

**PATIENT CONSENT AND FINANCIAL POLICY  
DISCLOSURE FOR MEDICAL TREATMENT**

1. **Consent for Health Care Services:** I authorize and consent for medical treatment at Silver State Spinecare/Forrest Burke, MD, PC, hereafter referred to as “The Entity”.
2. **Authorization for Release of information:** The Entity and my physician may release information from my medical records to any health care provider involved in my care and treatment. The Entity and my physician may also release information from my medical records to any person or organization liable for all or part of my charges, such as my insurance carrier, any third-party payer, the Medicare/Medicaid programs, and my employer’s work’s compensation carrier. I acknowledge that upon the disclosure of medical record information to an insurance company or other payer pursuant to this authorization, The Entity is no longer responsible for the confidentiality of any information known or possessed by the payer.
3. **Financial Agreement:** I understand that there is no guarantee of payment from any insurance company or other payer. I agree to pay all charges for the services provided by The Entity and of my physician, which are not paid by my health insurance or other payer. All charges are due and payable when I receive the bill. If payment is not made within 90 days from the date the bill was mailed from The Entity, I understand that a delinquent charge of interest at a rate of 1.5% monthly may be added to my bill. I agree to pay all reasonable legal expenses necessary for the collection of any debt. I understand that any credit or refund that I may be owed will be forwarded to me at the address on file with The Entity.
4. **Request for Additional Form Completion:** I understand that there will be a **\$20 charge** for each additional special form to be completed (beyond those used in normal medical reporting). Typical examples are FMLA and Disability forms.
5. **Assignment for Direct Payment:** I authorize that payment of any insurance benefits for health care services or goods may be made directly to The Entity and my physician. This includes auto insurance and health-care insurances such as Medicare/Medicaid.
6. **Privacy Practices Notice:** I hereby acknowledge that I have received a copy of the HIPAA Privacy Practices Notice.

**I acknowledge that:**

1. I have read this form and understand its contents.
2. I am the Patient, or person duly responsible either by the patient or otherwise to sign this agreement, consent to, and accept its terms.
3. I am responsible for the payment and/or co-payment that is due at the time of service.

\_\_\_\_\_  
Signature of Patient or Legally Responsible Person

\_\_\_\_\_  
Name (PRINT)

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Date

INITIAL VISIT

Name: \_\_\_\_\_ Age: \_\_\_\_\_

Who referred you: \_\_\_\_\_

Have you had similar symptoms in the past:  No  Yes: \_\_\_\_\_

If yes, what treatment did you receive: \_\_\_\_\_

REVIEW OF CURRENT SYMPTOMS

When did the current symptoms start: \_\_\_\_\_

Was this from:  Auto Accident  Work Comp (any restrictions): \_\_\_\_\_

Did the pain come on:  Suddenly  Gradually  Other: \_\_\_\_\_

Write a brief history of how your current symptoms started: \_\_\_\_\_

What is the most bothersome symptom: \_\_\_\_\_

Do you have:  Pain into your arm  Pain into your leg

Please tell us your: Height: \_\_\_\_\_ Weight: \_\_\_\_\_ R or L Handed

Please fill out the drawing and indicate your symptoms using the symbols below:

Stabbing Pain: ///

Numbness: ~ ~ ~

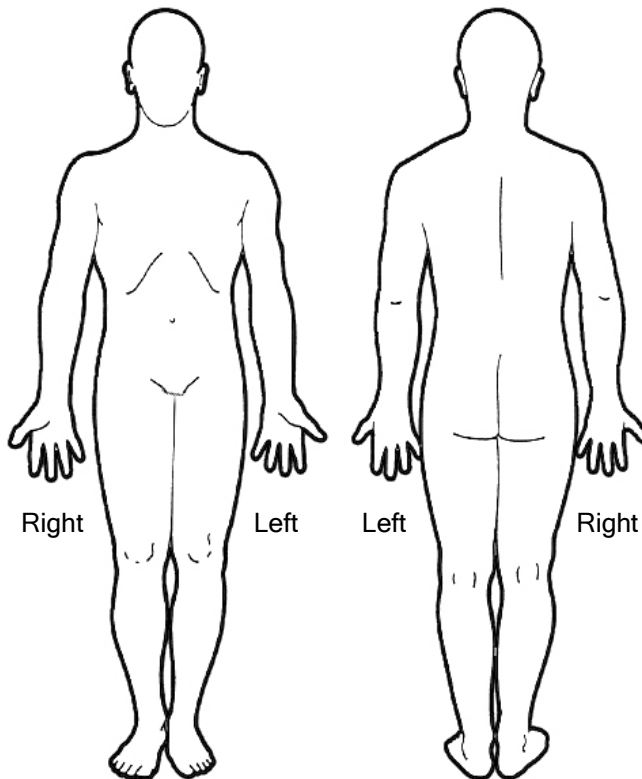
Pins and Needles: ^ ^ ^

Burning Pain: O O O

Aching Pain: X X X

Front Side

Back Side



**INITIAL VISIT (page 2)**

How do the following activities affect your symptoms: B = better W = worse N = no change

Bending Forward: \_\_\_\_\_ Sitting: \_\_\_\_\_ Coughing: \_\_\_\_\_  
Bending Backward: \_\_\_\_\_ Standing: \_\_\_\_\_ Walking: \_\_\_\_\_

Is any time of day worse: \_\_\_\_\_

What one thing makes your symptoms worse: \_\_\_\_\_

What one thing makes it better: \_\_\_\_\_

What was your pain like when it started: ☺ 0 1 2 3 4 5 6 7 8 9 10 ☹

What is your pain like today: ☺ 0 1 2 3 4 5 6 7 8 9 10 ☹

Have you had:  X-Ray  CT Scan  MRI: (Where) \_\_\_\_\_

Have you seen another specialist for this condition:  No  Yes: \_\_\_\_\_

If yes, who \_\_\_\_\_

Have you had any injections for this condition:  No  Yes: Helpful:  No  Yes

If yes, where did you have the injections: \_\_\_\_\_

Have you had Physical Therapy for this condition:  No  Yes Helpful:  No  Yes

If yes, where did you have the Physical Therapy: \_\_\_\_\_

Have you had Chiropractic for this condition:  No  Yes Helpful:  No  Yes

If yes, where did you have the Chiropractic: \_\_\_\_\_

Which medications have you tried that have NOT helped you: \_\_\_\_\_

\_\_\_\_\_

**PAST MEDICAL HISTORY**

Current Primary Care Physician: \_\_\_\_\_

Are you on Coumadin or any other Blood Thinners:  No  Yes: \_\_\_\_\_

Please list Current Medications: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Drug Allergies (and reaction): \_\_\_\_\_

Ongoing Medical Conditions: \_\_\_\_\_

\_\_\_\_\_

Surgeries and Year: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**INITIAL VISIT (page 3)**

**REVIEW OF SYSTEMS:** Please check No or Yes. (If yes, circle all that apply)

- No  Yes **GENERAL:**  
weight loss, fever, chills, night pain, difficulty sleeping, rashes, other
  
- No  Yes **HEAD:**  
headaches, sinus, nosebleeds, ringing in ears, deafness, other
  
- No  Yes **NEUROLOGIC:**  
seizures, loss or changes of vision, dizziness, other
  
- No  Yes **PSYCHIATRIC:**  
depression, hallucinations, nervous breakdown, mental disorder, other
  
- No  Yes **MUSCULOSKELETAL:**  
arthritis, swollen joints, muscle spasms, fibromyalgia, other
  
- No  Yes **CARDIOVASCULAR:**  
high blood pressure, palpitations, irregular heart rate, chest pain, other
  
- No  Yes **RESPIRATORY:**  
asthma, wheezing, shortness of breath, coughing, night sweats, other
  
- No  Yes **GASTROINTESTINAL:**  
nausea, abdominal pain, vomiting, ulcers, constipation, diarrhea, other
  
- No  Yes **GENITOURINARY:**  
urinary retention, urgency, painful urination, blood in urine, other
  
- No  Yes **ENDOCRINE:**  
diabetes, excessive hair growth/loss, thyroid, intolerance to heat/cold, other
  
- No  Yes **BLOOD AND LYMPH:**  
anemia, excessive bleeding/clotting, bruising, lumps in glands, other

Please provide details of anything circled above: \_\_\_\_\_

**FAMILY HISTORY:**

Family Medical History (first degree relatives): \_\_\_\_\_

Social:  Married  Single  Widowed  Divorced  Separated

Children:  No  Yes: (How many) \_\_\_\_\_

Do you:  Use Tobacco How much: \_\_\_\_\_

Drink alcohol How much: \_\_\_\_\_

Current employer: \_\_\_\_\_ How Long: \_\_\_\_\_

Previous employer: \_\_\_\_\_ How Long: \_\_\_\_\_

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Physician Signature