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:

Front Side                             Back Side

Stabbing Pain:  / / /  
Numbness:  ~ ~ ~  
Pins and Needles:  ^ ^ ^  
Burning Pain:  O O O  
Aching Pain:  X X X  

Right                        Left         Left                        Right
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:__________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
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:____________________

_____________________________________________ Patient Signature ________________________________
Date ______________________                  _______________________________ Physician Signature