ALABAMA SPINE & REHABILITATION CENTER

Full Legal Name: ____ Today's Date: ______________

Name you go by (if different from above name): __________________________________ Male ___ Female ___

Address: ____ City: __________________________

State: _________ Zip: _________ Email (write legibly): ____________________________________

Phone (Primary): ____________________________ Phone (Home): __________________________

Date of Birth: _______________ Age: ________ Social Security #: _________________________

PLEASE FILL OUT INSURANCE INFORMATION BELOW EVEN IF YOUR CARDS WERE TURNED IN:

Primary Insurance: _________________________ Contract #: ______________________________

Insured Name: _____________________________ *If not you*, Insured Date of Birth: ______________

Secondary Insurance: _________________________ Contract #: ____________________________

Primary Care Physician (Address & Phone if known): ______________________________________

PATIENT QUESTIONNAIRE:

Reason for seeking care? ____

Who might we ask referred you to us? ____

When was your most recent MRI or X-ray? ____

If pain is present, how long has it been occurring? ________________________________

If pain is present, what alleviates the pain? ______________________________________

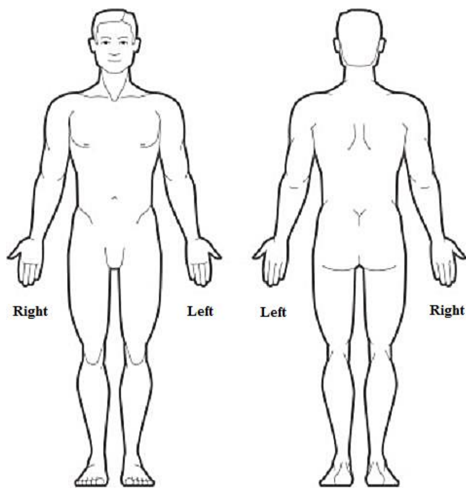
If pain is present, what worsens the pain? _______________________________________

Height? ___ feet __ inches   Weight? _____ pounds

Do you smoke Y/N? ____

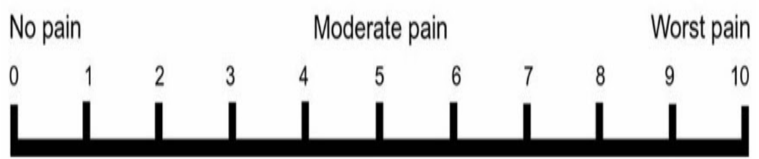
Alcohol Y/N? ____ Daily? ____ Weekly? ____ Social Occasions? ____

Caffeinated drinks per day? ____



Please **mark where** you feel pain on the figure/s to the ←left:

Please **circle** the degree of pain you currently have below where "0" is no pain & "10" is worst pain:



Please list all **PAST** medical / surgical history here *that has not already been accounted for* including, but not limited to outpatient procedures & overnight hospitalizations:

____
____
____
____

Please list all **allergies**:

Please list all **current medications**: (or) ☐ I will attach a list.

Patient Authorization for Use & Disclosure of Protected Health Information

By signing, I authorize Alabama Spine & Rehabilitation Center to use &/or disclose certain protected health information (PHI) about me to any participating hospitals or clinics that I want my records sent to. This authorization permits Alabama Spine & Rehabilitation Center to use &/or disclose the following individually identifiable health information about me: patient demographics, MRI or x-ray reports, treatment notes, prescriptions, medical history.

I understand that I do not have to sign this authorization in order to receive treatment from Alabama Spine & Rehabilitation Center. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to disclosure by the recipient & may no longer be protected by the HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon the authorization. My written revocation must be submitted to the privacy officer at: **Alabama Spine & Rehabilitation Center; 2017 Canyon Road, Suite 21; Vestavia Hills, Alabama 35216.**

Scheduling for Physical Therapy Guidelines:

If patient is late for a scheduled appointment more than 20 minutes without notifying a staff member, the appointment will be considered a "*no-show*" & the patient will have to reschedule. If patient calls & notifies a staff member prior to their expected appointment time, the appointment will be considered a "*cancellation*" & the patient will have to reschedule. Patient understands that if patient misses 3 consecutive scheduled visits in a row or if patient misses 2 or more consecutive scheduled or nonscheduled weeks of physical therapy, without physical therapist's consent, patient will be automatically discharged from physical therapy.

I (we) agree to pay for services rendered to the above-mentioned patient as the charge is incurred. I understand & agree that health & accident insurance policies are an arrangement between the insurance carrier & me & that I am personally responsible for payment of any & all services, covered or non-covered. I also understand that if I suspend or terminate my care, any fees for professional services rendered to me will be immediately due & payable. I hereby certify that the statements & answers given on this form are accurate to the best of my knowledge & understand it is my responsibility to inform this office of any changes in my health. I agree to allow this office to examine me for further evaluation. Please note that our policy is to bill your medical insurance as primary health insurance & then your corresponding auto accident insurance or lawyer as secondary coverage. We will not & cannot change how or to whom we bill after your initial evaluation. So please make sure you have the CORRECT, ACCURATE, & PROPER information. In addition, please note that if your medical insurance, auto accident &/or lawyer do not pay, you will be financially responsible for your bills from this clinic.

Patient Signature: ______________________________ Date: ________________