

Please indicate your relationship to the patient:

❒ Parent, guardian or caregiver of a minor patient.
❒ Guardian or conservator of an incompetent patient.
❒ Beneficiary or personal representative of a deceased patient.
❒ Other: _____(Specify Relationship)

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Informed Consent

To the Patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The nature of the chiropractic adjustment.

The primary treatment used by doctors of chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis / Examination / Treatment

As a part of the analysis, exanimation, and treatment, you are consenting to the following procedures: ***(Please initial each procedure to give consent.)***

__ spinal manipulative therapy	__ palpation	__ vital signs	__ range of motion testing
__ orthopedic testing	__ basic neurological testing		__ muscle strength testing
__ postural analysis testing	__ ultrasound	__ EMS	__ hot/cold therapy
__ radiographic studies	__ Other *(please explain)*: _____		

The risks inherent in chiropractic adjustment.

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. The Doctor will make every reasonable eff0rt during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to the Doctor's attention it is your responsibility to inform the Doctor.

The probability of those risks occurring.

Fractures are rare occurrences and generally result from some underlying weakness of the bone which we check for during the taking of your history and during exanimation and X-ray. Stroke and /or arterial dissection caused by chiropractic manipulation of the neck has been the subject of ongoing medical research and debate. The most current research on the topic is inconclusive as to a specific incident of this complication occurring. If there is a causal relationship at all it is extremely rare and remote. Unfortunately, there is no recognized screening procedure to identify patients with neck pain who are at risk of arterial stroke.

The availability and nature of other treatment options.

Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers
- Hospitalization
- Surgery

If you chose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated.

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

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CONSENT TO TREATMENT (MINOR)

I hereby request and authorize Physicians Plus Spine and Rehab Center to perform diagnostic tests and render chiropractic adjustments and other treatment to my minor son/daughter: _____ . This authorization also extends to all other doctors and office staff members and is intended to include radiographic examination at the doctor's discretion. As of this date, I have the legal right to select and authorize health care services for the minor child named above. (If applicable) Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse or other parent is not required. If my authority to so select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

DO NOT SIGN UNTIL YOU HA VE READ AND UNDERSTAND THE ABOVE. PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW

I have read ❒ or have had read to me ❒ the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Physicians Plus Spine and Rehab Center and have had my questions answered to my satisfaction. By signing below, I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Date: _____ Date: _____

_____ _____

Patient's Name Name of Parent or Guardian (if a minor)

_____ _____

Signature Signature of Parent or Guardian (if a minor)

Physicians Plus Spine and Rehab Center

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Consent for Financial Responsibility for Unreferred/Non-Covered Services

Patient Information

Patient Name: _____

Patient's Date of Birth: _____ Insurance ID #: _____

Patient's Address: _____

Patient's Phone: _____ Patient's Email: _____

Type of service(s): Chiropractic Manipulation, Exam(s), X-rays, Therapies/Modalities, Durable Medical Equipment, Massage Therapy, Strapping _____

Provider's Names:

Dr. Sean Feeney, M.S.D.C Dr. Preya Patel, D.C Dr. Todd Watson, D.C. Dr. Stephen Black, D.C.

Member Must Complete This Section

As a member of: (Circle one)

Aetna/Meritain Highmark Blue Cross Blue Shield Independence Blue Cross/Keystone

Multiplan/PHCS First Health United Health Care UMR

AmeriHealth Caritas Highmark Health Options Delaware First Health

I understand that… (Signing below acknowledges the following and takes responsibility for them):

1.) A referral from my Primary Care Physician maybe required for any and all non-Emergency outpatient hospital/ specialist services. I acknowledge that I do not have a referral with me at this time, but I choose to receive the services without the required referral. I understand that without the appropriate referral, I will be held responsible for any payments incurred for these services. (HMO)

2.) I understand that this is a non-covered service for which my insurance carrier will not make payment and I agree to be financially liable for any payments incurred for these services. I understand that I have the right to appeal this determination. (ANY)

3.) I understand that certain services will only be covered by my insurance carrier when performed by designated providers or in certain settings (e.g., capitated radiology or lab services, and DME services). I understand and agree that I will be financially responsible for certain services that I choose to receive from the provider noted above rather than the designated network provider or in the appropriate setting. The provider has specifically explained to me the services for which I will be financially responsible. (ANY)

4.) I understand that I will be responsible for all fees incurred if this visit or any other service precedes the effective date that has been assigned to my enrollment or my dependent's enrollment. (ANY)

_____ _____ _____

Patient's Signature Patient's Printed Name Date

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LightForce Laser Therapy Informed Consent

Laser therapy is a safe, non-invasive, FDA cleared modality for the treatment of pain, inflammation, and the temporary increase of microcirculation. Increased microcirculation can provide relief for many acute and chronic conditions. Laser therapy utilizes visible and invisible laser radiation; therefore, appropriate eye protection is required at all times during treatment.

Effects of your treatment will continue for up to 18 hours. Individuals respond uniquely to treatment. You may see immediate results after the first treatment, or depending on the severity of your condition, you may require several treatments before beginning to feel results.

Increased soreness may occur after your first laser session. This is a normal healing phenomena known as retracing. Mild bruising may occur from the soft tissue manual therapy element of your treatment program.

- ❑ I understand the above and consent to treatment.
- ❑ I understand that failing to complete any part of my treatment program will reduce my chances of success.

This form is a tool to help your clinician determine if you are a candidate for laser therapy. Please check YES or NO to the questions below:

YES ❑ NO ❑ Do you have a pacemaker or any other implanted device?

YES ❑ NO ❑ Are you pregnant?

YES ❑ NO ❑ Do you have cancer?

YES ❑ NO ❑ Are you taking medication that may increase your sensitivity to light?

YES ❑ NO ❑ Have you had a steroid injection in the last 7 days?

If you answer yes to any of these questions, you will need to discuss details of your condition with your clinician prior to receiving treatment.

By signing this form, I agree with the statements above and give my consent for Physicians Plus Spine and Rehab Center to proceed with Laser therapy.

_____ _____ _____

Patient's Signature Patient's Printed Name Date

lightforce® therapy lasers

The ultimate decision to recommend treatment lies with your health care provider. Speak with your health care provider if you have further questions about therapy treatment.