Physicians Plus Spine & Rehab Center
1701 Pulaski Hwy Bear, DE 19701
P.) 302-300-1111
F.) 302-257-5628

Work Related Injury

File #

Name:_____ **| Preferred Name:**_____ **Date:** _____
Address: _____ **City:** _____ **State:** _____ **Zip:** _____
DOB:_____ **Age** _____ **Social Security #**_____
Home #:_____ **Work #:**_____ **Cell #:**_____
Dominant Hand: **Right / Left** **| Email address:** _____

Primary Care Physician: _____
Referred to Physicians Plus by Whom: _____

Date of Injury: _____ **Time:** _____
or
Period of time over which your injury occurred: _____

Name of Insurance Company Responsible for the Payment of Your Injuries:_____
Address: _____ **City:**_____ **State:**_____**Zip:**_____
Claim#:_____ **Claim Agent:** _____ **Ph#**_____

Very Important (for your protection)
❑ **Yes** ❑ **No**
I have completed and turned in all of the paperwork, forms, etc. required by the Insurance Company in order to initiate payment on my medical bills. You should be fully aware that it is your responsibility to complete the necessary paperwork as mandated by the Insurance Carrier that is responsible for the payment of all medical expenses that you may have already accrued from other treatment(s) or shall accrue from this or any subsequent treatment(s).
If this paperwork is not completed (in a timely manner) the Insurance Company will not initiate the payment of your benefits and may choose to deny payment on your entire claim, regardless of the party at fault.
We are here to help you simplify this process by answering any questions to the best of our ability. Please do not hesitate to ask for assistance.

❒ **Yes** ❒ **No** Do you have any Private Health Insurance (this is for your protection in case of the denial of your claim)?

Name of Private Insurance:_____
ID#: _____
*** Please Note, this information is for your protection in case there is an emergency**
*** Please provide a copy of your private insurance card**

❒ **Yes** ❒ **No** Do you have an attorney to assist you?
If yes, Name of Law Firm:_____
Name of Attorney:_____
Address: _____City:_____
State:_____ Zip:_____

Employer: _____ Phone:_____
Occupation:_____ Job: Position_____
Employer Address:_____City:_____State:_____Zip:_____
How long have you been employed by your present employer?_____

❒ **Yes** ❒ **No** Did your injuries occur from a single incident.
If yes, what date?_____ Approx Time?(if known)_____

❒ **Yes** ❒ **No** Did your injuries occur over a period of time?
If yes, approximately what was the time phrase of occurance? _____

❒ **Yes** ❒ **No** Were you performing your normal job duties when injured?

❒ **Yes** ❒ **No** Did your injuries occur on your jobsite?
If no to above question, where did your injury occur? _____
_____

Injury Details

Briefly describe how you injured yourself:_____
_____
_____
What were your immediate symptoms?_____
_____
_____

❒ **Yes** ❒ **No** Did anyone witness your injuries?
❒ **Yes** ❒ **No** Did you report your injuries to your supervisor?
❒ **Yes** ❒ **No** Did you report your injuries to someone other that your supervisor?
Name of the person you reported your injuries to:_____
Name of the contact person (if needed) to discuss your condition:_____
Telephone #:_____

❒ **Yes** ❒ **No** Were you given any specific recommendations after reporting your injuries?
If yes, please briefly describe_____
_____
_____

❒ **Yes** ❒ **No** ❒ **Don't Recall** After your injury, did you lose consciousness?
If yes, please describe_____
❒ **Yes** ❒ **No** Did you sustain any cuts, lacerations or bruises?
If yes, please describe_____
❒ **Yes** ❒ **No** Have your symptoms changed since you originally got injured?
If yes, please describe_____
❒ **Yes** ❒ **No** ❒ **Don't Recall** Did your feet/ankles get twisted or jammed into the floorboard?

❒ **Yes** ❒ **No** Did your body strike anything else within the vehicle? If yes, please describe_____
_____

❒ Yes ❒ No Did you go to your company's employee health center?
If yes, what treatment was conducted? _____
_____

❒ Yes ❒ No Were you given any specific recommendations or placed on any restrictions from employee health? _____
If yes, what were they? _____

❒ Yes ❒ No Did you see a company physician?

❒ Yes ❒ No If yes, was any treatment conducted?
If treatment was rendered at employee health, please briefly describe_____
_____
_____

❒ Yes ❒ No Were you taken to the Emergency Room immediately after the accident? (If yes, how were you transported) ❒ Ambulance ❒Drove Self ❒ Driven by another ❒ Medi-Vac

❒ Yes ❒ No Did you go to the Emergency Room later in the day or at all? If you went to the Emergency Room, which one? _____

If you went to the Emergency Room, did you (check all that apply)
❒ get examined ❒ have x-rays ❒ have a Cat Scan ❒ have an EKG
❒ get stitches ❒ get casted ❒ get admitted to the hospital
❒ other:_____

❒ Yes ❒ No Were you prescribed any medications? If yes, which ones?_____
_____

Follow-up Treatment

❒ Yes ❒ No Have you seen your family physician? If yes, what medications/treatments were prescribed?_____

❒ Yes ❒ No Was physical therapy prescribed?
If yes, where?_____
For how long?_____
Approximate times per week?_____

❒ Yes ❒ No Have you been referred to any specialist (i.e. Neurosurgeon, Neurologist, Orthopedic Surgeon, Physiatrist, etc.)
If yes, please list:
1. _____
2. _____
3. _____
4. _____
5. _____

❒ Yes ❒ No Due to your injuries, have you had any of the following tests?

LOCATION

❒ X-Rays_____
❒ MRI_____
❒ Cat Scan_____
❒ EMG_____
❒ Other_____
_____

Present complaints due to accident:

❒ Yes	❒ No	Headaches	❒ Yes	❒ No	Cramp of muscles in left leg
❒ Yes	❒ No	Dizziness	❒ Yes	❒ No	Cramping of muscles in right leg
❒ Yes	❒ No	Light sensitivity	❒ Yes	❒ No	Left knee pain
❒ Yes	❒ No	Nausea with headaches	❒ Yes	❒ No	Right knee pain
❒ Yes	❒ No	Jaw pain	❒ Yes	❒ No	Left foot and/or ankle pain
❒ Yes	❒ No	Facial pain	❒ Yes	❒ No	Right foot and/or ankle pain
❒ Yes	❒ No	Heaviness of head	❒ Yes	❒ No	Anxiety
❒ Yes	❒ No	Neck pain and/or stiffness	❒ Yes	❒ No	Tension
❒ Yes	❒ No	Numb, tingling and/or weak down left arm	❒ Yes	❒ No	Insomnia
❒ Yes	❒ No	Numb, tingling and/or weak down right arm	❒ Yes	❒ No	Depression
❒ Yes	❒ No	Left shoulder pain	❒ Yes	❒ No	Difficulty with concentration
❒ Yes	❒ No	Right shoulder pain	❒ Yes	❒ No	Irritability
❒ Yes	❒ No	Cramping of muscles in left arm	❒ Yes	❒ No	Loss of taste
❒ Yes	❒ No	Cramping of muscles of right arm	❒ Yes	❒ No	Loss of smell
❒ Yes	❒ No	Mid back pain and/or stiffness	❒ Yes	❒ No	Vision change
❒ Yes	❒ No	Pain into rib cage	❒ Yes	❒ No	Memory loss
❒ Yes	❒ No	Sternal pain	❒ Yes	❒ No	Fatigue
❒ Yes	❒ No	Low back pain and/or stiffness	❒ Yes	❒ No	Mental dullness
❒ Yes	❒ No	Numb, tingling and/or weak down left leg	❒ Yes	❒ No	Ringing or buzzing in ears
❒ Yes	❒ No	Numb, tingling and/or weak down right leg			

Notes:

Present Medications

Injury Related	Prior to Injury

As a result of your injuries, are any of the following conditions difficult or impossible to perform? Check all that apply.

❒ **Yes** ❒ **No** ❒ **Not Applicable** Heavy lifting (50 lbs. and above from ground level)
❒ **Yes** ❒ **No** ❒ **Not Applicable** Moderate lifting (25 lbs. to 49 lbs. from ground level)
❒ **Yes** ❒ **No** ❒ **Not Applicable** Light lifting (Less than 25 lbs. from ground level)
❒ **Yes** ❒ **No** ❒ **Not Applicable** Bending
❒ **Yes** ❒ **No** ❒ **Not Applicable** Twisting
❒ **Yes** ❒ **No** ❒ **Not Applicable** Standing
❒ **Yes** ❒ **No** ❒ **Not Applicable** Sitting
❒ **Yes** ❒ **No** ❒ **Not Applicable** Sleeping
❒ **Yes** ❒ **No** ❒ **Not Applicable** Gripping
❒ **Yes** ❒ **No** ❒ **Not Applicable** Pushing
❒ **Yes** ❒ **No** ❒ **Not Applicable** Pulling
❒ **Yes** ❒ **No** ❒ **Not Applicable** Reaching
❒ **Yes** ❒ **No** ❒ **Not Applicable** Housework
❒ **Yes** ❒ **No** ❒ **Not Applicable** Dressing self (i.e. putting shoes on)
❒ **Yes** ❒ **No** ❒ **Not Applicable** Bathing/ Showering
❒ **Yes** ❒ **No** ❒ **Not Applicable** Brush teeth in morning
❒ **Yes** ❒ **No** ❒ **Not Applicable** Shaving
❒ **Yes** ❒ **No** ❒ **Not Applicable** Caring for children
❒ **Yes** ❒ **No** ❒ **Not Applicable** Sexual Activities

❒ **Yes** ❒ **No** Is there anything that makes you feel better? (i.e.: medication, exercise, heat/ice, rest)
(if yes , please explain) _____
_____

Past Medical History

❒ **Yes** ❒ **No** 1. Did you have any of your current complaints prior to the accident?
(if yes, please explain)_____
_____
_____

❒ **Yes** ❒ **No** 2. Have you ever had an auto and/or work comp claim(s) in the past? (if yes, please list them and approx. dates): _____
_____
_____

❒ **Yes** ❒ **No** 3. Have you ever been given an impairment rating or been listed with permanent injuries?_____

❒ **Yes** ❒ **No** 4. Have you had any other major injuries in the past? (i.e., Auto accidents, falls, traumas etc. If yes, please explain) _____
_____

(Do you have any of the following disorders?)

❒ **Yes** ❒ **No** Allergies
❒ **Yes** ❒ **No** Anemia
❒ **Yes** ❒ **No** Asthma
❒ **Yes** ❒ **No** Cancer
❒ **Yes** ❒ **No** Chronic Obstructive Pulmonary Disease
❒ **Yes** ❒ **No** Diabetes
❒ **Yes** ❒ **No** Depression/Anxiety
❒ **Yes** ❒ **No** Emphysema
❒ **Yes** ❒ **No** Gastrointestinal problems (i.e. Colitis, Chron's Disease)
❒ **Yes** ❒ **No** Heart Disease
❒ **Yes** ❒ **No** Hepatitis / Cirrhosis
❒ **Yes** ❒ **No** High Blood Pressure
❒ **Yes** ❒ **No** High Cholesterol
❒ **Yes** ❒ **No** HIV / AID's
❒ **Yes** ❒ **No** Stroke
❒ **Yes** ❒ **No** Thyroid Disease
❒ **Yes** ❒ **No** Ulcers (peptic or gastric)
❒ **Yes** ❒ **No** Other Medical Conditions (if yes, please describe): _____
_____

Surgical History: (List surgeries (other than surgeries due to this accident) and approximate dates)

1. _____
2. _____
3. _____
4. _____
5. _____

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 **Date**

_____
Signature of Patient

Social History

1. Martial Status: _____ Number of Children:_____

2. Education Status (check all that apply):
- ❒ Grade School
- ❒ High School
- ❒ GED
- ❒ Some College
- ❒ Associates Degree
- ❒ Specialty Degree (PTA, Dental Hygienist, Chiropractic Tech, MRI Tech)
- ❒ 4 Year Degree
- ❒ Graduate Degree
- ❒ Doctorate (PhD, EdD, etc)
- ❒ Professional Degree (MD, DO, DC, DDS, DVM, DPMETC)
- ❒ Professional Health Care Degree (RN, PT, ATC, PA, CNP, etc.)

Job Description and Work History

Employer: _____
Job Title: _____
❒ **Yes** ❒ **No** Does your job require lifting? If yes, what is the maximum amount you are required to lift? _____

Place a ✓ next to all that apply to your job requirements:

❒ Lifting (max weight)	❒ Pushing
❒ Bending	❒ Pulling
❒ Twisting	❒ Reaching
❒ Gripping	❒ Overhead Activity
❒ Repetitive Use of arms	❒ Repetitive use of legs

Others: _____

What is the average number of hours you are required to sit per day? _____
What is the average number of hours you are required to stand per day? _____
What is the average number of hours you are required to work per week? _____

❒ **Yes** ❒ **No** Do you smoke tobacco? (if yes how much do you smoke) _____ packs per week.
❒ **Yes** ❒ **No** Do you chew tobacco? (if yes, On Rare Occasions _____ Moderate _____ Heavy _____).

❒ **Yes** ❒ **No** Do you consume alcohol?
a. Never _____
b. Very Rarely _____
c. Lightly_____ (average 1 drink or less per day)
d. Moderately _____ (average 2-3 drinks per day)
e. Heavily _____ (average 4 or more drinks per day)

Scale: 1 Drink = 12 oz. of Beer
5 oz. of Wine
1 oz. of Hard Liquor

❒ **Yes** ❒ **No** Have you ever been addicted to alcohol, prescription drugs, or street drugs?

Recreational Activities

List some of the hobbies or recreational activities you enjoyed prior to your injury. Place an **X** by those activities you can no longer perform/enjoy because of your injury (i.e., hiking, dancing, playing with and/or lifting children, jogging, aerobics, working out, going out with friends, etc.).

1._____ 4._____

2._____ 5. _____

3._____ 6._____

Disability and/or Job Restrictions:

❒ **Yes** ❒ **No** Are you currently on disability due to your injuries (i.e. not working at all)?
If yes, what is the name of the Doctor who placed you on disability?
_____
If yes, dates of disability: _____

❒ **Yes** ❒ **No** Where you previously disabled do to your injuries?
If yes, what is the name of the Doctor who placed you on disability?
_____
If yes, dates of disability: _____

❒ **Yes** ❒ **No** Do you currently have any job restrictions?
If yes, what is the name of the Doctor who gave you restrictions?
_____
Please describe your restrictions:_____
_____
_____

About Your Injuries

Important – **We strive to learn as much as possible about each and every injury that occurred to you as a result of this motor vehicle accident so that we may establish a comprehensive and efficient treatment plan.**

Please complete the left side of the page (below) to let us know where you are injured, but you are not required to go into detail. The right side of the page will be utilized by your physician and your injuries will be covered in detail.

Patient Overview of Symptoms	**Physician Detailed Review / Symptoms**
As a result of your injury please check any of the following activities that you find to be difficult and / or painful.	**(This side office use only- please do not write in box)**
1._____ Headaches	**___ 1. Headaches:** **Frequency: 100% 75% 50% 25%** **Description: throb ache** **Regions:** suboccip || temporal || entire head **VAS**: _____/10 ☐ Concussion ☐ Photophobia ☐ Nausea ☐ Dizziness ☐ Vertigo ☐ Cognitive Impairment
2._____ Jaw Pain	**___2. TMJ:** _____ _____/10 ☐ Auscultory click ☐ Deviation ☐ Pain with Chewing ☐ Tooth Fractures
3._____ Neck Pain	**___3. Cervical Spine:** **Frequency: 100% 75% 50% 25%** **Description: throb ache dull sharp burn deep** ☐ LUE Radicular Features ☐ RUE Radicular Features **VAS**: _____/10

About Your Injuries

Patient Overview of Symptoms	Physician Detailed Review / Symptoms
As a result of your injury please check any of the following activities that you find to be difficult and / or painful. **4._____Left Shoulder Pain** **5._____ Right Shoulder Pain** **6._____ Mid Back Pain** **7._____ Low Back Pain**	**(This side office use only- please do not write in box)** **___4. Left Shoulder:** **Frequency: 100% 75% 50% 25%** **Description: throb ache dull sharp burn deep** **VAS**: _____/10 **___5. Right Shoulder:** **Frequency: 100% 75% 50% 25%** **Description: throb ache dull sharp burn deep** **VAS**: _____/10 **___6. Mid Back:** **Frequency: 100% 75% 50% 25%** **Description: throb ache dull sharp burn deep** **VAS**: _____/10 **___7. Low Back:** **Frequency: 100% 75% 50% 25%** **Description: throb ache dull sharp burn deep** ☐ LLE Radicular Features ☐ RLE Radicular Features **VAS**: _____/10

About Your Injuries

Patient Overview of Symptoms	Physician Detailed Review / Symptoms
As a result of your injury please check any of the following activities that you find to be difficult and / or painful.	**(This side office use only- please do not write in box)**
8.____ Left Knee Pain	**___ 8. Left Knee:** **Frequency: 100% 75% 50% 25%** **Description: throb ache dull sharp burn deep** VAS_____/10 ☐ Clicking ☐ Locking
9.____ Right Knee Pain	**___ 9. Right Knee:** **Frequency: 100% 75% 50% 25%** **Description: throb ache dull sharp burn deep** VAS_____/10 ☐ Clicking ☐ Locking
10.____ Left or Right Foot/Ankle Pain	**___ 10. Left or Right Foot/Ankle:** **Frequency: 100% 75% 50% 25%** **Description: throb ache dull sharp burn deep** VAS_____/10
11.____ Left or Right Elbow Pain	**___11. Left or Right Elbow:** **Frequency: 100% 75% 50% 25%** **Description: throb ache dull sharp burn deep** VAS_____/10 ☐ Contusion ☐ Jammed
12.____ Right or Left Wrist Pain	**___12. Right or Left Wrist/Hand** **Frequency: 100% 75% 50% 25%** **Description: throb ache dull sharp burn deep** VAS_____/10
13.____ Rib Cage Pain	**___ 13. Ribcage / Sternal Pain:** **Frequency: 100% 75% 50% 25%** **Description: throb ache dull sharp burn deep** VAS_____/10

About Your Injuries

Patient Overview of Symptoms
Physical Limitations

As a result of your injury please check any of the following activities that you find to be difficult and / or painful.

___ Lifting
___ Bending
___ Twisting
___ Turning
___ Reaching
___ Sitting
___ Standing
___ Walking
___ Pushing
___ Pulling
___ Gripping
___ Sexual Activity
___ Performing every day activities of daily such as dressing, housework, driving, shaving, etc

Patients Overview of Symptoms
Secondary Symptoms

As a result of your injury please check any of the following activities that you find to be difficult and / or painful.
Additionally, I have experienced:

A._____ Difficulty Sleeping

B._____ Nervousness

C._____ Depression

D._____ Difficulty Concentrating

E._____ Difficulty Breathing

F._____ Visual Changes

G._____ Irritation

H._____ Difficulty tasting / smelling

I. _____ Please list any social or recreational activities that you once enjoyed prior to your injuries but now find it either difficult or impossible (i.e. playing with children, exercising, golf, traveling or general social activities).

1. _____

2. _____

3. _____

4. _____

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	__ range of motion testing
__ orthopedic testing	__ basic neurological testing	__ muscle strength testing
__ postural analysis testing	__ ultrasound	__ hot/cold therapy
__ radiographic studies	__ EMS	__ vital signs

__ 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.

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 Doctor's Name

_____ _____

Signature Signature

_____

Signature of Parent or Guardian (if a minor)

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)

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)

Our Financial Policy

Thank you for choosing Physicians Plus Spine and Rehab Center LLC. as your healthcare provider. The following is our Financial Policy. Our main concern is that you receive the proper and optimal treatments needed to restore your health. Therefore, if you have any questions or concerns about our payment policies, please do not hesitate to ask our office staff. We ask that all patients read and sign Our Financial Policy, as well as complete our Patient Information Forms prior to seeing the doctor.

As a service to you, we will process your insurance claim for you. **By signing this form, you are assigning your benefits from your carrier to Physicians Plus Spine and Rehab Center so that the physician will be reimbursed directly for the services rendered to you. Your patient responsibility will be due at the time of service.** As we do accept your assignment of benefits, you must understand that:

1.) Your insurance policy is a contract between you, your employer, and/or the insurance company. We are not a party to that contract. Our relationship is with ***you***, not your insurance company.

2.) It is your responsibility to know your benefits and to obtain any authorization/referrals that are required for services provided. All charges are your responsibility whether your insurance company pays or not. Any services not covered by your benefits or any plans that our office does not participate with are your responsibility and payment is expected at time of services. We encourage you to review your policy guidelines to be sure of your coverage.

3.) Fees for these services, along with unpaid deductibles, coinsurance, and co-payments, will be due at time of service. You will be responsible for all attorney fees or collection fees related to the collection of your account.

4.) If the insurance company does not pay your balance within 30 days, we ask that you contact the carrier to help speed things up.

5.) If the insurance company does not pay your balance due within 90 days, we may then require you to pay the balance due, and you may seek reimbursement from your insurance carrier.

6.) We will prepare any necessary reports and forms needed to help assist in collecting payment from the insurance company and any amount authorized to be paid will directly to Physicians Plus Spine and Rehab Center and a credit will be added to your account with our office. If payment is sent to you from the insurance company instead of our office than you are responsible for that balance upon receipt of said payment.

7.) If your treatment is related to a personal injury case (motor vehicle accident) or work related injury, we understand that legal action by your attorney can often extend for some time. In this instance, we will be willing to waive payment from you until settlement. Please be aware that it is your responsibility to provide our office with complete billing information, (insurance carrier's name, full address/ claim number, and adjuster's name and phone number). We will not hold a balance without a signed, by both parties, ***LIEN ASSIGNMENT – LETTER OF PROTECTION*** on file.

Again, thank you for choosing Physicians Plus Spine & Rehab Center as your healthcare provider. We appreciate your trust in us and we appreciate the opportunity to serve you.

Authorization and Release of Information: A photocopy of this assignment shall be considered as effective and valid as original. I understand and agree to authorize the release of any information that Physicians Plus Spine & Rehab Center deem appropriate or pertinent concerning my physical condition and/or case to any insurance company, attorney, or adjuster involved with this case. I also authorize the release of any information pertinent to process any claim for reimbursement of charges incurred by me because of professional services rendered by you (Physicians Plus Spine and Rehab Center, including designated associates and assistants) and hereby release you of any consequence thereof.

Insurance Assignment: I hereby authorize and direct all payments for medical services rendered to myself or my dependent payable to Physicians Plus Spine and Rehab Center. I understand that I am responsible for any amount not covered by insurance. I authorize the use of my signature on all insurance submissions.

Insurance Authorization: I hereby authorize Physicians Plus Spine & Rehab Center to file a formal written complaint with the Insurance Commissioner when necessary.

HIPPA Policy: My signature below confirms that I have been made aware of the Notice of Privacy Practices and can be provided a copy upon request.

_____ _____

Patient's Name Date

_____ _____

Signature Signature of Parent or Guardian (if a minor)