Spine Dynamics PC 788 Prince Avenue, Ste. C, Athens, GA 30606

Patient Demographics Information

Patient Information:

Referring Physician _____ Primary Care Physician _____

Last Name _____ First Name _____ M I _____

Preferred Name to be called _____

Patient's Address (No., Street) _____

City _____ State _____ Zip Code _____

Home Telephone ( ) _____ Cell Phone ( ) _____

Work Telephone ( ) _____ Sex ☐ Male ☐ Female Age _____

Date of Birth _____ / _____ / _____

Marital Status ☐ Married ☐ Divorced ☐ Single ☐ Widowed

Emergency Contact _____ Phone ( ) _____

Relationship to patient _____

Employment Status ☐ Employed ☐ Retired ☐ Student (part time) ☐ Student (full time)

Employer's Name _____ Occupation _____

Employer's Address (No., Street) _____

City _____ State _____ Zip Code _____

Are you the Policy Holder for the insurance? yes no - If not please fill out primary persons information.

Primary Insurance Information:

Name of Policy Holder _____ Relationship to Patient _____

Policy Holder's Date of Birth _____

What is the best way to contact you for cancellations, appointment changes, etc…? ☐ work ☐ cell ☐ home

Do you prefer to have your appointment reminders ☐ phoned ☐ emailed ☐ text

☐ Email Address _____

☐ Phone # to Text _____

How did you hear about Spine Dynamics PC?

_____ I was a previous patient. _____ Physician

_____ Employer _____ Friend (friends' name _____)

_____ Phone Book _____ Other (please specify _____)

Spine Dynamics 1765 Old West Broad Street, Bldg 1, Ste. 100, Athens, GA 30606

MEDICAL HISTORY

Name _____ Today's Date _____

Referring MD _____ Next Appointment _____

When did you first notice the pain? _____

On a scale of 0 - 10 (0 = no pain, 10 = worst pain you can imagine), rate the following:

Worst pain thus far : _____ Least pain thus far : _____ Today's pain : _____

For this condition, have you seen any of the following ?

□ Medical Doctor From _____ to _____ □ Physical Therapist From _____ to _____

Therapist's Name _____ Location _____

List any diagnostic tests that you have had for this condition (X-ray, MRI, etc..) _____

Do you have any medical problems that would limit your ability to exercise? □ Yes □ No If yes, please explain:

_____

Please describe any surgeries in the past 10 years and include dates: _____

_____

What do you hope to accomplish with therapy? _____

_____

Injury Work Related? □ Yes □ No Injury the result of an auto accident? □ Yes □ No

Are you currently working? □ Yes □ No If yes, how much? □ Full Duty □ Restricted Duty

How many work days have you missed? _____ Do you have a case manager? □ Yes □ No

Case Manager's Name: _____ Phone # _____

Please list your work duties. _____

What critical work duties have been affected by your injury / condition? _____

_____

_____

Have you ever been diagnosed with any of the following?

Tuberculosis	□ Yes	□ No	Stroke	□ Yes	□ No
Heart Condition	□ Yes	□ No	High / Low Blood Pressure	□ Yes	□ No
Pregnancy (current)	□ Yes	□ No	Vision / Hearing Problems	□ Yes	□ No
Dizzy / Fainting spells	□ Yes	□ No	Arthritis	□ Yes	□ No
Epilepsy	□ Yes	□ No	Hepatitis	□ Yes	□ No
Cancer	□ Yes	□ No	Diabetes	□ Yes	□ No
Breathing Problems	□ Yes	□ No	Rheumatic Fever	□ Yes	□ No
Pacemaker	□ Yes	□ No	Angina or Chest Pain	□ Yes	□ No
Back Injury	□ Yes	□ No	Kidney Problems	□ Yes	□ No
Disease of the arteries	□ Yes	□ No	Disability of feet / ankles	□ Yes	□ No
Asthma	□ Yes	□ No	Swollen and stiff painful joints	□ Yes	□ No
Lung Disease	□ Yes	□ No	MRSA infection	□ Yes	□ No
Shortness of Breath	□ Yes	□ No	VRE infection	□ Yes	□ No

If you checked any of the above, please explain : _____

_____

_____

_____

Please list any other medical conditions: _____

_____

Please list all medications that you are currently taking:

Medications	Reason for medication	Dosage	Frequency & How Taken

Are you allergic to any medications? _____

_____

Other allergies? _____

_____

Spine Dynamics

Orthopedic and Sports Physical Therapy
788 Prince Avenue Suite C
Athens GA 30606
(706)543-2111

INSURANCE AND PAYMENT POLICY
CONSENT FOR TREATMENT FORM

I consent to receiving physical therapy services which are deemed medically necessary by my referring and/or primary care physician. I understand that I have the right to ask and have any questions answered prior to receiving any treatment, including any risks or alternatives to the treatment plan that has been prescribed by my physician and/or recommended by my therapist. I authorize **Spine Dynamics, PC** to release to my insurance company, employer, and referring physician any information required during my examination or treatment. I authorize any physician, hospital, or clinic to provide details of my history to **Spine Dynamics, PC**.

As a courtesy to our patients, **Spine Dynamics, PC** will verify and file insurance; however, this does not guarantee payment. I understand that **Spine Dynamics, PC** will bill my insurance company (if applicable) for services rendered. I hereby assign payment directly to Spine Dynamics, PC for medical benefits payable for these services. **I understand that I am responsible for payment for all services rendered regardless of insurance coverage.**

If patient fails to inform Spine Dynamics of any insurance changes, you will be charged a fee for any additional paperwork. If for any reason, your insurance company denies a claim due to other insurance policies, you will be responsible for payment for all services rendered, regardless of insurance coverage.

If patient is a minor, I am responsible for payment of services
(Adult accompanying minor is responsible for any outstanding balance)

Patient
signature_____Date:_____

THE PERSON WITH MINOR PATIENT IS RESPONSIBLE FOR BILL. BY SIGNING BELOW I UNDERSTAND THAT I AM RESPONSIBLE FOR PAYMENT.

Signature_____Date:_____

PLEASE PRESENT ALL INSURANCE CARDS TO THE FRONT DESK

Spine Dynamics

Orthopedic and Sports Physical Therapy
788 Prince Avenue Suite C
Athens GA 30606
(706)543-2111

Patient Acknowledgement of Notice of Privacy Practices

As required by the privacy Standards of the Health Insurance Portability and Accountability Act of 1996 (HIPAA),

I have had the opportunity to review and/or request a copy of the Notice of Privacy Practices of Spine Dynamics, PC on the date indicated below.

I understand that if any changes are made to this Notice of Privacy Practices, a revised copy of the notice will be posted at the office.

You may release my protected health information to the following person(s):

_____

_____

_____

Spine Dynamics
Orthopedic and Sports Physical Therapy
788 Prince Avenue Suite C
Athens GA 30606

Phone: (706) 543-2111
Fax: (706) 543-2190

Print Name of Patient:

_____

Signature of Patient:

_____
(Or Personal Representative)

Date: _____

SPINE DYNAMICS PC

24 Hour Cancellation Policy

Spine Dynamics has a 24 hour cancellation/rescheduling policy. This policy is in place out of respect for our therapists and our clients. Cancellations with less than 24 hours notice are difficult to fill. By giving last minute notice or no notice at all, you prevent someone else from being able to schedule into that time slot. If you no show 2 times, there will be a **$50 no show charge** thereafter. By signing below, you acknowledge that you have read and understand the cancellation policy for Spine Dynamics as described above.

Thank you for your understanding and cooperation.

_____ _____

Printed Name Date

_____

Signature

Have you had any X-Rays/MRI's that are related to the condition you're being seen for?
□ Yes □ NO

****If YES, please proceed to fill out this form so that we can request those records****

Where did you have the x-ray/MRI done?
□Athens Diagnostic Center □St. Mary's □Athens Regional Medical Center
□MRI and Imaging of Athens

SPINE DYNAMICS, PC
788 Prince Avenue Ste. C
Athens, Ga. 30606
706-543-2111
Fax 706-543-2190

Authorization for Disclosure of Protected Health Information

I hereby authorize_____to release all _____records to Spine

Dynamics, PC. A copy shall be as valid as the original document.

I understand that when my PHI is disclosed pursuant to this Authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing, except (1) to the extent that the Practice has acted in reliance upon this Authorization (2) to the extent that the Authorization was obtained as a condition of obtaining insurance coverage, there is other law that grants the insurer the right to contest a claim under the policy. I understand that my revocation must be submitted in writing to the Practice's Privacy Official/Committee at 788 Prince Ave. Suite C Athens, Georgia 30606, by sending a written request stating that I wish to revoke this Authorization to the attention of the Privacy Official/Committee. I understand that the Practice may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this Authorization. By signing this authorization, I authorize SPINE DYNAMICS, PC (the "Practice") to use and/or disclose certain protected health information (PHI) to or for the party or parties listed above.

Print Patient's Name: _____

Date of Birth: _____/_____/_____

Signature_____
Signature of Patient or Personal Representative

Date: _____

If signed by a Personal Representative, please state authorization to do so:

_____