SPINAL CORRECTION CENTERS SINCE 1997

Entrance Application

We are honored you chose us to evaluate your health. To better serve you, please fill out the personal information below. If you need assistance, please inform our front desk team member.
Thank you and welcome to **Spinal Correction Centers** !

Patient Information

First Name: _____ Middle _____ Last _____ Gender: __M __ F

Address: _____

City: _____ State: _____ Zip Code: _____ Cell Phone Carrier: _____

Home Phone: _____ Cell Phone: _____ Social Security Number: _____

Email Address: _____ Birthdate: _____ Age: _____

Marital Status: __ S __ M __ W __ D Job Title: _____ Work Phone: _____

Spouse Name: _____ Birthdate: _____ Social Security Number: _____

Children: Names and Ages: _____

Insurance Information

Name of person on the insurance card: _____ DOB: _____

Name of employer: _____

Employer phone number: _____ City: _____

Person responsible for this account: _____

Additional Information

In case of emergency, whom should we contact? _____

Relation to patient: _____ Phone Number: _____

Family Physician: _____

May we send your Family Physician updates on your progress? _____Yes _____ No

What is your primary complaint? _____

_____

Is this worker's compensation? _____ Is this personal injury? _____

Office use only **Account Number** **Date**

NAME: DATE: / / Account#:

HISTORY OF ILLNESS / INJURY / PAIN

LOCATION

Chief complaint and its location: _____

_____

TIMING & DURATION

How often do you experience this pain? _____Constant _____Frequent _____Intermittent _____Occasional

What caused the onset? _____

_____

Date of onset? / / _____Immediate _____Gradual

Please list your most recent incident (minor or major) that prompted this visit.)

SEVERITY

On a scale of 0 to 10 with 0 representing no pain and 10 being the most severe pain imaginable, use the key below to rate the severity of your pain.

0 = None 1 = Minimal 2 = Very Mild 3 = Mild 4 = Mild to Moderate 5 = Moderate
6 = Moderate to Severe 7 = Mildly Severe, Restricts Some Activity 8 = Severe, Limits Most Activity
9 = Very Severe 10 = Excruciating

Sitting here today, right now, what is the intensity of your pain on a scale of 0 to 10?

_____0 _____1 _____2 _____3 _____4 _____5 _____6 _____7 _____8 _____9 _____10

What is the least intense the symptom has been on a scale of 0 to 10?

_____0 _____1 _____2 _____3 _____4 _____5 _____6 _____7 _____8 _____9 _____10

What is the most intense the symptom has been on a scale of 0 to 10?

_____0 _____1 _____2 _____3 _____4 _____5 _____6 _____7 _____8 _____9 _____10

ASSOCIATED SIGNS & SYMPTOMS

Please check those that apply · _____Inflexibility _____Stiffness _____Spasms _____Cramps

If this pain radiates or travels, please identify where to: _____

_____

QUALITY

How would you best describe the sensation of the pain/symptom:

_____ Sharp _____ Stabbing _____ Aching _____ Pins & Needles _____ Pounding _____ Shooting
_____ Burning _____ Dull _____ Tingling/Numb _____ Throbbing _____ Crawling _____ Stinging

MODIFYING FACTORS

What aggravates the pain/symptom?

_____Sneezing _____Lifting _____Exercising _____Looking up/down _____Walking
_____Coughing _____Sitting _____Stooping _____Looking side/side _____Standing
_____Stress _____Driving _____Getting out of bed _____Pushing _____Pulling
_____Repetitive movement _____Carrying _____Straining at BM _____Climbing stairs _____Getting in/out of car

Other: _____

What relieves this pain/symptom?

_____Resting _____Sleeping _____Lifting _____Exercising _____Looking up/down
_____Shower _____Advil _____Stooping _____Looking side/side _____Mineral Ice
_____Other: _____

Over the past weeks/months this complaint is: _____Improving _____Getting worse _____About the same

Have you seen anyone for this condition? _____YES _____NO WHOM? _____

Doctor Signature: _____

Patient Signature: _____

NAME: DATE: / / Account#:

SECONDARY COMPLAINT & LOCATION

Location_____Sitting here today, right now, what is the intensity of your pain on a scale of 0 to 10?

_____0 _____1 _____2 _____3 _____4 _____5 _____6 _____7 _____8 _____9 _____10

What is the least intense the symptom has been on a scale of 0 to 10?

_____0 _____1 _____2 _____3 _____4 _____5 _____6 _____7 _____8 _____9 _____10

What is the most intense the symptom has been on a scale of 0 to 10?

_____0 _____1 _____2 _____3 _____4 _____5 _____6 _____7 _____8 _____9 _____10

ASSOCIATED SIGNS & SYMPTOMS Please check those that apply · _____Inflexibility_____Stiffness _____Spasms_____Cramps

If the pain radiates or travels, please identify where to:_____

QUALITY

How would you best describe the sensation of the pain/symptom:

_____ Sharp _____ Stabbing _____ Aching _____ Pins & Needles _____ Pounding _____ Shooting
_____ Burning _____ Dull _____ Tingling/Numb _____ Throbbing _____ Crawling _____ Stinging

Over the past weeks/months this complaint is: _____Improving _____Getting worse _____About the same

THIRD COMPLAINT & LOCATION

Location_____Sitting here today, right now, what is the intensity of your pain on a scale of 0 to 10?

_____0 _____1 _____2 _____3 _____4 _____5 _____6 _____7 _____8 _____9 _____10

What is the least intense the symptom has been on a scale of 0 to 10?

_____0 _____1 _____2 _____3 _____4 _____5 _____6 _____7 _____8 _____9 _____10

What is the most intense the symptom has been on a scale of 0 to 10?

_____0 _____1 _____2 _____3 _____4 _____5 _____6 _____7 _____8 _____9 _____10

ASSOCIATED SIGNS & SYMPTOMS Please check those that apply · _____Inflexibility_____Stiffness _____Spasms_____Cramps

If the pain radiates or travels, please identify where to:_____

QUALITY

How would you best describe the sensation of the pain/symptom:

_____ Sharp _____ Stabbing _____ Aching _____ Pins & Needles _____ Pounding _____ Shooting
_____ Burning _____ Dull _____ Tingling/Numb _____ Throbbing _____ Crawling _____ Stinging

Over the past weeks/months this complaint is: _____Improving _____Getting worse _____About the same

KEY VALUE QUESTIONS

1. What is your pain keeping you from doing that is most important in your life?

_____

_____

2. What do you enjoy doing most in your life?

_____

_____

NOTES / COMMENTS:

_____

_____

_____

Doctor Signature: _____

Patient Signature: _____

NAME: DATE: / / Account#:

Please place a checkmark by the condition that applies to you: P = Present • N = Not Present • PP = If it has ever been present in the past

P	N	PP	
			Fatigue
			Fever
			Chills
			Night Sweats
			Fainting
			Nervousness
			Concentration Loss

P	N	PP	
			Irritability
			Depression
			Memory Loss
			Headache
			Muscle Pain
			Muscle Weakness
			Muscle Cramps

P	N	PP	
			Joint Stiffness
			Spinal Curvature
			Back Pain
			Hot Joints
			Joint Swelling
			Stiff Neck
			Lumps / Masses

P	N	PP	
			Seizures
			Dizziness
			Tremors
			Loss of Sensation
			Loss of Coordination
			Ringing in the Ears
			Difficulty of Speech

P = Present • N = Not Present • PP = If it has ever been present in the past • Do the same for your family

Family History Key: F = Father • M = Mother • B = Brother • S = Sister • GF = Grandfather • GM = Grandmother

Family History

P	N	PP	Past Problem	When and Explanation of Condition (use back if needed)	F	M	B	S	GF	GM
			Cancer							
			Stroke							
			Thyroid Problems							
			Asthma							
			Heart Attack							
			HIV							
			Angina/Chest Pain							
			Diabetes							
			Arthritis							
			Other							

Do you have a pacemaker? _____YES _____NO

Are you Pregnant? _____YES _____NO

Do you think you may be pregnant? _____YES _____NO

FOR DOCTOR'S USE ONLY – PATIENT PLEASE PROCEED TO PAGE 4

REVIEW OF SYSTEMS

SYSTEM REVIEWED

- o Allergic / Immunologic
- o Constitutional
- o Endocrine
- o Gastrointestinal
- o Genitourinary
- o Integumentary
- o Neurological
- o Respiratory
- o Cardiovascular
- o Ears / Nose / Mouth
- o Eyes
- o All other system reviews negative
- o Hematological / Lymphatic
- o Musculoskeletal
- o Psychiatric

Notes / Comments: _____

Doctor Signature: _____

Patient Signature: _____

NAME:_____ DATE:____/____/____ Account#:_____

PLEASE LIST PAST SURGERIES:

1. _____ Year_____ 2. _____ Year_____
3. _____ Year_____ 4. _____ Year_____
5. _____ Year_____ 6. _____ Year_____

List any other key slips, falls or accidents you've had to present:	Date
1)	
2)	
3)	
4)	
5)	

What medications are you currently taking? (Include Date)	
1)	4)
2)	5)
3)	6)

Marital Status: ____Married____Divorced ____Single ____Separated ____Widowed

Number of Children:_____ Children's Name(s): _____

Frequency of Exercise:_____Never ____Rarely ____Occasionally ____Moderately ____Regularly

Intensity of Exercise: ____Low Level ____Medium Level ____High Level ____Competition Level

Sufficient Rest: ____Never ____Rarely ____Occasionally ____Moderately

Hours of Sleep: ____6 ____8 ____10 ____More than 10

Well balanced diet: ____Never ____Rarely ____Occasionally ____Moderately

Do you use Tobacco?_____No ____Occasionally ____1 to 2 ____2 to 3 ____4 to 5 ____More than 5 /day

Do you drink caffeinated beverages? ____No ____Occasionally ____1 to 2 ____2 to 3 ____4 to 5 ____More than 5 drinks/day

Do you drink alcoholic beverages? ____No ____Occasionally ____1 to 2 ____2 to 3 ____4 to 5 ____More than 5 drinks/day

Hobbies:

_____

_____

Patient history was obtained from:_____Patient _____Father _____Mother _____Son _____Daughter

Notes / Comments: _____

_____

_____

_____

_____

_____

_____

_____

Doctor Signature: _____

Patient Signature: _____

CONSENT TO TREATMENT

Health care providers are required to advise patients of the nature of the treatment to be provided, the risks and benefits of the treatment, and any alternatives to the treatment.

There are some risks that may be associated with treatment, in particular you should note:

a. 'While rare, some patients have experienced rib fractures or muscle and ligament sprains or strains following treatment;

b. There have been rare reported cases of disc injuries following cervical and lumbar spinal adjustment although no scientific study has ever demonstrated such injuries are caused, or may be caused, by spinal or soft tissue manipulation or treatment.

c. There have been reported cases of injury to a vertebral artery following osseous spinal manipulation. Vertebral artery injuries have been known to cause a stroke, sometimes with serious neurological impairment and may, on rare occasion, result in paralysis or death. The possibility of such injuries resulting from cervical spine manipulation is extremely remote;

Osseous and soft tissue manipulation has been the subject of government reports and multi-disciplinary studies conducted over many years and have demonstrated it to be highly effective treatment of spinal conditions including general pain and loss of mobility, headaches and other related symptoms. Musculoskeletal care contributes to your overall well-being. The risk of injuries or complications from treatment is substantially lower than that associated with many medical or other treatments, medications, and procedures given for the same symptoms.

I acknowledge I have discussed the following with my healthcare provider:

a. The condition that the treatment is to address;
b. The nature of the treatment;
c. The risks and benefits of that treatment; and
d. Any alternatives to that treatment.

I have had the opportunity to ask questions and receive answers regarding the treatment.

I consent to the treatments offered or recommended to me by my healthcare provider, including osseous and soft tissue manipulation. I intend this consent to apply to all my present and future care with _____ (health care provider's name).

Dated this _____ **day of** _____ **20**____

_____
Patient signature (or Legal Guardian)

_____
Signature of Witness

_____
Print Name

_____
Print Name

SCC

Policies

1. All first visit charges are payable when services are rendered.

2. The fee paid for treatment x-rays is for analysis only. The film itself is the property of this office. Once films are used for treatment purposes, they cannot be released. Copies can be made if necessary.

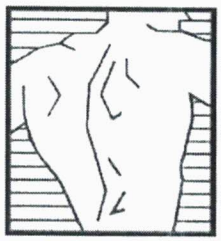
3. Method of payment you plan to use to take care of today's charges:
   _____ Cash _____ Check ____ Visa/MasterCard

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand Spinal Correction Centers will prepare any necessary reports and forms to assist in making collections from the insurance company and that any amount authorized to be paid directly to Spinal Correction Centers will be credited to my account upon receipt. *However*, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment.

I also understand that if I suspend or terminated care at this office, any outstanding charges for professional services rendered to me will be immediately due and payable. I agree that I will be responsible for all attorney and legal fees if legal action becomes necessary to collect this account. I authorize Spinal Correction Centers to obtain a credit report if deemed necessary.

Patient Signature: _____ **Date:** _____

Guardian Signature Authorizing Care: _____ **Date:** _____



SPINAL CORRECTION CENTERS SINCE 1997

GENERAL RELEASE OF MEDICAL CHART AND X-RAYS

I, _____ have requested the release of my

_____ Medical Records

_____ X-rays

_____ Complete Chart

Which is a part of _____

I hereby acknowledge receipt of my records and/or X-rays. In consideration of the foregoing, I hereby release and forever discharge the aforesaid medical facility from any and all responsibility or liability of any kind, nature or character whatsoever arising from said treatment.

Patient Signature_____ Date___/___/___

Guardian Signature Authorizing Care_____ Date___/___/___

1075 MAIN STREET, DUNEDIN, FL 34698 | P: (727)734-7611 | F: (727)736-1124

SCC, LLC
PO BOX 2721
Dunedin, FL 34697

Insurance Company Name: _____

For and in consideration of the above-mentioned provider agreed to pursue my insurance provider for payment of benefits do and not requiring prepayment for services. I hereby irrevocably assign to the aforementioned medical provider any benefits I may have in accordance with Florida statute 627. 736. This includes any benefits from my insurance company or any other entity that may be responsible for expenses incurred in I authorize the provider to Pro suit said action and collect legal expenses as they see fit this document constitutes an assignment of benefits. I hereby further give a lean-to the provider against any and all insurance benefits named herein, in any and all proceeds of any settlement judge or verdict which may be paid to me as a result of the injuries or illness for which I have been treated by the provider. This is to act as an irrevocably assignment of my rights and benefits to the extent of the services provided. I agree to cooperate with the provider and any attorney that the provider chooses and to do all things reasonable to effect payment of the bills by the insurance company to the provider including but not limited to disclosing patient's medical condition and treatment this assignment concerns only the bills for the provider and those costs included but not limited to attorney's fees court costs and interest necessary in procuring payment from the above-named insurance company ect. this assignment is not intended to assign any other causes of actions that may belong to the undersigned patient. I agreed to pay any applicable deductible or co-payment not covered by the PIP insurance coverage. I understand that this is a benefit inconvenience to me and that the provider will pursue collection against the insurance company on my behalf. I hereby instruct and I wrecked my insurance company to pay my benefits by check made payable to and mailed to the provider at the address listed above furthermore I hereby give the provider limited power of attorney to endorse or sign my name on any and all checks for payment to the provider. This agreement is intended to serve as an assignment of the patient's rights and benefits under his or her aforementioned insurance policy in favor of the provider. If any language within this agreement has the effect of invalidating this assignment that language shall be deemed void and the assignment shall remain in full force and effect. A photocopy of this assignment shall be considered as effective and valid as the original.

_____ _____

Patient Signature Date

_____ _____

Witness Signature Date

SCC LLC

Chiropractic Office HIPAA Form

THIS NOTICE PERTAINS TO PRIVACY MEASURES TO ALL DOCTORS AND MASSAGE THERAPISTS PRACTICING WITH SPINAL CORRECTION CENTER.

PATIENT CONSENT FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

With my signature below, I give consent for the Doctor (the Practice) to use and/or disclose information about me (or someone else for whom I have the legal authority to sign) that is protected under federal privacy law for the sole purpose of treatment, payment, and health care operations.

I have reviewed the Privacy Policy of this Practice prior to signing this consent. The Privacy Policy may be amended from time to time, and I may always obtain a copy of the current policy without charge by asking for it.

I have the right to request restriction on how my information is used and/or disclosed in order to execute treatment, payment, or healthcare operations. While the Practice is not required to agree to restrictions, the Practice is bound to adhere to any such restrictions to which it has agreed.

I have the right to revoke this consent in writing. Revocations will be honored from the time written and delivered to the Practice, but revocation cannot affect action already taken in reliance upon the consent given.

I realize that my personal information that is protected by federal privacy law may be used and/or disclosed at my consent and that the information may be subject to re- disclosure by the recipient. The re-disclosure by said recipient may not be protected by federal privacy law.

The Practice may communicate confidential information to me, including any invoices for services, at the following address/phone number/fax number/e-mail address:

_____

The Practice may communicate confidential information about me to the following individual(s):

_____

_____ _____/_____/_____

Patient/Patient Representative **Date**