US PAIN AND REHABILITATION CENTER

PATIENT REGISTRATION FORM

Last Name _____ **MI** _____ **First Name** _____

Date of Birth _____ **Gender:** 0 Male 0 Female **Marital Status:** Single / Married

Employment Status: Employed / Unemployed / Student

Home Address_____

Street ***City*** ***State*** ***Zip***

Home Phone _____ **Work Phone** _____ **Cell Phone** _____

Authorization and Consent

1. I request medical care from US Pain and Rehabilitation Center or one of their affiliates. I agree to this care.

Insurance and Payment Information:

US Pain and Rehabilitation Center receives payment for patient care from insurance companies, Medicare, and/or other third party programs.

1) I agree to have my insurance company, Medicare, or other third party payment program make payments directly to US Pain and Rehabilitation Center and/or its Affiliates
2) I agree to let my doctor(s) and/or the US Pain and Rehabilitation Center submit claims and required treatment information to my insurance company, Medicare, or other third party payment program for my care, and receive payments directly.
3) I understand that I must pay all charges, co-payments, and deductibles that are not covered by my insurance company, Medicare, or third party payment program.

Permission to Communicate with Your Primary Care Physician and/or Other Community Care Providers: In order to ensure continuity of care, it is often necessary to communicate information to your primary care physician, other community care providers and to your insurance company. These communications may include information about your medical treatment. This information is limited to that which is necessary to the determination of coverage and the coordination of your care. Many insurance companies require us to document whether or not you will allow your clinician to communicate with your primary care physician and/or Health Insurance Company.

Signature of the patient (or person authorized to sign for patient) _____

Relationship to Patient _____ **Date** _____

1997 Sloan Place, Suite 23, St Paul, MN 55117 – Phone: 651-800-4909 Fax: 651-800-4906

email: info@uspainandrehabcenter.com

US PAIN AND REHABILITATION CENTER
1997 Sloan Place, Suite 23, St. Paul, MN 55117
PHONE: 651-800-4909 FAX: 651-800-4906

ACKNOWLEDGMENT OF RECEIPT OF HIPAA PRIVACY NOTICE

I, _____, have received a copy of this office's Notice of Privacy Practices. I understand that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

Conduct, plan and direct my treatment and follow-up among the health care providers who may be directly and indirectly involved in providing my treatment.

Obtain payment from third-party payers.

Conduct normal health care operations such as quality assessments and accreditation.

_____

Patient

_____

Signature

_____

Date

For Office Use Only

We attempted to obtain written Acknowledgment of receipt of our Notice of Privacy Practices, but Acknowledgment could not be obtained because:

- ☐ **Individual refused to sign**
- ☐ **Communications barriers prohibited obtaining the Acknowledgment**
- ☐ **An emergency situation prevented us from obtaining Acknowledgment**
- ☐ **Other (Please Specify)** _____

_____

_____

Staff signature **Date**

ASSIGNMENT, LIEN, AND AUTHORIZATION

FOR DIRECT PAYMENTS BY MY PAYERS TO US PAIN AND REHABILITATION CENTER

("Assignment & Lien")

Purpose. The purpose of this Assignment & Lien is to assist the Office in collecting from various Payers who may be responsible for paying on my Charges. Accordingly, I agree to the following and direct all Payers as follows: **Definitions.** In this Assignment & Lien, the following terms shall have the following meaning: "Office" and "Clinic" shall refer to US Pain and Rehabilitation Center located at 1997 Sloan Place, Suite 23, Saint Paul, MN 55117;"Payer" shall refer to without limit any insurance carrier, health benefit plan administrator and fiduciary, health maintenance organization, preferred and independent provider organization, attorney, at-fault party, individual, and any other entity, which may elect or be obligated to pay or disburse Proceeds, either now or in the future; "Proceeds" shall include without limit the proceeds from any settlement, judgment, or verdict, the proceeds from any promise to pay or reimburse, the proceeds relating to "health-care-insurance receivables" and/or "payment intangibles" as such are defined by the applicable Uniform Commercial Code, and the proceeds relating to the following benefits, plans, or coverages: individual and group health benefits, Medicare, Medicaid, workers' compensation, disability, liability, uninsured and underinsured motorist, no-fault, medical payments benefits, personal injury protection, lost wages, lost services, property damage, and malpractice; "Charges" shall include without limit the full fees for the Office's services (including without limit treatment, medical equipment, supplies, supplements, narrative reports, photocopies, depositions, and testimony), any Collection Costs incurred by the Office, interest and delinquency penalties to the extent permitted by law, and any other charges incurred by me at the Office; "Collection Costs" shall include without limit any pre- and post judgment court costs, filing fees, service of process charges, attorneys fees, fees or costs associated requests for reconsideration, independent reviews or appeals to any Payer, and any other costs of collection incurred by the Office in any effort or action to collect my Charges either from me or from any Payer.

Assignment and Lien Terms. I hereby assign to the Office to the extent permitted by law, but only to the extent of my Charges, all of my rights, remedies, and benefits relating to any Payer, including without limit my right to receive Proceeds from any Payer now or in the future, and any and all causes of action that I might have against any Payer now or in the future, the right to prosecute such causes of action either in my name or in the Office's name, and the right to settle or otherwise resolve such causes of action as the Office sees fit. I further grant a contractual lien to the Office with respect to my Charges. I further intend for this Assignment & Lien to create a secured interest under the applicable Uniform Commercial Code with respect to my Charges, which lien shall attach to all Proceeds to the extent permitted by law and shall also be automatically perfected effective as of the date and time that my condition first arose, and further authorize the Office to file the form(s) normally filed with the secretary of state or other governmental agency relating to such lien. Consistent with these terms, I hereby direct any and all Payers, to pay the Proceeds directly to, immediately to, and exclusively in the name of, the Office to the extent of my Charges.

Specific Direction to Any Attorney I Retain, Such as in Accident Cases. In the event that I retain one or more attorneys to assist me in collecting any Proceeds, I hereby direct (and the Office hereby requests) each attorney to provide immediate notice to the Office regarding any Proceeds received by the attorney, to promptly pay the Office in-full out of such Proceeds, and to provide a full accounting of such Proceeds to the Office. I agree that the purpose of any Proceeds received by the attorney shall be primarily to pay my Charges. I further agree to and hereby irrevocably waive any present or future right I may have, whether arising under a "Common Fund Doctrine" or other legal basis, to require the Office to reduce its Charges or balance by a proportionate or weighted share of my attorney's fees, costs, and other expenses of pursuing collection of my claims, including the Office's Charges.

Disclosure Directives. I hereby direct each and every Payer to immediately release to the Office any Pertinent Information relating to (a) any coverage I may have and (b) any Determination by the Payer relating to the Office's Charges. "Pertinent Information" shall include without limit the amount of total coverage available and remaining, as well as the amount of any outstanding claims which the Payer has received from any claimant relating to my condition. "Pertinent Information" shall also include without limit copies of all documents, records, and other information (a) relied upon by the Payer in making a Proceeds Determination, or (b) was submitted, considered, or generated in the course of making a Proceeds Determination without regard to whether such document, record, or other information was relied upon in making the Proceeds Determination. "Proceeds Determination" shall include without limit any determination by the Payer to pay, deny, or delay payment of any Proceeds relating to the Office's Charges, as well as a decision to refer the Charges to an independent review or audit, utilization review, or independent medical exam. I further authorize and direct the Office to release any information relating any services rendered to or for me by the Office to all Payers, including without limit a copy of my Charges and a copy of this Assignment & Lien.

Miscellaneous. Except as provided in this paragraph, this Assignment & Lien shall not be modified or revoked without the expressed, written consent of the Office. I hereby revoke, with the Office's consent, the terms of any previously signed documents, but only to the extent those terms conflict with the terms of this Assignment & Lien. I agree that each and every provision of this Assignment & Lien is reasonably necessary for the protection of the rights and interests of the Office and myself. However, should any provision of this Assignment & Lien be found to be invalid, illegal or unenforceable, or for any reason cease to be binding on any party hereto, all other portions and provisions of this Assignment & Lien shall, nevertheless, remain in full force and effect. This Assignment & Lien shall be governed under the laws of the state where the Office is located, and is performable in the county where the Office is located. In any action based upon this Assignment & Lien, I hereby consent to personal jurisdiction and venue of any court in said county and waive all objections based on improper jurisdiction, venue, or forum inconvenience. I further waive any statute of limitations which may apply in any action based upon this Assignment & Lien.

I have read, understood, and agree to the terms of this Assignment& Lien.

Patient Name (print): _____

Patient Signature: _____ **Date**: _____/_____/_____

Name of Custodial Parent or Legal Guardian, on Behalf of the Patient (please print): _____

Parent/Guardian Signature: _____ Date: _____/_____/_____

Patient Health Questionnaire - PHQ

ChiroCare Form PHQ-202

ChiroCare Use Only rev 5/27/2003

Patient Name _____ **Date** _____

1. Describe your symptoms _____

_____

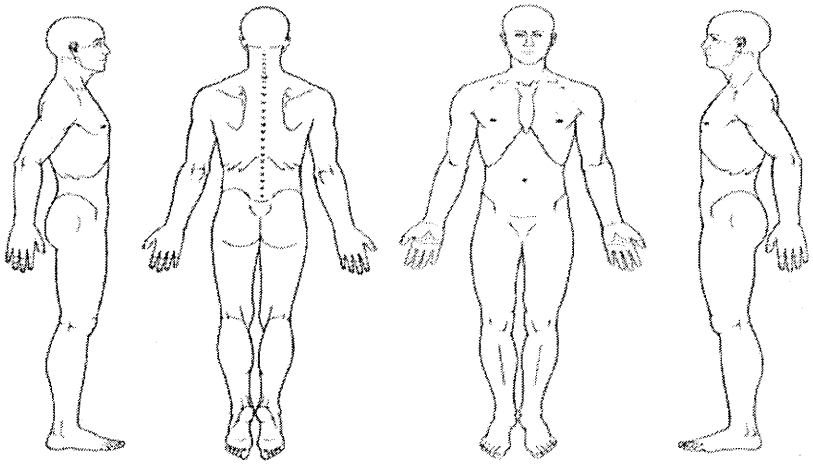
a. When did your symptoms start? _____

b. How did your symptoms begin? _____

2. How often do you experience your symptoms?

① Constantly (76-100% of the day)
② Frequently (51-75% of the day)
③ Occasionally (26-50% of the day)
④ Intermittently (0-25% of the day)

Indicate where you have pain or other symptoms



3. What describes the nature of your symptoms?

① Sharp ④ Shooting
② Dull ache ⑤ Burning
③ Numb ⑥ Tingling

4. How are your symptoms changing?

① Getting Better
② Not Changing
③ Getting Worse

5. During the <u>past 4 weeks:</u>

a. Indicate the average intensity of your symptoms

None ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ Unbearable

b. How much has pain interfered with your normal work (including both work outside the home, and housework)

① Not at all ② A little bit ③ Moderately ④ Quite a bit ⑤ Extremely

6. During the <u>past 4 weeks</u> how much of the time has your condition interfered with your social activities?
(like visiting with friends, relatives, etc)

① All of the time ② Most of the time ③ Some of the time ④ A little of the time ⑤ None of the time

7. In general would you say your overall health right now is...

① Excellent ② Very Good ③ Good ④ Fair ⑤ Poor

8. Who have you seen for your symptoms?

① No One
② Other Chiropractor
③ Medical Doctor
④ Physical Therapist
⑤ Other

a. What treatment did you receive and when? _____

b. What tests have you had for your symptoms and when were they performed?

① Xrays *date:* _____ ③ CT Scan *date:* _____
② MRI *date:* _____ ④ Other *date:* _____

9. Have you had similar symptoms in the past? ① Yes ② No

a. If you have received treatment in the past for the same or similar symptoms, who did you see?

① This Office
② Other Chiropractor
③ Medical Doctor
④ Physical Therapist
⑤ Other

10. What is your occupation?

① Professional/Executive
② White Collar/Secretarial
③ Tradesperson
④ Laborer
⑤ Homemaker
⑥ FT Student
⑦ Retired
⑧ Other

_____

a. If you are not retired, a homemaker, or a student, what is your current work status?

① Full-time
② Part-time
③ Self-employed
④ Unemployed
⑤ Off work
⑥ Other

Patient Signature _____ **Date** _____

Patient Health Questionnaire - page 2

ChiroCare of Minnesota, Inc.

ChiroCare Use Only rev 1/20/99

Patient Name _____ **Date** _____

What type of regular exercise do you perform? ① None ② Light ③ Moderate ④ Strenuous

What is your height and weight? Height [ ][ ][ ] (Feet / Inches) Weight [ ][ ][ ] lbs.

For each of the conditions listed below, place a check in the Past column if you have had the condition in the past. If you presently have a condition listed below, place a check in the Present column.

Past	Present		Past	Present		Past	Present	
○	○	Headaches	○	○	High Blood Pressure	○	○	Diabetes
○	○	Neck Pain	○	○	Heart Attack	○	○	Excessive Thirst
○	○	Upper Back Pain	○	○	Chest Pains	○	○	Frequent Urination
○	○	Mid Back Pain	○	○	Stroke			
○	○	Low Back Pain	○	○	Angina	○	○	Smoking/Use Tobacco Products
						○	○	Drug/Alcohol Dependence
○	○	Shoulder Pain	○	○	Kidney Stones			
○	○	Elbow/Upper Arm Pain	○	○	Kidney Disorders	○	○	Allergies
○	○	Wrist Pain	○	○	Bladder Infection	○	○	Depression
○	○	Hand Pain	○	○	Painful Urination	○	○	Systemic Lupus
			○	○	Loss of Bladder Control	○	○	Epilepsy
○	○	Hip/Upper Leg Pain	○	○	Prostate Problems	○	○	Dermatitis/Eczema/Rash
○	○	Knee/Lower Leg Pain				○	○	HIV/AIDS
○	○	Ankle/Foot Pain	○	○	Abnormal Weight Gain/Loss			
			○	○	Loss of Appetite	***Females Only***		
○	○	Jaw Pain	○	○	Abdominal Pain	○	○	Birth Control Pills
○	○	Joint Swelling/Stiffness	○	○	Ulcer	○	○	Hormonal Replacement
○	○	Arthritis	○	○	Hepatitis	○	○	Pregnancy
○	○	Rheumatoid Arthritis	○	○	Liver/Gall Bladder Disorder	○	○	
○	○	General Fatigue	○	○	Cancer	***Other Health Problems/Issues***		
○	○	Muscular Incoordination	○	○	Tumor	○	○	
○	○	Visual Disturbances	○	○	Asthma	○	○	
○	○	Dizziness	○	○	Chronic Sinusitis	○	○	

Indicate if an immediate family member has had any of the following:

○ Rheumatoid Arthritis ○ Heart Problems ○ Diabetes ○ Cancer ○ Lupus ○ _____

List all prescription and over-the-counter medications, and nutritional/herbal supplements you are taking:

_____ _____ _____

_____ _____ _____

List all the surgical procedures you have had and times you have been hospitalized:

_____ _____ _____

_____ _____ _____

Patient Signature _____ **Date** _____

Doctor's Additional Comments

_____

_____

_____

Doctors Signature _____ **Date** _____

COLLISION INFORMATION

Name: _____ Today's Date: ____/____/____

Where did the collision occur: Street:_____ City:_____ State:_____

Date when collision occurred: ____/____/____ **Time:** AM or PM. Was the road: ❑ Dry ❑ Wet ❑ Snowy ❑ Icy

Where you the: ❑ Driver ❑ Front middle passenger ❑ Front right passenger ❑ Back left ❑ Back middle ❑ Back right

Insurance Company:_____ **Claim#:**_____

Describe what happened:_____

_____

_____

_____

CRASH DETAILS

❑ Yes	❑ No	N/A	If you were ***driving***, were both hands on the wheel at impact?
❑ Yes	❑ No	N/A	If you were a ***passenger***, did your hands and/or feet brace yourself?
❑ Yes	❑ No		Did you have your seat belt and shoulder strap on?
❑ Yes	❑ No		Was your seat up (meaning not reclined) at the time of impact?
❑ Yes	❑ No		Were you wearing a bulky coat or slippery pants?
❑ Yes	❑ No	N/A	Did the seat belt engage?
❑ Yes	❑ No	N/A	Did the airbag engage/go off?
❑ Yes	❑ No	Not Sure	Did you hit the dash, steering wheel, side door or window with any of your body parts?
❑ Yes	❑ No		Did you know you were going to be hit?
❑ Yes	❑ No	Not Sure	Did you brace yourself with your hands or feet?
❑ Yes	❑ No	N/A	If you were ***driving***, was your foot on the brake at impact?
❑ Yes	❑ No	Not Sure	Was your head turned at the time of impact?
❑ Yes	❑ No	Not Sure	Were you leaning forward at the time of impact?
❑ Yes	❑ No	N/A	Did your glasses fly-off at impact?
❑ Yes	❑ No	Not Sure	Was your body turned at the moment of impact?
❑ Yes	❑ No	Not Sure	Did you get hit or pushed into another car, tree, railing, etc?
❑ Yes	❑ No		Any damage or marks on your vehicle, the vehicle that hit you, or another object that was hit?
			What part of your vehicle was hit/damaged (**driver's side or passenger side**)?_____

_____

1. Was the car you were in: Stopped (or) Moving? Was the other vehicle: Stopped (or) Moving?
2. What make and model of vehicle were you in?_____ The other vehicle?_____
3. What kind of seat were you in? __ Bucket __ Bench __ Fabric __ Leather/Vinyl
4. Did the car have headrests? ❑ Yes ❑ No
5. Did you hit your head on the headrest? ❑ Yes ❑ No On the back window if in a small truck? ❑ Yes ❑ No
6. Was the headrest positioned: __ below __ level with __ above the center of your head
7. Did your head hurt after the collision? ❑ Yes ❑ No Did your TMJ/jaw hurt after the collision? ❑ Yes ❑ No
8. How soon after the collision did you notice any pain? _____

PROVIDERS SEEN

9. Did the crash affect: ❑ dizziness ❑ memory ❑ concentration ❑ headaches ❑ balance ❑ nightmares ❑ breathing ❑ fatigue ❑ irritability ❑ ability to read ❑ ability to listen ❑ appetite ❑ nausea ❑ vision
10. Did you lose consciousness/get "knocked out"? (circle one) Yes No Not Sure
11. Did you go the hospital? Yes No Were you transported by ambulance? Yes No
12. Was the car you were in drivable after the collision? Yes No Not Sure
13. Is there anything else you want us know? _____

_____

List **all** providers seen since injury occurred:

1. Clinic/Doctor/Hospital Name_____City_____
2. Clinic/Doctor/Hospital Name_____City_____
3. Clinic/Doctor/Hospital Name_____City_____
4. Clinic/Doctor/Hospital Name_____City_____
5. Clinic/Doctor/Hospital Name_____City_____

❑ Yes ❑ No Do you have pictures of your vehicle? Where is it being repaired?_____

❑ Yes ❑ No N/A Do you have a copy of the police report?

Name of your Attorney if you have one:_____

Name of Your Car Insurance Co._____ Your Health Ins. Co. _____

Name of the Other Drivers Car Insurance if Applicable_____