Silver State Spinecare
PMR Specialists
Back Pain ~ Neck Pain ~ Carpal Tunnel Syndrome ~ Spinal Injections ~ EMG

PATIENT CONSENT FOR TREATMENT AND FINANCIAL AGREEMENT
HIPAA – DISCLOSURE OF PROTECTED MEDICAL INFORMATION

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. **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.

3. **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.

4. **Authorization for Release of Protected Health Information:** The Entity and my physician may release information from my medical records to any health care provider involved in my care and treatment or any appropriate governmental agency. 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, Medicare, and my employer's worker's compensation carrier. I acknowledge that upon the disclosure of Protected Health 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. I also understand that my records may be destroyed after 7 years.

5. **HIPAA Privacy Practices Notice:** I hereby acknowledge that I am aware that a copy of the HIPAA Privacy Practices Notice is available upon my request.

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 it 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	Print Name
_____	_____
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:

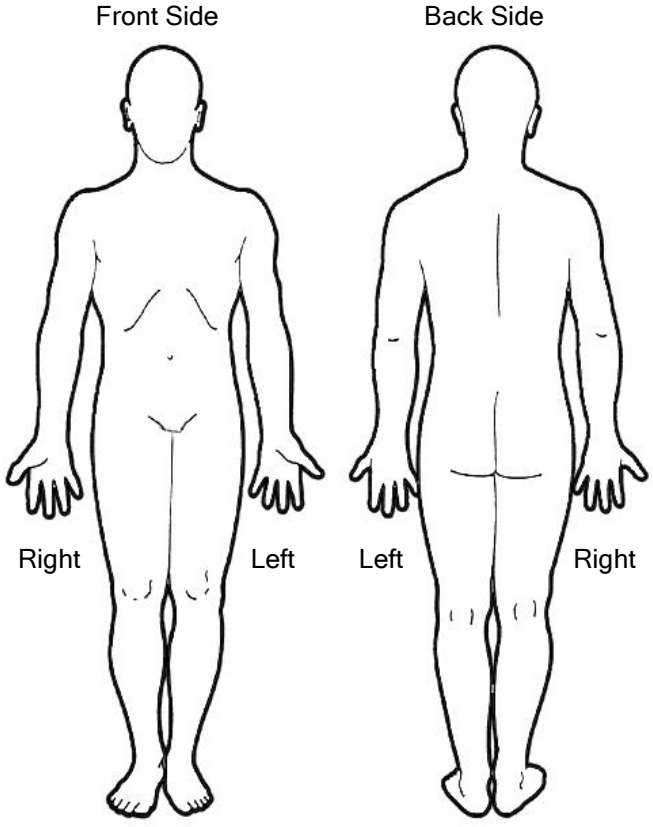
Stabbing Pain: / / /

Numbness: ~ ~ ~

Pins and Needles: ^ ^ ^

Burning Pain: O O O

Aching Pain: X X X



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 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: ☐ No ☐ Yes: Helpful: ☐ No ☐ Yes

If yes, where:_____

Have you had Physical Therapy: ☐ No ☐ Yes: Helpful: ☐ No ☐ Yes Visits: #_____

If yes, where:_____

Have you had Chiropractic: ☐ No ☐ Yes: Helpful: ☐ No ☐ Yes Visits: #_____

If yes, where:_____

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:_____

_____

_____

_____

Silver State Spinecare

INITIAL VISIT (page 3)

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

☐ No ☐ Yes **GENERAL:**
cancer, 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, anxiety, hallucinations, 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 ☐ No ☐ Yes How much:_____

☐ Drink alcohol ☐ No ☐ Yes How much:_____

Current employer:_____ How Long:_____

Previous employer:_____ How Long:_____

_____ _____ _____

Date Patient Signature Physician Signature