# ABOUT THE PATIENT

Charlotte Spine & Pain Relief Center 7215 A Lebanon Rd. Charlotte, NC 28227

Name _____ Today's Date _____ Birthdate _____ Age_____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____ Gender ☐ M ☐ F

Last 4 digits of your SSN _____ Spouse's name _____ Spouse phone # _____

Kid's Names and Ages _____ Name of MD _____

Your Employer _____ Type of Work _____

Email address _____ Have you been to a chiropractor before? ☐ No ☐ Yes

How did you hear about our office?_____ Emergency Contact _____ Ph # _____

- I authorize the doctor or staff to render care as deemed appropriate for me and / or my child.
- I authorize Charlotte Spine & Pain Relief Center to release and / or request records to or from other Providers as may be necessary.
- I understand I am responsible for all bills incurred in this office.
- I authorize assignment of my insurance benefits (if applicable) directly to the provider.
- Person responsible for this account if other than the patient?_____
- I understand that after any initial promotional services all care is rendered at usual and customary fees.
- For my balance my preferred payment method is: ☐ Cash ☐ Check ☐ Credit Card ☐ Car/Work Ins.

_____ _____

Patient / Parent Signature (This represents a long term authorization for all occasions of service) Date

# REASON FOR SEEKING CARE

PRESENT COMPLAINTS

1. _____ How long has this been an issue? _____

Is it: ☐ Dull ☐ Sharp ☐ Ache ☐ Numb / Tingle ☐ Stabbing ☐ Constant ☐ Occasional ☐ Staying the same ☐ Getting worse ☐ Mild ☐ Moderate ☐ Severe ☐ Worse in the morning ☐ Worse in evening ☐ Pain radiates to_____

2. _____ How long has this been an issue? _____

Is it: ☐ Dull ☐ Sharp ☐ Ache ☐ Numb / Tingle ☐ Stabbing ☐ Constant ☐ Occasional ☐ Staying the same ☐ Getting worse ☐ Mild ☐ Moderate ☐ Severe ☐ Worse in the morning ☐ Worse in evening ☐ Pain radiates to_____

3. _____ How long has this been an issue? _____

Is it: ☐ Dull ☐ Sharp ☐ Ache ☐ Numb / Tingle ☐ Stabbing ☐ Constant ☐ Occasional ☐ Staying the same ☐ Getting worse ☐ Mild ☐ Moderate ☐ Severe ☐ Worse In the morning ☐ Worse in evening ☐ Pain radiates to_____

4. _____ How long has this been an issue? _____

Is it: ☐ Dull ☐ Sharp ☐ Ache ☐ Numb / Tingle ☐ Stabbing ☐ Constant ☐ Occasional ☐ Staying the same ☐ Getting worse ☐ Mild ☐ Moderate ☐ Severe ☐ Worse in the morning ☐ Worse in evening ☐ Pain radiates to_____

5. Does your condition affect: ☐ Sleep ☐ Work ☐ Daily Routine ☐ Sitting ☐ Driving

_____

6. What makes it better?_____

7. What makes it worse? _____

8. What Doctors have you seen for this?_____

_____

9. Type of treatment:_____

10. Results: _____

NOTES: _____

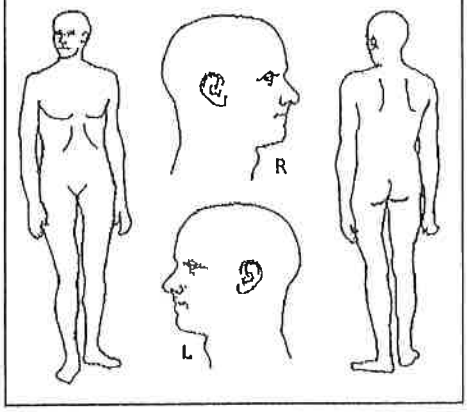
_____

_____

Are you pregnant?

☐ Yes ☐ No

Please mark all areas of concern.



## GENERAL HEALTH HISTORY

Charlotte Spine & Pain Relief Center 7215 A Lebnon Rd. Charlotte, NC 28227

Patient Name_____ *Mark the conditions that apply to you.*

| Past | Present | | Past | Present | |
|---|---|---|---|---|---|
| ☐ | ☐ | Headaches | ☐ | ☐ | Urinary Problems |
| ☐ | ☐ | Migraines | ☐ | ☐ | Easy Bruising |
| ☐ | ☐ | Shortness of Breath | ☐ | ☐ | Tobacco Use |
| ☐ | ☐ | Allergies / Asthma | ☐ | ☐ | Menstrual Problems |
| ☐ | ☐ | Medication Side Effects | ☐ | ☐ | Fibromyalgia |
| ☐ | ☐ | Diabetes | ☐ | ☐ | Blood Thinner use |
| ☐ | ☐ | Hands or Feet cold | ☐ | ☐ | HIV Positive |
| ☐ | ☐ | Muscle aches | ☐ | ☐ | Cancer |
| ☐ | ☐ | Trouble Walking | ☐ | ☐ | Depression |
| ☐ | ☐ | Leg / Foot Numbness | ☐ | ☐ | Alcohol Use |
| ☐ | ☐ | Fainting | ☐ | ☐ | ___High or ___Low Blood Pressure |
| ☐ | ☐ | Gall Bladder Trouble | ☐ | ☐ | Stroke History |
| ☐ | ☐ | Ringing in Ears | ☐ | ☐ | High Cholesterol |
| ☐ | ☐ | Ear Problems | ☐ | ☐ | TMJ |
| ☐ | ☐ | Sleeping Problems | ☐ | ☐ | Digestive Problems |
| ☐ | ☐ | Vision Problems | ☐ | ☐ | Pain all Over |
| ☐ | ☐ | Thyroid Problems | ☐ | ☐ | Tension / Irritability |
| ☐ | ☐ | Liver Disease | ☐ | ☐ | Chest Pains |
| ☐ | ☐ | Kidney Problems | ☐ | ☐ | Heart Pacemaker |
| ☐ | ☐ | Light Bothers Eyes | ☐ | ☐ | Heart Problems |
| ☐ | ☐ | Other _____ | | | |

1. List any medications you are taking and reason:_____

_____

2. Please list all doctors you are currently seeing: _____

_____

3. Has any Doctor or other professional advised you to "Go to a Chiropractor? ": ☐ No ☐ Yes, Name_____

_____

_____

## PAST HISTORY

4. List any past auto collisions:_____ Was any care received?_____
5. List any past work injuries: _____ Was any care received?_____
6. List any past sport, recreational, or home injuries_____
7. Please describe any past conditions and treatment received: _____

_____

8. Please list any past hospitalizations and surgeries: _____

_____

## FAMILY HISTORY

Father's side: ☐ Heart Disease ☐ Cancer ☐ Diabetes ☐ Heavy Medication use ☐ Arthritis ☐ Other_____

Mother's side: ☐ Heart Disease ☐ Cancer ☐ Diabetes ☐ Heavy Medication use ☐ Arthritis ☐ Other_____

Is there any other family history you want us to know?_____

CharlotteSpine
& Pain Relief Center

# OFFICE POLICY

SPINAL CHECK-UP:

- We recommend everyone have their spine checked early for spinal problems. Prevention is the best medicine.
- Children especially to see if their spine is developing abnormally? A spinal check–up is easy and fun for kids.

WE ALSO OFFER:

- Supplements, ice packs, nutritional/exercise counseling, custom orthotics.
  *Please ask if you have any questions about these services!*

AGREEMENTS FOR TOP RESULTS:

- Remember it takes time and effort to Improve your health. *No time + No effort = No results*
- Please keep your appointments and make-up any missed or rescheduled visits within a day whenever possible.
- Please call if you are going to be late or need to reschedule to allow someone else to use your time.
- Feel free to refer your family and friends in for care. We are here to help them too.
- If you're paid ahead, understand you will get any unused money back if care needs to end early.
- If your care is due to an accident, then all information must be obtained at the beginning of care.
- I agree to allow my/family name, photo, video, or testimonial to be used during the normal course of business.
- I understand that adjusting time is for adjustments and I can always talk to the Doctor by special appointment or phone call. They are here to help you any way they can. We want you to do great! ☺

OFFICE VISITS MAY INCLUDE:

- **Specific Chiropractic Adjustments** to promote mobility, stimulate soft tissue, improve nerve flow, enhance alignment. This is when the Doctor works on your neck or back, sometimes making a popping sound. **$50 to $75**
- **Extremity Adjustments** to promote mobility, stimulate soft tissue, enhance alignment of extremity joints. **$45**
- **Non-Surgical Decompression** to help with disc bulges/herniations or degenerative disc in neck or low back **$60**
- **Infra-red technology** to promote circulation for neuropathy in hands or feet. **Cost varies for number of areas**
- **Intersegmental / Mechanical traction** to relax soft tissues, aid healing and mobility. This is the blue table with the rollers that effectively extend, stretch, and traction the spine. **$30**
- **Cold therapy** to reduce swelling, this is the ice pack used on the area of concern. **$10**
- **Cold Laser Therapy** to decrease inflammation in the area and promote healing. **$20**
- **Electric Muscle Stim.** To control swelling, modulate pain, tone muscles. **$27**
- **Manual Therapy / Manual Traction** to modulate pain, increase flexibility, reduce swelling, mobilize soft tissues. This is hands-on work to your spine or other joints, performed by the Doctor. **$45**
- **Therapeutic Exercises** to improve spinal flexibility, strength and motion. These are stretches or exercises that you perform or the Doctor administers to you. Excellent for the neck, mid, and lower back. **$45 per unit**
- **Supports/Pillow/Braces** if needed and as priced.

Patient: _____ Date _____ Staff_____

7215 Lebanon Road Suite A Charlotte, NC 28227 704-573-7161

# Paying for your care is easy here!

**Mark and initial which one is you:**

☐ No Insurance:

- Easy! Our Care Plans and simple payment arrangements have helped thousands of people and will work great for you too!

*Initial*_____

☐ Health Insurance:

- These days, insurance pays very little if anything for natural drugless care to get you healthy. So we make it easy!
- **You pay us. We will send any insurance claims in for you that we can at no charge. We are out of network with all insurance companies so we might have to give you a special form. If they pay anything after your deductible, co-ins and co-pays are met, the money will go directly to you.**
- Of course you can use your HSA, HRA and Flex dollars here!
- For your convenience, all payment arrangements are made in advance. We will never surprise you with a bill in the mail.

*Initial*_____

☐ Auto Injury

- Auto related injuries are covered 100%. Even if you were at fault or were a passenger. You can get the care you need and it costs you 0 as long as we have all information.
- All we need is your claim numbers, insurance company, and attorney info.

*Initial*_____

☐ Work Injury

- Work injuries are covered 100% for up to 12 weeks of care.
- All we need is your claim number and Work Comp ins. info.

*Initial*_____

☐ Medicare

- Regardless of your condition, Medicare pays for up to a maximum of 12 weeks of care. They have very strict rules and limitations.
- After this you will receive a significant Medicare discounts.
- **Medicare supplements normally don't pay anything.**

*Initial*_____

To: _____

_____

_____

I, _____ (print name) hereby authorize and request that you release a copy of my patient records containing protected health information, including any diagnoses, x-rays and other diagnostic imaging, laboratory studies, scans, prognosis, treatment and recommendations, as well as any other data pertinent to my treatment to:

**Charlotte Spine & Pain Relief Center**
**7215 Lebanon Road Suite A**
**Charlotte, NC 28227**
**(704) 573-7161 Phone**
**(704) 573-3799 Fax**

_____ _____
Date Signed Patient Signature

_____ _____
Expiration Date Patient Date of Birth

_____ _____
Staff Witness Signature of Legal Guardian (for minor)

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have reviewed the Notice of Privacy Practices of Charlotte Spine & Pain Relief Center.
(Please initial one of the following options and sign below.)

_____ I wish to receive a paper copy of Privacy Notice.

_____ I do not request a copy of the Privacy Notice at this time. I acknowledge that I can request a copy at any time and the Privacy Notice is posted in the office.

Please initial below:

_____ I acknowledge that it is the policy of Charlotte Spine & Pain Relief to leave reminder messages on my answering machine or with another person in my home. I may make a request of an alternative means of communication (within reason) in writing.

_____ I acknowledge that if I should have a problem or question in regard to my rights, I may speak with the Privacy Officer, Dr. Helmendach, about my concerns.

_____ _____
Patient Name (Print) Date

_____ _____
Signature of Patient/Guardian Patient DOB

_____ _____
Witness (Office Staff) Date

# Charlotte Spine & Pain Relief Center

## NOTICE OF PRIVACY PRACTICES

**THIS IS A NOTICE OF PRIVACY PRACTICES WHICH DESCRIBES HOW MEDICAL INFORAMTION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

This notice is effective as of January 1st, 2013

Charlotte Spine & Pain Relief Center is required by law to maintain the privacy of protected health information, and must inform you of your privacy practices and legal duties.

Charlotte Spine & Pain Relief Center is required to abide by the terms of the Notice of Privacy Practices that is most current. We reserve the right to change the terms of the Notice of Privacy Practices at any time. Any changes will be effective for all protected health information that we maintain. The revised Notice will be posted in the waiting room.

Charlotte Spine & Pain Relief Center has a Privacy Officer to answer any questions about our privacy practices and to ensure that we comply with applicable laws and regulations. The Privacy Officer will also take your complaints and can give you information about how to file a complaint.

Our Privacy Officer is Dr. Helmendach. You may contact the Privacy Officer at (704) 573-7161.

Use and disclosure of your protected health information that we may make to carry out treatment, payment, and health care operations.

Charlotte Spine & Pain Relief Center may use information in your record to provide treatment to you. We may disclose information in your record to help you get health care services from another provider, a hospital, etc. For example, if we want an opinion about your condition from a specialist, we may disclose information to the specialist to obtain that consultation.

Charlotte Spine & Pain Relief Center may use or disclose information from your record to obtain payment for the services you receive. For example, we may submit your diagnosis with a health insurance claim in order to demonstrate to the insurer that the services should be covered.

Charlotte Spine & Pain Relief Center may use or disclose information from your record to allow "health care operations." These operations include activities like reviewing records to see how care can be improved, contacting you with information about treatment alternatives, and coordination care with other providers. For example, we may use information in your record to train our staff about your condition and its treatment.

**Your rights**

You may ask use to restrict the use and disclosure of certain information in your record that otherwise would be allowed for treatment, payment, or health care operations. However, we do not have to agree to these restrictions.

You have a right to receive confidential communications from us. If you want to receive bills and other information at an alternative address, please notify our staff.

You have a right to inspect the information in your record, and may obtain a copy of it. This may be subject to certain limitations and fees. The limitations are as follows: 1.) Personal Injury cases 2.) Workers' Compensation cases and 3.) Accounts that have an outstanding balance with our office. Your request must be in writing.

If you believe information in your record is inaccurate or incomplete, you may request amendment of the information. You must submit sufficient information to support your request for amendment. Your request must be in writing.

You have the right to request an accounting of certain disclosures made by us.

You have the right to complain to us about our privacy practices (including the actions of our staff with respect to the privacy of your health information). You have the right to complain to the Secretary of the Department of Health and Human Services about our privacy practices. You will not face retaliation from us for making complaints.

Except as described in the notice, we may not make any use or disclosure of information from your record unless you give your written authorization. You may revoke an authorization in writing at any time, but this will not affect any use or disclosure made by us by the revocation. In addition, if the authorization was obtained as a condition of obtaining insurance coverage, the insurer may have the right to contest the policy or a claim under the policy even if you revoke the authorization.

**Use or disclosure of your protected health information that we are required to make without your permission**

In certain circumstances, we are required to make a disclosure of your health information. For example, state law requires us to report suspected child abuse or neglect. Also, we must disclose information to the Department of Health and Human Services, if requested, to prove that we are complying with regulations that safeguard your health information.

**Use or disclosure of your protected health information that we are required to make without your permission**

There are certain situations where we are allowed to disclose information from your record without your permission. In these situations, we must use our professional judgment before disclosing information about you. Usually we must determine that the disclosure is in your best interest, and may have to meet certain guidelines and limitations.

Charlotte Spine & Pain Relief Center may assist in in health oversight activities, such as investigations of possible health care fraud.

Charlotte Spine & Pain Relief Center may disclose information from your record as authorized by workers' compensation laws.

Charlotte Spine & Pain Relief Center may disclose information from your record as authorized to assist in the investigation of personal injuries and automobile accidents.

Charlotte Spine & Pain Relief Center may disclose information from your record if ordered to do so by a court, grand jury, or administrative tribunal. Under certain conditions, we may disclose information in response to a subpoena or other legal process, even if a court does not order this.

Our office staff may contact you at home or at work to provide appointment reminders as a courtesy. However, you are responsible for remembering your appointment. If you require an alternative contact location, please let our staff know.

Charlotte Spine & Pain Relief Center may contact you with information about treatment alternatives or other health-related benefits or services that may be of interest to you.

Charlotte Spine & Pain Relief Center may contact you for marketing purposes like a testimonial video on website or in office.

Patient Name: _____