SPINALWORKS
Medical Group

New Patient Intake

Patient Information

Patient Name:_____ Preferred First Name:_____

Permanent Address:_____ City:_____ St:_____ Zip:_____

Birthdate: _____ SSN #:_____ Gender: ☐ M ☐ F ☐ Prefer not to answer

Cell #:_____ Work #:_____ Home #:_____

Race: ☐ White ☐ Black/African American ☐ Asian ☐ Hispanic/Latino ☐ American Indian/Alaskan Native

How did you hear about us? ☐ Internet Search ☐ Groupon ☐ Insurance Website ☐ Friend

Email Address:_____ Occupation:_____

Employer:_____ City, St, Zip_____

Emergency Contact:_____ Phone:_____ Relationship:_____

Guardian Information (If patient is a Minor/under the age of 18)

Name:_____ Relationship to Patient:_____

SSN #:_____ Birth Date:_____ Gender: ☐ M ☐ F ☐ Prefer not to answer

Permanent Address:_____ City:_____ St:_____ Zip:_____

Sect. 1) Primary Insurance (Please skip if you have no insurance or you have already given your insurance card)

Primary Company_____ Insured's Name_____

Policy #_____ Group #_____ Insured's DOB_____

Patient's relationship to Insured: ☐ Parent ☐ Spouse ☐ Self

Secondary Insurance (Please skip if you do not have insurance or you have already given your insurance card)

Primary Company_____ Insured's Name_____

Policy #_____ Group #_____ Insured's DOB_____

Patient's relationship to Insured: ☐ Parent ☐ Spouse ☐ Self

Sect. 2) Self-Pay Agreement (Complete if you do NOT have insurance)

I agree to pay for medical and therapy services rendered at Spinalworks Medical Group. I understand that I am responsible for letting Spinalworks Medical Group know if I need a payment plan.

X_____ Date:_____

Sect. 3) Release of Information: I authorize Spinalworks Medical Group to release medical information requested by my health insurance, Medicare, or third-party payers in order to assist in the payment of claims.

X_____ Date:_____

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What is the reason for your visit?_____
_____ Is your condition related to an auto collision? ☐ Y ☐ N

Allergies (include seasonal and sinus if present)_____
_____

Current Medication:_____
_____

Review of Systems (Please check all current or previous conditions as they may apply)

1.General Symptoms

☐ Allergies ☐ Fever ☐ Nervousness
☐ Loss of Consciousness ☐ Excess Sweating ☐ Convulsions
☐ Blackouts ☐ Pain at Night ☐ Loss of Sleep
☐ History of headaches ☐ Generalized Pain

2. Neurological Symptoms

☐ Dizziness ☐ Fainting ☐ Problem Speaking ☐ Blurred Vision ☐ Nausea ☐ Numbness/Tingling

3. Ears/Eyes/Nose/Throat Symptoms

☐ Failing Vision ☐ Vision Problems ☐ Eye Pain ☐ Ringing in Ears ☐ Hearing Loss ☐ Other:

4. Respiratory Symptoms

☐ Asthma ☐ Chronic Cough ☐ Difficulty Breathing ☐ Shortness of Breath ☐ Bronchitis ☐ Emphysema

5. Cardiovascular Symptoms

☐ Bleeding Disorder ☐ Hardening of arteries ☐ Previous Heart Attacks
☐ High Blood Pressure ☐ Swelling of Ankles ☐ Phlebitis/Varicose Veins
☐ Low Blood Pressure ☐ Poor Circulation ☐ Pacemaker or similar device
☐ Previous incident of stroke ☐ Angina (Chest Pain)
☐ Cerebral vascular aneurism ☐ Chronic Congestive Heart failure

6. Gastrointestinal Symptoms

☐ Constipation/diarrhea ☐ Jaundice ☐ Ulcer ☐ Diabetes ☐ Indigestion

7. Genitourinary Symptoms

☐ Trouble Urinating ☐ Kidney Infection ☐ Prostate Trouble

8. Gastrointestinal Symptoms (FEMALE ONLY)

☐ Hot flashes ☐ Irregular/Absent Cycle ☐ Cramping/Backache

Hospitalizations/Surgeries

_____ Year:_____Surgeon/Hospital:_____
_____ Year:_____Surgeon/Hospital:_____

Family History

Mother	☐ Hypertension	☐ Diabetes	☐ Cancer	☐ Other:_____
Father	☐ Hypertension	☐ Diabetes	☐ Cancer	☐ Other:_____
Brother	☐ Hypertension	☐ Diabetes	☐ Cancer	☐ Other:_____
Sister	☐ Hypertension	☐ Diabetes	☐ Cancer	☐ Other:_____

Social History

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed
Work Status: ☐ Working full-time ☐ Part-time ☐ Retired ☐ Student ☐ Disabled ☐ On Leave
Do you drink alcohol? ☐ None ☐ Yes, _____ drinks/week
Do you use smoke/use tobacco? ☐ No ☐ Yes, _____ packs/day _____ times/week
Do you exercise? ☐ No ☐ Yes_____ days/week

Patient drug allergies_____

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Summary Notice of Privacy Practices

We strive to make sure that your Protected Health Information (PHI) remains confidential. Your medical records, paper and electronic, are safeguarded and released only with your consent or to your insurance carrier, other medical professionals directly involved with your care, or as required by law. Our "notice of Privacy Practices" policy manual explains how your medical information may be used and disclosed, is available for your review on our website at www.spinalworksdallas.com or you may ask our front desk for a copy.

Consent of Treatment

I hereby voluntarily consent to treatment from Spinalworks Medical Group encompassing routine diagnostic procedures, examination, and medical treatment including (but not limited to) routine laboratory work and administration of medications as prescribed by the Providers. I further consent to the performance of those diagnostic procedures, examinations, and rendering of medical treatment by Spinalworks Medical Group Center's medical Providers and staff, as is necessary in the medical staff's judgment. I understand that this consent will be valid and remain in effect as long as I attend the clinic.

ASSIGNMENT OF HEALTH PLAN BENEFITS AND RIGHTS
AS WELL AS AN APPOINTMENT AND/OR DESIGNATION AS MY PERSONAL REPRESENTATIVE
AND AN ERISA/PPACA REPRESENTATIVE AND BENEFICIARY

I understand and agree that (regardless of whatever health insurance or medical benefits I have), I am ultimately responsible to pay SPINALWORKS MEDICAL GROUP, PLLC as well as all employees, employers, representatives, and agents thereof, (hereinafter collectively referred to as "Healthcare Provider") the balance due on my account for any professional services rendered and for any supplies, tests, or medications provided. I hereby authorize payment of, and assign my rights to, any health insurance or medical plan benefits directly to Healthcare Provider for any and all medical/healthcare services, supplies, tests, treatments, and/or medications that ***have been*** or ***will be*** rendered or provided; as well as designating and appointing any provider from Spinalworks Medical Group, PLLC as my beneficiary under all health insurance or medical plans which I may have benefits under. I hereby authorize the release of any health status, conditions, symptoms or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other remedies necessary in connection with same. I hereby assign directly to any provider from Spinalworks Medical Group, PLLC all rights to payment, benefits, and all other legal rights under, or pursuant to, any health plan (including, but not limited to, any ERISA governed plan/insurance contract, PPACA governed plan/insurance contract) rights that I (or my child, spouse, or dependent) may have under my/our applicable health plan(s) or health insurance policy(ies). I also hereby appoint and designate that any provider from Spinalworks Medical Group, PLLC can act on my/our behalf, as my/our Personal Representative, ERISA Representative, and PPACA Representative as to any claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals and/or legal action (including in my name and on my behalf) to obtain and/or protect benefits and/or payments that are due (or have been previously paid) to either any provider from Spinalworks Medical Group, PLLC, myself, and/or my family members as a result of services rendered by any provider from Spinalworks Medical Group, PLLC, and to pursue any and all remedies to which I/we may be entitled, including the use of legal action against the health plan, the insurer, or any administrator. I hereby also declare that any provider from Spinalworks Medical Group, PLLC is my/our beneficiary regarding my/our health plan as contemplated by both ERISA and PPACA, and that any provider from Spinalworks Medical Group, PLLC can pursue any and all rights that I/we may have under state and/or federal law regarding my/our health plan. This assignment, appointment, and designation will remain in effect unless revoked by me in writing. *It is my intent that the effective date of this document shall relate back to include all services, supplies, test, treatments, or medications that have been previously provided by Healthcare Provider.* A photocopy or scan or this document is to be considered as valid and as enforceable as the original.

I have read and agree to the above.

Patient Name: _____ **Date:** _____

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Authorization for Disclosure of Medical Information

With my signature below, I authorize Spinalworks Medical Group to disclose any protected health information about me to carry out any treatment, healthcare operations, or payments. Please refer to Spinalworks Medical Group's 'Notice of Privacy Practices' for a more complete description of such disclosures. I have the right to review the 'Notice of Privacy Practices' at any time.

_____ **(Initials)** I acknowledge receipt of 'Notice of Privacy Practices.' I understand I may receive communication from Spinalworks Medical Group via text, call, or email regarding appointment reminders or to obtain feedback on my experience with the practice. If at any time I wish to revoke the consent to receive that communication, I understand that I have the right to do so by notifying Spinalworks Medical Group of that request.

With My Consent (please initial only one)

_____ **(Initials)** Spinalworks Medical Group may call my cell or home to leave a message on my answering machine/voice mailbox. Spinalworks Medical Group may send mail or email about any items that may assist Spinalworks Medical Group in carrying out any treatment, payments, or operations such as appointment reminders, insurance information, or billing information and any calls pertaining to any clinical care including examination and test results. (Laboratory, X-rays, etc.)

_____ **(Initials)** Spinalworks Medical Group may NOT leave any voice mail messages on my machine or voice mailbox or speak with anyone in my household other that myself about anything that pertains to treatment at Spinalworks Medical Group.

I understand that all records, written and oral, or in electronic format are confidential and cannot be disclosed for any reasons outside of treatment, payment or healthcare operations. I understand that I have been provided with a 'Notice of Privacy Practices' handout that provides a more complete description of information uses and disclosures. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and the office and I must agree on the use and disclosure of my Protected Health Information. A photocopy or fax of this consent is as valid as this original. I understand that I may revoke this consent, in writing, except where disclosures have already been made in reliance.

Patient Signature_____ **Date**_____

Printed Name_____ **Date of Birth**_____

May we speak to anyone else about your treatment?

I give permission to Spinalworks Medical Group to release my private health information, including appointment day/time, to the following person(s); spouse, family member, etc.: ☐ **Only disclose to me**

Authorized Individual_____ **Relationship**_____

Authorized Individual_____ **Relationship**_____