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

Emergency Contact ______________________ Phone #______________________

- 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. ______________________ Rate your pain on 0-10 scale with 10 being worst ________

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. ______________________ Rate your pain on 0-10 scale with 10 being worst ________

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. ______________________ Rate your pain on 0-10 scale with 10 being worst ________

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. ______________________ Rate your pain on 0-10 scale with 10 being worst ________

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? ______________________

NOTES: ______________________

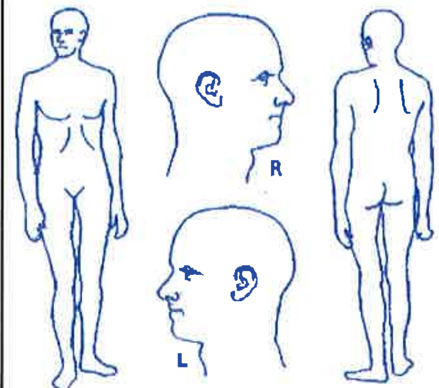
____

____

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?______________________________

COLLISION INFORMATION

Charlotte Spine & Pain Relief Center 7215 A Lebanon Rd.
Charlotte, NC 28227 704-573-7161

Name: ______________________________ Today's Date: __________

Where did the collision occur: Street: ____________________ City: ____________ State: ______

Date when collision occurred: ____________ AM or PM. Was the road: ❑ Dry ❑ Wet ❑ Snowy ❑ Icy

Where you the: ❑ Driver ❑ Front middle passenger ❑ Front right passenger ❑ Back left ❑ Back middle ❑ Back right

Describe in detail what happened: ______________________________

____

____

____

____

CRASH DETAILS

❑ Yes ❑ No If driving, were both hands on the wheel at impact?
❑ Yes ❑ No If passenger, did your hands brace yourself?
❑ Yes ❑ No Did you have your seat belt and shoulder strap on?
❑ Yes ❑ No Was your seat up at the time of impact?
❑ Yes ❑ No Where you wearing a bulky coat or slippery pants?
❑ Yes ❑ No Did the seat belt engage?
❑ Yes ❑ No Did the airbag engage?
❑ Yes ❑ No Did you hit the dash, steering wheel or window?
❑ Yes ❑ No Did you know you were going to be hit?
❑ Yes ❑ No Did you brace yourself with hands or feet?
❑ Yes ❑ No If driving, was your foot on the brake at impact?
❑ Yes ❑ No Was your head turned at impact? If yes, which direction R or L
❑ Yes ❑ No Were you leaning forward?
❑ Yes ❑ No Did your glasses fly-off at impact?
❑ Yes ❑ No Was your body turned at the moment of impact?
❑ Yes ❑ No Did you get hit into another car, tree, railing, etc?
❑ Yes ❑ No Any damage or marks on your vehicle, the vehicle that hit you, or another object that was hit?
What part of the vehicle was hit? ______________________________

1. What make and model of vehicle were you in? ____________ The other vehicle? ____________
2. What kind of seat were you in? __ Bucket __ Bench __ Fabric __ Leather/Vinyl
3. Did the car have headrests? ❑ Yes ❑ No
4. Did you hit your head on the headrest? ❑ Yes ❑ No On the back window if in a small truck? ❑ Yes ❑ No
5. Was the headrest positioned: __ below __ level with __ above the center of your head
6. Did your head hurt after the collision? ❑ Yes ❑ No Did your TMJ/jaw hurt after the collision? ❑ Yes ❑ No
7. How soon after the collision did you notice any pain? ______________________________
8. Did the crash affect: ❑ dizziness ❑ memory ❑ concentration ❑ headaches ❑ balance ❑ nightmares ❑ breathing ❑ fatigue ❑ irritability ❑ ability to read ❑ ability to listen ❑ appetite ❑ nausea ❑ vision
9. Is there anything else you want us to know? ______________________________

____

PROVIDERS SEEN

List all providers seen since injury occurred:

1. Clinic/Doctor/Hospital Name____________________City__________

Any treatment received? ____________________

2. Clinic/Doctor/Hospital Name____________________City__________

Any treatment received? ____________________

❑ Yes ❑ No Do you have pictures of your vehicle? Where is it being repaired?__________

❑ Yes ❑ No Do you have a copy of the police report?

Name of your Attorney if you have one:____________________

Name of Your Car Insurance Co._______________ Your Health Ins. Co. __________

Name of the Other Divers car Insurance if Applicable____________________

Charlotte Spine & Pain Relief Center

7215-A Lebanon Rd., Charlotte, NC 28227
Phone: 704-573-7161 fax: 704-573-3799

ASSIGNMENT, LIEN AND AUTHORIZATION

To whom it may concern:

I hereby authorize and direct you, my insurance company, and/or attorney, to pay directly to **Charlotte Spine & Pain Relief Center** such sums as may be due and owing this clinic for services rendered to me. To withhold such sums from any disability benefits, medical payments benefits, no-fault, health and accident benefits, workmen's compensation benefits, or any other insurance benefits obligated to reimburse me or from my settlement, judgment or verdict on my behalf as may be necessary to adequately protect this clinic. I hereby further give lien to **Charlotte Spine & Pain Relief Center** against any and all insurance benefits named herein, and any and all proceeds of any settlement, judgment or verdict which may be paid to me as a result of the injuries or illnesses for which I have been treated by this office. This is to act as an assignment of my rights and benefits to the extent of **Charlotte Spine & Pain Relief** and the services they provided.

I understand that I remain personally responsible for the total amounts due to **Charlotte Spine & Pain Relief Center** for their services. I further understand and agree that this Assignment, Lien and Authorization doesn't constitute any consideration for the clinic to await payments and they may demand payments from me immediately upon rendering services at their option, if I have not given them all information needed on the financial policy.

I authorize **Charlotte Spine & Pain Relief Center** to release any information pertinent to my case to any insurance company, adjuster or attorney to facilitate collection of money under this Assignment, Lien and Authorization.

If I as a patient have medical payments benefits on my auto insurance, then said benefits are to be paid directly to **Charlotte Spine & Pain Relief Center** upon receipt of bills from the clinic.

Signed: ______________________________ Print Name: ______________________

Parent/guardian signature (if patient is a minor) ______________________________

Date: ________________ Witness: ______________________________

704-573-7161

MEDPAY INFORMATION

A lot of people have benefits (MEDPAY) included in their automobile policies and don't even realize it. Our office highly recommends that you use your Medpay coverage, if you have it, in the event that you've been injured in an automobile accident, regardless of who is at fault.

Here are 3 reasons why we recommend that we file your Medpay.

1) **Medpay is similar to Health Insurance-** Using it does not cause your rates to increase. If your rates increase, it's not because you filed your Medpay, it's most likely because: a) It was determined that you were at fault, b) you received the police citation or ticket, or c) you've been involved in numerous reported auto accidents within a brief period of time and therefore are now considered to be "high-risk."

2) **Filing your Medpay doesn't relieve the other party from having to pay in full for your loss.** On the contrary, by filing your Medpay, when you collect from the other driver's Liability insurance, a greater amount of the settlement will go directly to you because your bill at our office may be paid in full. If the other driver's Liability insurance refuses to make payment to you for whatever reason, filing your Medpay will help to insure that you are not stuck with all the medical bills.

3) **If you have Medpay coverage and choose not to file it, then you are paying for an option, but not receiving any benefit.**

For the same reasons, our office also recommends that you file your commercial Health Insurance. The important thing to remember is that you are not guaranteed of receiving full payment from the other driver's Liability insurance company. Filing both your Medpay and your Health Insurance will help to insure that you are not left to pay the medical bills. If we receive overpayment on your account, we will be happy to refund you the difference.

Name ________________________________ Date __________________

704-573-7161

Office Policies for Personal Injury Patients

This office will accept you as a new patient based on our clinical examination and belief that chiropractic care will be effective for the treatment of your injuries. Your responsibility to this office will be to follow the doctor's recommendations and to provide the appropriate financial information so that payment for services can be received.

Patients need to bring the following:

1- Copy of police report and/or a copy of the exchange slip.

2- Copy of personal automobile policy
This is to verify Medical Payments covered by your Automobile insurance.

3- Name of individual and insurance company of party that's liable. Please include policy number.

4- Name and telephone number of attorney if an attorney has been retained.

You are asked to give 24 hour notice if you need to reschedule an appointment. All appointments that have been missed without notice may be billed to your account.

Following the completion of your treatment in this office, your bill will be forwarded to the responsible party. Please note that this account is still your responsibility & will be subject to monthly interest charges of 1.5% effective 30 days following your initial visit.

Signature________________________________ Date______________

7215 Lebanon Road • Charlotte, NC 28227
CLTspine.com

PERSONAL INJURY CASE
INSURANCE DATA COLLECTION FORM

LIABILITY AUTO INSURANCE POLICY OF PARTY @ FAULT:

COMPANY NAME: ______________________________

POLICY #: ______________________________

CLAIM #: ______________________________

MAILING ADDRESS FOR CLAIMS:

____

____

COMPANY TELEPHONE #: ______________________________

COMPANY FAX #: ______________________________

ADJUSTER ASSIGNED TO CASE: ______________________________

PATIENT'S INSURANCE POLICY? **Y** **N**
INSURANCE OF "OTHER" DRIVER @ FAULT? **Y** **N**

PATIENT'S HEALTH INSURANCE:

INSURANCE COMPANY NAME: ______________________________

CUSTOMER SERVICE PHONE #: ______________________________

ID #: ______________________________

GROUP #: ______________________________

SUBSCRIBER NAME: ______________________________

SUBSCRIBER DOB: ______________________________

MEDPAY INFO (YOUR PERSONAL AUTO INSURANCE POLICY)

INSURANCE COMPANY: ______________________________
POLICY #: ______________________________
CLAIM #: ______________________________
TELEPHONE # ______________________________
ADJUSTER ASSIGNED: ______________________________
AMOUNT OF MEDPAY BENEFIT: $1000 $2000 $5000
(please circle one)

Charlotte Spine & Pain Relief
Consent to Treatment Form

I hereby authorize the doctors of Charlotte Spine & Pain Relief to treat my case as they deem appropriate through the use of specific chiropractic manipulation, nutritional support, durable medical equipment and diagnostic testing. I realize the goal of holistic healthcare is to strengthen the patient's body in order to heal themselves.

It is understood and agreed that the amount paid the clinic for x-rays is for interpretation only. The x-ray films will remain the property of this office, to be kept on file. The patient also agrees that he/she is responsible for all bills incurred at this office.

Patient Name (print): ______________________________

Patient Signature: ________________________________

Witness: _______________ Date: _______________

X-Ray Questionnaire for Women Only:

Our consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze your condition. Should x-rays be necessary we would like to confirm that you are not pregnant at this time.

Name: _________________________

- There is a possibility that I may be pregnant at this time.
- Yes, I am definitely pregnant.
- No, I am definitely not pregnant at this time.
- I request that x-ray films not be taken because:

  ____

  ____

Date of last menstrual period: ____________________

___________________________ ____________________

Patient's Signature Date

To: ____

____

____

I, ____________________ 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 Name
____________________ Expiration Date	____________________ Patient Date of Birth
____________________ Staff Witness	____________________ Signature of Patient or Legal Guardian

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Patient Name: ____________________ Date: ____________________

Charlotte Spine & Pain Relief Center
7215-A Lebanon Rd.
Charlotte, NC 28227
704-573-7161

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name: ______________________________ DOB: ______________

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

______________________________ ______________
Witness (Office Staff) Date

Patient Name: ______________________________ 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: ______________________________