

Date: _____

Name: Mr. Mrs. Miss Ms. _____ Social Security #: _____

Birthdate: _____ Age: _____ Sex: M/F _____ Marital Status: M S D Sep.

Address: _____ City: _____ State: _____ Zip: _____

Work Phone: _____ Home Phone: _____ Cell: _____ Email: _____

Occupation: _____ Employed by: _____

Address: _____ City: _____ State: _____ Zip: _____

Person to contact in case of an emergency: _____ Phone: _____

CODE:

ASSIGNMENT OF BENEFIT

I hereby authorize you to pay directly to Southeastern Healthcare, PC benefits due to me under the terms of my policy of insurance issued by your company. Please send such benefits to 2595 S. 17th Street, Wilmington, NC 28401. Payment is authorized upon your receipt of the itemized statement for services rendered to me. Your policy was in full force and effect at the time that these services were rendered. Payment of such amounts to the above provider in whole or part, shall constitute payment as if said payment were made directly to me. I hereby authorize SEHC to endorse/sign my name on any and all checks listing me as a payee which are presented to the Office for payment of an account relating to me, my spouse, or any of my dependents.

Insured: _____ Signature of Insured: _____

Date of Birth: _____ Date: _____

Insurance Carrier: _____ Employer of Insured: _____ Policy #: _____

PRIVATE PAY

I understand fully and agree that I am personally responsible for the total amounts due to Southeastern Healthcare, PC for the services rendered. If the bill remains unpaid, and no satisfactory arrangements have been made and executed on it, the account will be reported to the credit bureau and assigned for collection.

Patient Signature: _____ Date: _____

32M-0719

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including various modes of physical therapy, and if necessary, diagnostic x-rays on me (or on the patient named below, for whom I am legally responsible: _____) by the chiropractic physician and/or anyone working in this office authorized by the chiropractic physician.

I further understand that such chiropractic services by the Physician of Chiropractic named here _____ and/or other licensed Physicians of Chiropractic who may treat me now or in the future of this office. I have had an opportunity to discuss with Dr. _____ and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine and all healthcare, the practice of chiropractic carries some risks to treatment; including, but not limited to: fractures, disc injuries, strokes (CVA), dislocations, and sprains. I do not expect the physician to be able to anticipate and explain all risks and complications. Further, I wish to rely on the physician to exercise judgement during the course of the procedure which the physician feels are in my best interests at the time, based upon the facts then known.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its contents, and by signing below, I agree to the treatment recommended by my physician. I intend this consent form to cover the entire course of treatment for my present condition(s) and for any condition(s) for which I seek treatment at this facility.

To be completed by the patient:

To be completed by the patient's representative, if necessary, (e.g. if the patient is a minor or is physically or mentally incapacitated)

Print Patient's Name

Print Name of Patient

Signature of Patient

Print Name of Representative

Signature of Representative

INJURY / ACCIDENT

File# _____

Patient Name _____ DOB: _____ Today's Date: _____

Date of Accident: ____/____/____ City of Accident: _____

Treatment after accident:

- Taken to hospital by ambulance same day Taken to hospital by someone else same day
 Drove myself to hospital same day Visited hospital day after accident or later

Check which type of Images were taken: X-Ray CT MRI none

Other than Hospital doctors, what other healthcare have you received in regards to this accident?

- Primary Care Medac Chiropractor Physical therapy Pain Management specialist

Have you been prescribed any medications? (Check all that apply)

- Anti-inflammatories Muscle relaxers Pain medications YES NO

Since accident symptoms are getting worse about the same slightly better coming and going constant

Are you presently able to work? YES NO

During the Accident:

Where were you? Driver's seat front passenger seat rear seat pedestrian on a bicycle on a motorcycle

The impact came from? Behind front driver's side passenger's side

Did your body strike anything in the vehicle other than the seatbelt? YES NO

What part of your body? Head Shoulder Knee Other →please specify _____

Did you lose consciousness? YES NO

Personal History:

Please list any surgeries, fractures, dislocations particularly those relating to the spine, and their dates:

1. _____ Date ____/____/____ 2. _____ Date ____/____/____
3. _____ Date ____/____/____ 4. _____ Date ____/____/____

Do you have an attorney representing you regarding this accident? YES NO Who? _____

Major Complaint:

Check all that pertain to your complaint:

- | | | |
|--|--|---------------------------------------|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Mid back pain | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Neck pain | <input type="checkbox"/> Low back pain | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Shoulder joint pain | <input type="checkbox"/> Hip joint pain | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Numbness/tingling arm | <input type="checkbox"/> Knee joint pain | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Pain down the arm | <input type="checkbox"/> Pain down the leg | |
| <input type="checkbox"/> Upper back pain | <input type="checkbox"/> Numbness/tingling leg | |

PAIN DRAWING

Mark areas of pain on figures below:

POSTERIOR ANTERIOR

Neck pain

Upper back

Mid back pain

Low back pain

Numbness/tingling legs

Pain down the leg

_____ Other

_____ Other

_____ Other

Headache

Shoulder joint pain

Numbness/tingling arm

Pain down the arm

Hip joint pain

Knee joint pain

Other _____

Other _____

Other _____

Women:

Is it possible you are pregnant? YES NO Date of Last Menstrual cycle: ____/____/____

DOCTORS ONLY:

O: [Onset] Date ____/____/____

P: [Provocation] sitting standing physical activity lifting bending lying down sitting to standing

Q: [Quality] dull ache sharp shooting throbbing burning intermittently sharp

R: [Radiates] NO YES Radiates to: _____

S: [Severity]

1) ____/10 _____	4) ____/10 _____
2) ____/10 _____	5) ____/10 _____
3) ____/10 _____	6) ____/10 _____

T: [Time] worsening same better

Other Details: _____

Signature: _____ ____/____/____

**AUTO / ACCIDENT INJURY
ASSIGNMENT OF PROCEEDS, LIEN, AND AUTHORIZATION**

I hereby authorize and direct any and all insurance carriers, attorneys, agencies, governmental departments, companies, individuals, and/or other legal entities ("payers"), which may elect or be obligated to pay, provide, or distribute benefits to me for any medical conditions, accidents, injuries, or illnesses, past, present, or future ("condition") to pay directly and exclusively in the name of Southeastern Healthcare such sums as may be owing to Southeastern Healthcare for charges incurred by me at the office relating to my condition ("charges"), with such payments to be made exclusively in the name of Southeastern Healthcare. I further grant a lien to Southeastern Healthcare with respect to my charges. This lien shall apply to all payers and to the full extent permitted by law. For the purposes of this document (herein, "Assignment and Lien"), "benefits" shall include, but not be limited to, proceeds from any settlement, judgement, or verdict, as well as any proceeds relating to commercial health or group insurance, attorney retainer agreements, medical payments benefits, personal injury protection, no-fault coverage, uninsured and underinsured motorist coverage, third-party liability distributions, disability benefits, worker's compensation benefits, and any other benefits or proceeds payable to me for the purposes stated herein.

In the event that I retain one or more attorneys to represent me in this matter who are not located in North Carolina, I will direct each attorney to issue a letter of protection to this office regarding my charges. Upon issuance, I hereby agree that such letter(s) of protection cannot be revoked or modified without the expressed written consent of this office.

I authorize this office to release any information regarding my treatment or pertinent to my case(s) to all payers as defined above to facilitate collection under this Assignment and Lien. I further authorize and direct all payers to release to Southeastern Healthcare any information regarding any coverage or benefits which I may have including, but not limited to, the amount of the coverage, the amount paid this far, and the amount of any outstanding claims. I hereby direct this Office to file a copy of the Assignment and Lien, together with any applicable charges, with any or all payers, regardless of whether a claim has been established with said payers. I hereby authorize Southeastern Healthcare to endorse/sign my name on any all checks listing me as a payee which are presented to the Office for payment of an account relating to me, my spouse, or any of my dependents. I further authorize Southeastern Healthcare to apply any credited balances on charges incurred by me to any other outstanding charges still owed by me, my spouse, or my dependents, regardless of these other charges are related to my condition.

I understand that I remain personally responsible for the total amounts due Southeastern Healthcare for their services. This Assignment and Lien does not constitute any consideration for this Office to await payments and it may demand payments from me immediately upon rendering services at its option. If this Office must take any action to collect an outstanding balance on my account, I will be responsible for payment and will reimburse Southeastern Healthcare for all costs of such collection efforts, including, but not limited to, all court cost and all attorney fees.

This Assignment and Lien shall not be modified or revoked without the mutual written consent of Southeastern Healthcare and myself. I hereby revoke any previously signed authorizations, whether executed at this office or any other office to the extent that the terms of those authorizations conflict with the terms of the Assignment and Lien.

Patient Name (please print): _____

Patient Signature: _____ Date: ____ / ____ / ____

Name of Custodial Parent or Legal Guardian (please print): _____ Date: ____ / ____ / ____

Parent/Guardian Signature: _____

Election Not to File Health Insurance Claims (Personal Injury / Accident)

The chiropractor(s) at this clinic are participating ("in-network") providers for your health benefit plan. As participating providers, we are obligated to file claims for reimbursement with your plan for all covered services provided to you UNLESS you instruct us in writing not to file.

You have indicated that rather than using your own health insurance, you wish to consider seeking payment from other third-party payors such as the at-fault driver's liability insurance. To help you make an informed decision, please carefully review the following information.

If you elect NOT to file claims on your health insurance:

1. The clinic will rely on your decision and extend credit to you for the cost of care based on the assumption that your bill will be paid by sources other than your health insurance. You will be required to assign to the clinic the right to receive monies paid by liability insurers, medical payments insurers or other third-party payors to the extent necessary to satisfy your bill.
2. You will not be required to pay co-payments/co-insurance and/or deductibles that would normally be required by your health benefit plan.
3. The cost of your treatment will be billed at the clinic's usual rates rather than the discounted rates that routinely apply to services covered by your health benefit plan.
4. If the combined payments received from other sources do not fully satisfy your bill, you may be personally liable for any unpaid balance.
5. None of the charges for your treatment will be applied towards satisfying the annual deductibles associated with your health benefit plan.

If you elect TO file claims on your health insurance:

1. Your health insurance should pay the cost of *covered* services associated with this accident/injury EXCEPT FOR copayments, co-insurance and/or deductibles, which you will be expected to pay directly to the clinic at the time services are rendered.
2. You will be responsible for paying to the clinic the cost of any non-covered services you elect to receive, and your payment will be due at the time services are rendered.
3. If your health benefit plan initially pays the clinic for your treatment and later determines that it is not legally responsible for payment, the plan administrator may require the clinic to refund to the plan all or part of the payments received. If that happens, you will become responsible for reimbursing the clinic the amount it was required to refund.
4. Your health benefit plan requires the clinic to submit claims in a timely fashion and while timely filing requirements vary, most plans require claims to be filed within 3-6 months from date of service. If your action or inaction causes a claim to be submitted late, the claim could be denied, and you would be responsible for paying this clinic for those services which were denied.

Election not to file health insurance claims:

1. By my signature below, I attest that I have read and understand the above information regarding the options available to me and have been given an opportunity to ask questions and to have those questions answered.
2. I hereby instruct the clinic not to file claims on my health insurance for services associated with this accident/injury, and I authorize the clinic to seek payment from, and send my treatment records to, other third-party payors who are potential sources of payment.
3. I understand that the clinic is relying on my decision not to file health insurance claims, and that with regards to claims related to this accident/injury, this decision is irrevocable.
4. I understand that no subsequent action on my part shall impair the clinic's right to bill and receive payments from third-party payors; subject only to any contractual obligation the clinic may have to my health benefit plan.

Printed Name of Patient

Printed Name of Clinic Representative

Signature of Patient (or parent/legal guardian, as applicable)

Signature of Clinic Representative

Date: _____

Date: _____

A complete copy of this executed agreement must be maintained in the patient's health care record, and a copy must be provided to the patient.

ADVANTAGE RADIOLOGY SERVICE

(419) 269-2424 (800) 442-1202

PATIENT _____ CLINIC _____ FILM DATE _____
AGE _____ SEX M F SOCIAL SECURITY# _____ / _____ / _____ DATE OF BIRTH _____
PATIENT ADDRESS _____ CITY _____ STATE _____ ZIP _____

X-RAY ASSIGNMENT AGREEMENT

I understand that the services of a chiropractic radiologist are being utilized to insure the highest quality interpretation of my x-rays. I acknowledge that these services are separate from those of the clinic where I am receiving care, and that the charges for these services will be submitted to my insurance carrier, Workers' Compensation carrier or State Bureau, and/or to my attorney in the case of personal injury.

In the event that I receive payment for these services, I agree to promptly remit payment to Advantage Radiology Service (ARS).

I assign my insurance benefits and rights to payment to ARS to the extent of their charges, and authorize them, or their agents, to bill and release information to my insurance company, attorney, and/or any third-party payer. I authorize my treating physician, insurance company, attorney, and/or any third-party payer to provide ARS or their agents with any information concerning my claim, their services, and/or payment for the services provided.

By my signature below, I acknowledge that I have read, understand, and agree to the above provisions, and I assign my insurance benefits as described above.

SIGNATURE : _____ DATE : _____

WITNESS : _____

PATIENT HISTORY

PATIENT PRESENTATION _____

TRAUMA? YES NO EXPLAIN _____

PAST MEDICAL HISTORY _____

MALIGNANCY? YES NO DETAILS _____

DIAGNOSIS/CONCERNS/QUESTIONS [NO ICD CODES PLEASE] _____

ADVANTAGE RADIOLOGY SERVICE

(419) 269-2424 (800) 442-1202

CASH (no insurance) _____ MEDICARE ONLY _____ MEDICAID ONLY _____

STANDARD

NEED NON-PARTICIPATING PROVIDER INSURANCE NAME & BILLING ADDRESS
*PLEASE ATTACH COPY OF FRONT AND BACK OF INSURANCE CARD(S).

INSURANCE NAME & BILLING ADDRESS (PRIMARY)				INSURANCE NAME & BILLING ADDRESS (SECONDARY)					
CARRIER		TELEPHONE		CARRIER		TELEPHONE			
ADDRESS				ADDRESS					
CITY		STATE	ZIP	CITY		STATE	ZIP		
RELATIONSHIP TO INSURED SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER _____				RELATIONSHIP TO INSURED SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER _____					
INSURED NAME		INSURED DATE OF BIRTH		INSURED NAME		INSURED DATE OF BIRTH			
INSURED SOCIAL SECURITY #		INSURED ID #		INSURED SOCIAL SECURITY #		INSURED ID #			
INSURED GROUP #		BCBS 3 LTR PREFIX		INSURED GROUP #		BCBS 3 LTR PREFIX			
INSURED EMPLOYER		TELEPHONE		INSURED EMPLOYER		TELEPHONE			
IF W/C: EMPLOYER ADDRESS		CITY	ST	ZIP	IF W/C: EMPLOYER ADDRESS		CITY	ST	ZIP

AUTO ACCIDENT/PI/WORKERS' COMPENSATION

RELATED TO EMPLOYMENT? YES NO AUTO ACCIDENT? YES NO
OTHER? YES NO

CLAIM # _____ DATE OF INJURY _____

W/C CARRIER OF AUTO INSURANCE			NAME & BILLING ADDRESS <small>LIST BOTH LIABILITY & MED PAY CARRIERS (USE ADDITIONAL PAPER IF NECESSARY)</small>			ATTORNEY NAME & BILLING ADDRESS		
CARRIER		TELEPHONE		ATTORNEY NAME		TELEPHONE		
INSURANCE ADDRESS				ATTORNEY ADDRESS				
CITY		STATE	ZIP	CITY		STATE	ZIP	
RELATIONSHIP TO INSURED SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER _____				*PLEASE LIST BOTH LIABILITY AND MED PAY CARRIERS (USE ADDITIONAL PAPER IF NECESSARY)				
INSURED NAME		INSURED SOC. SECURITY #						
IF PI: ADJUSTERS NAME		ADJ: TELEPHONE		IF W/C: ALLOWED DIAGNOSIS ICD-9 CODES				

PLEASE COMPLETE PATIENT HISTORY ON REVERSE SIDE

HEALTH HISTORY CONFIDENTIAL

Name _____ Today's date _____

Age _____ Birthdate _____ Date of Last Physical Exam _____

What is the reason for your visit? _____

SYMPTOMS Check symptoms you currently have or have had in the past year.

<p>General</p> <input type="checkbox"/> Chills <input type="checkbox"/> Depression <input type="checkbox"/> Dizziness <input type="checkbox"/> Fainting <input type="checkbox"/> Fever <input type="checkbox"/> Forgetfulness <input type="checkbox"/> Headaches <input type="checkbox"/> Loss of Sleep <input type="checkbox"/> Nervousness <input type="checkbox"/> Numbness <input type="checkbox"/> Sweats <input type="checkbox"/> Loss of weight	<p>Gastrointestinal</p> <input type="checkbox"/> Appetite poor <input type="checkbox"/> Bloating <input type="checkbox"/> Bowel changes <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Excessive hunger <input type="checkbox"/> Excessive thirst <input type="checkbox"/> Gas <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Indigestion <input type="checkbox"/> Nausea <input type="checkbox"/> Rectal bleeding <input type="checkbox"/> Stomach pain <input type="checkbox"/> Vomiting <input type="checkbox"/> Vomiting blood	<p>Eye/Ear/Nose/Throat</p> <input type="checkbox"/> Bleeding gums <input type="checkbox"/> Blurred vision <input type="checkbox"/> Crossed eyes <input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Double vision <input type="checkbox"/> Earache <input type="checkbox"/> Ear discharge <input type="checkbox"/> Hay fever <input type="checkbox"/> Hoarseness <input type="checkbox"/> Loss of hearing <input type="checkbox"/> Nosebleeds <input type="checkbox"/> Persistent cough <input type="checkbox"/> Ringing in ears <input type="checkbox"/> Sinus problems <input type="checkbox"/> Vision-flashes <input type="checkbox"/> Vision-halos	<input type="checkbox"/> Splitting headaches <input type="checkbox"/> Neck pain <input type="checkbox"/> Pain between shoulder blades <input type="checkbox"/> Low back pain <input type="checkbox"/> Pain in shoulders, arms, hands, hips, legs, feet or toes <input type="checkbox"/> Sciatica <input type="checkbox"/> Chronic aches <input type="checkbox"/> Pain on inspiration <input type="checkbox"/> Pain with coughing or sneezing <input type="checkbox"/> Muscle weakness <input type="checkbox"/> Numbness/tingling in arms, shoulders, hands, legs, feet or toes <input type="checkbox"/> Joint stiffness <input type="checkbox"/> Joint pain <input type="checkbox"/> Joint swelling	<input type="checkbox"/> Multiple tender points <input type="checkbox"/> Injury from motor vehicle accident <input type="checkbox"/> Other injury _____ <input type="checkbox"/> Tension headache <p>Cardiovascular</p> <input type="checkbox"/> Irregular heart beat <input type="checkbox"/> Chest pain <input type="checkbox"/> High blood press <input type="checkbox"/> Low blood press <input type="checkbox"/> Poor circulation <input type="checkbox"/> Rapid heart beat <input type="checkbox"/> Varicose veins <input type="checkbox"/> Ankle swelling	<p>MEN only</p> <input type="checkbox"/> Lump in testicles <input type="checkbox"/> Other _____
<p>Skin</p> <input type="checkbox"/> Bruise easily <input type="checkbox"/> Hives <input type="checkbox"/> Itching <input type="checkbox"/> Mole change <input type="checkbox"/> Rash <input type="checkbox"/> Scars <input type="checkbox"/> Sore that will not heal	<p>Genitourinary</p> <input type="checkbox"/> Blood in urine <input type="checkbox"/> Frequent urination <input type="checkbox"/> Lack of bladder control <input type="checkbox"/> Painful urination	<p>Muscle/Joint/Bone</p> <input type="checkbox"/> Migraines <input type="checkbox"/> Headaches upon rising, wear off during day	<p>MEN only</p> <input type="checkbox"/> Breast lump <input type="checkbox"/> Erection difficulty <input type="checkbox"/> Sore on penis <input type="checkbox"/> Penis discharge	<p>WOMEN only</p> <input type="checkbox"/> Abnormal pap smear <input type="checkbox"/> Bleeding between periods <input type="checkbox"/> Breast lump <input type="checkbox"/> Extreme menstrual pain <input type="checkbox"/> Hot flashes <input type="checkbox"/> Nipple discharge <input type="checkbox"/> Painful intercourse <input type="checkbox"/> Vaginal discharge <input type="checkbox"/> Other _____	<p>Date of last menstrual period _____ Date of last Pap smear _____ Have you had a Mammogram? _____ Are you pregnant? _____ Number of children _____</p>

CONDITIONS Check conditions you have or have had in the past.

<input type="checkbox"/> AIDS <input type="checkbox"/> Alcoholism <input type="checkbox"/> Anemia <input type="checkbox"/> Anorexia <input type="checkbox"/> Appendicitis <input type="checkbox"/> Arthritis <input type="checkbox"/> Asthma <input type="checkbox"/> Bleeding disorder	<input type="checkbox"/> Breast lump <input type="checkbox"/> Bronchitis <input type="checkbox"/> Bulimia <input type="checkbox"/> Cancer <input type="checkbox"/> Cataracts <input type="checkbox"/> Chemical dependency <input type="checkbox"/> Chicken pox <input type="checkbox"/> Diabetes	<input type="checkbox"/> Emphysema <input type="checkbox"/> Epilepsy <input type="checkbox"/> Glaucoma <input type="checkbox"/> Goiter <input type="checkbox"/> Gonorrhea <input type="checkbox"/> Gout <input type="checkbox"/> Heart Disease <input type="checkbox"/> Hepatitis <input type="checkbox"/> Hernia	<input type="checkbox"/> Herpes <input type="checkbox"/> High cholesterol <input type="checkbox"/> HIV positive <input type="checkbox"/> Kidney disease <input type="checkbox"/> Liver disease <input type="checkbox"/> Measles <input type="checkbox"/> Migraine headaches <input type="checkbox"/> Miscarriage <input type="checkbox"/> Mononucleosis	<input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Mumps <input type="checkbox"/> Pacemaker <input type="checkbox"/> Pneumonia <input type="checkbox"/> Polio <input type="checkbox"/> Prostate Problems <input type="checkbox"/> Psychiatric care <input type="checkbox"/> Pneumonia fever <input type="checkbox"/> Scarlet fever	<input type="checkbox"/> Stroke <input type="checkbox"/> Thyroid problems <input type="checkbox"/> Tonsillitis <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Typhoid fever <input type="checkbox"/> Ulcers <input type="checkbox"/> Vaginal Infections <input type="checkbox"/> Venereal disease
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MEDICATION List medications you are currently taking. ALLERGIES to medications or substances.

Pharmacy Name: _____ Phone Number: _____

FAMILY HISTORY Fill in health information about your family.

Relation	Age	State of Health	Age at Death	Cause of Death	Check ✓ if your blood relative have any of the following:	
					✓ Disease	Relationship
Father					Arthritis, Gout	
Mother					Asthma, Hay Fever	
Brothers					Cancer	
					Chemical Dependency	
					Diabetes	
					Heart Disease, Strokes	
					High Blood Pressure	
Sisters					Kidney Disease	
					Tuberculosis	
					Other	

HOSPITALIZATIONS			PREGNANCY HISTORY		
Year	Hospital	Reason for Hospitalization & Outcome	Year	Sex	Complications

HEALTH HABITS		
Check ✓ which substance you use and describe how much you use		
Have you ever had a blood transfusion: <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, please give approximate dates: _____	Caffeine	
	Tobacco	
	Drugs	
	Other	

SERIOUS ILLNESS/INJURY	DATE	OUTCOME

OCCUPATIONAL CONCERNS	
Check ✓ if your work exposes you to the following:	
	Stress
	Hazardous Substances
	Heavy Lifting
	Other
Your occupation:	

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

_____ Signature	_____ Date
_____ Reviewed by	_____ Date

AUTHORIZATION for USE, DISCLOSURE and/or REQUEST of PROTECTED HEALTH INFORMATION

SECTION A: Psychotherapy Notes. Check if this authorization is for psychotherapy notes.

If this authorization is for psychotherapy notes, you must **not** use it as an authorization for any other type of protected health information. Identify the psychotherapy notes by checking "Other" in Section C and describing in the space provided, do not check any other boxes or types of information.

SECTION B: The Individual (or the Individual's Personal Representative) confirming the authorization.

I authorize the use and/or disclosure of my protected health information as described in Section C below. I understand that this authorization is voluntary.

I understand that, if the persons or organizations I authorize below are not health care providers, they may further disclose the protected health information and it may no longer be protected by federal health information privacy laws.

Patient's Name: _____ Date of Birth _____ Social Security # (last 4 digits only) _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

SECTION C: The use, disclosure and/or request being authorized (minimum necessary).

- Present year only 1 year 2 years **History/Office Notes**
 Present year only 1 year 2 years **Labs**
 Last **Eye Exam** Last **Foot Exam** 2 years **Pap Smears** 2 years **Mammograms** All **Immunization** summaries
 All **Colonoscopy** and **EGD** procedure reports All **Pathology** reports All **Radiologic studies** (*Bone Density, CT/CTA, MRI/MRA, US, Vascular, etc*)
 All **Cardiac Studies** All **Hospital Admissions, H&Ps, Consults, Operative reports, Discharges**
 Other (Please be specific and DO NOT request ALL Records) _____

Entities Authorized to Use or Disclose:

Records requested **FROM:**
Name of provider/organization: _____

Address _____

Phone#: _____ Fax #: _____

Entities Authorized to Use or Disclose:

Records requested **SENT TO:**
Name of provider/organization/person: _____

Address _____

Phone#: _____ Fax #: _____

SECTION D: Preference for Receipt of Records.

- Regular Mail Fax # _____ (Maximum 50 pgs)
 Pick up by: _____ (2-3 day processing minimum) Where: _____
 Retrieve from Website (Personal copies only)
 Electronic Copy (disk)

SECTION E: Purpose of Use, Disclosure and/or Request of Protected Health Information.

- Personal Use ***You will be charged a state regulated fee for a personal copy of your records (\$10 minimum/\$50 maximum)**
 Changing Provider/Continuity of Care Insurance Attorney
 Other _____

SECTION F: Expiration.

This authorization will expire (**complete one**):

- Until I revoke permission in writing 2 years after my death Future Date ____/____/____
 On the occurrence of the following event: _____

Right to Revoke: I understand that I may revoke this authorization at any time by giving written notice of my revocation to the Contact Office listed below. I understand that revocation of this authorization will **not** affect any action you took in reliance on this authorization before you received my written notice of revocation.

Contact Office: Southeastern Healthcare Privacy Officer

Address: 2595 S. 17th Street, Wilmington, NC 28401 **Phone:** 910) 392-1252 **Fax:** (910) 392-1244 **Email:** lisa@sehcn.net

Inability to Condition Treatment: I understand that Southeastern Healthcare may not condition my treatment on my refusal to sign this authorization.

SECTION G: SIGNATURE

SIGNATURE—YOU MAY REFUSE TO SIGN THIS AUTHORIZATION AND THE REQUEST WILL BE CONSIDERED NULL & VOID.
PERSONAL COPIES WILL INCUR A FEE. REFER TO "SECTION E" FOR INFORMATION.

Signature: _____ Date: _____

If this authorization is signed by a personal representative on behalf of the individual, complete the following:

Personal Representative's Name: _____ Relationship to Individual _____

WITNESS: _____ Date: _____

YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER YOU SIGN IT.
Include this authorization in the individual's medical record.

AUTHORIZATION for USE and/or DISCLOSURE of PROTECTED HEALTH INFORMATION

I authorize the use and/or disclosure of my protected health information as described in Section B below. I understand that this authorization is voluntary.

I understand that, if the persons or organizations I authorize below are not health care providers, they may further disclose the protected health information and it may no longer be protected by federal health information privacy laws.

Section A: Patient Information (please print):

Account #: _____ Patient's Name: _____ Social Security # _____

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____ Phone: _____

Section B: Protected Health Information to be Used and/or Disclosed:

Do you wish for us to discuss all your protected health information with your family/friends or do you prefer that only specific information be released?

- All medical information, except psychotherapy information.
- Psychotherapy notes. ***If this authorization is for psychotherapy notes, you must not use it as an authorization for any other type of protected health information.***
- Specific information (*please describe*): _____

Entities Authorized to Use or Disclose: Southeastern Healthcare

Families, Friends, and Other Authorized to receive and use (*please name specifically any family/friends to which we may release your protected health information either in writing or verbally*):

Section C: Purpose of Use or Disclosure of Protected Health Information.

- So family member, friend or caregiver may have knowledge of or assist in my medical care or payment for medical care.
- At the request of the individual
- Other _____

Section D: Expiration.

This authorization will expire (*complete one*):

- Until I revoke permission in writing 2 years after my death Future Date ____/____/____
- On the occurrence of the following event: _____

Right to Revoke: I understand that I may revoke this authorization at any time by giving written notice of my revocation to the Contact Office listed below. I understand that revocation of this authorization will *not* affect any action you took in reliance on this authorization before you received my written notice of revocation.

Contact Office: Southeastern Healthcare Privacy Officer **Address:** 2595 S. 17th Street, Wilmington, NC 28401
Phone: (910) 392-1252 **Fax:** (910) 392-1244 **Email:** Lisa@sehc.net

Inability to Condition Treatment: I understand that Southeastern Healthcare may not condition my treatment on my refusal to sign this authorization.

If you would like for us to leave medical information regarding your care (i.e. lab results) or appointments on an answering machine, please complete the section below.

Southeastern Healthcare may leave a message regarding my medical information on the
answering machine at this number: (____) _____ - _____.

I acknowledge that I have been made aware of Southeastern Healthcare's Notice of Privacy Practices. I have had full opportunity to read and consider the contents of the Southeastern Healthcare Notice of Privacy Practices.

SIGNATURE - YOU MAY REFUSE TO SIGN THIS AUTHORIZATION

Signature: _____ **Date:** _____

If this authorization is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____ Relationship to Patient: _____

NECK INDEX

Patient Name _____ Date _____

This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

- ① I have no pain at the moment.
- ② The pain is very mild at the moment.
- ③ The pain comes and goes and is moderate.
- ④ The pain is fairly severe at the moment.
- ⑤ The pain is very severe at the moment.
- ⑥ The pain is the worst imaginable at the moment.

Sleeping

- ① I have no trouble sleeping
- ② My sleep is slightly disturbed (less than 1 hour sleepless).
- ③ My sleep is mildly disturbed (1-2 hours sleepless).
- ④ My sleep is moderately disturbed (2-3 hours sleepless).
- ⑤ My sleep is greatly disturbed (3-5 hours sleepless).
- ⑥ My sleep is completely disturbed (5-7 hours sleepless).

Reading

- ① I can read as much as I want with no neck pain.
- ② I can read as much as I want with slight neck pain.
- ③ I can read as much as I want with moderate neck pain.
- ④ I cannot read as much as I want because of moderate neck pain.
- ⑤ I can hardly read at all because of severe neck pain.
- ⑥ I cannot read at all because of neck pain.

Concentration

- ① I can concentrate fully when I want with no difficulty.
- ② I can concentrate fully when I want with slight difficulty.
- ③ I have a fair degree of difficulty concentrating when I want.
- ④ I have a lot of difficulty concentrating when I want.
- ⑤ I have a great deal of difficulty concentrating when I want.
- ⑥ I cannot concentrate at all.

Work

- ① I can do as much work as I want.
- ② I can only do my usual work but no more.
- ③ I can only do most of my usual work but no more.
- ④ I cannot do my usual work.
- ⑤ I can hardly do any work at all.
- ⑥ I cannot do any work at all.

Personal Care

- ① I can look after myself normally without causing extra pain.
- ② I can look after myself normally but it causes extra pain.
- ③ It is painful to look after myself and I am slow and careful.
- ④ I need some help but I manage most of my personal care.
- ⑤ I need help every day in most aspects of self care.
- ⑥ I do not get dressed. I wash with difficulty and stay in bed.

Lifting

- ① I can lift heavy weights without extra pain.
- ② I can lift heavy weights but it causes extra pain.
- ③ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
- ④ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
- ⑤ I can only lift very light weights.
- ⑥ I cannot lift or carry anything at all.

Driving

- ① I can drive my car without any neck pain.
- ② I can drive my car as long as I want with slight neck pain.
- ③ I can drive my car as long as I want with moderate neck pain.
- ④ I cannot drive my car as long as I want because of moderate neck pain.
- ⑤ I can hardly drive at all because of severe neck pain.
- ⑥ I cannot drive my car at all because of neck pain.

Recreation

- ① I am able to engage in all my recreation activities without neck pain.
- ② I am able to engage in all my usual recreation activities with some neck pain.
- ③ I am able to engage in most but not all my usual recreation activities because of neck pain.
- ④ I am only able to engage in a few of my usual recreation activities because of neck pain.
- ⑤ I can hardly do any recreation activities because of neck pain.
- ⑥ I cannot do any recreation activities at all.

Headaches

- ① I have no headaches at all.
- ② I have slight headaches which come infrequently.
- ③ I have moderate headaches which come infrequently.
- ④ I have moderate headaches which come frequently.
- ⑤ I have severe headaches which come frequently.
- ⑥ I have headaches almost all the time.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Neck
Index
Score

Patient's Comments _____

Patient's Signature

Date

Doctor's Comments _____

Doctor's Signature

Date

BACK INDEX

Patient Name _____ Date _____

This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

- ① The pain comes and goes and is very mild.
- ② The pain is mild and does not vary much.
- ③ The pain comes and goes and is moderate.
- ④ The pain is moderate and does not vary much.
- ⑤ The pain comes and goes and is very severe.
- ⑥ The pain is very severe and does not vary much.

Sleeping

- ① I get no pain in bed.
- ② I get pain in bed but it does not prevent me from sleeping well.
- ③ Because of pain my normal sleep is reduced by less than 25%.
- ④ Because of pain my normal sleep is reduced by less than 50%.
- ⑤ Because of pain my normal sleep is reduced by less than 75%.
- ⑥ Pain prevents me from sleeping at all.

Sitting

- ① I can sit in any chair as long as I like.
- ② I can only sit in my favorite chair as long as I like.
- ③ Pain prevents me from sitting more than 1 hour.
- ④ Pain prevents me from sitting more than 1/2 hour.
- ⑤ Pain prevents me from sitting more than 10 minutes.
- ⑥ I avoid sitting because it increases pain immediately.

Standing

- ① I can stand as long as I want without pain.
- ② I have some pain while standing but it does not increase with time.
- ③ I cannot stand for longer than 1 hour without increasing pain.
- ④ I cannot stand for longer than 1/2 hour without increasing pain.
- ⑤ I cannot stand for longer than 10 minutes without increasing pain.
- ⑥ I avoid standing because it increases pain immediately.

Walking

- ① I have no pain while walking.
- ② I have some pain while walking but it doesn't increase with distance.
- ③ I cannot walk more than 1 mile without increasing pain.
- ④ I cannot walk more than 1/2 mile without increasing pain.
- ⑤ I cannot walk more than 1/4 mile without increasing pain.
- ⑥ I cannot walk at all without increasing pain.

Personal Care

- ① I do not have to change my way of washing or dressing in order to avoid pain.
- ② I do not normally change my way of washing or dressing even though it causes some pain.
- ③ Washing and dressing increases the pain but I manage not to change my way of doing it.
- ④ Washing and dressing increases the pain and I find it necessary to change any way of doing it.
- ⑤ Because of the pain I am unable to do some washing and dressing without help.
- ⑥ Because of the pain I am unable to do any washing and dressing without help.

Lifting

- ① I can lift heavy weights without extra pain.
- ② I can lift heavy weights but it causes extra pain.
- ③ Pain prevents me from lifting heavy weights off the floor.
- ④ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
- ⑤ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
- ⑥ I can only lift very light weights.

Traveling

- ① I get no pain while traveling.
- ② I get some pain while traveling but none of my usual forms of travel make it worse.
- ③ I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
- ④ I get extra pain while traveling which causes me to seek alternate forms of travel.
- ⑤ Pain restricts all forms of travel except that done while lying down.
- ⑥ Pain restricts all forms of travel.

Social Life

- ① My social life is normal and gives me no extra pain.
- ② My social life is normal but increases the degree of pain.
- ③ Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc.).
- ④ Pain has restricted my social life and I do not go out very often.
- ⑤ Pain has restricted my social life to my home.
- ⑥ I have hardly any social life because of the pain.

Changing degree of pain

- ① My pain is rapidly getting better.
- ② My pain fluctuates but overall is definitely getting better.
- ③ My pain seems to be getting better but improvement is slow.
- ④ My pain is neither getting better or worse.
- ⑤ My pain is gradually worsening.
- ⑥ My pain is rapidly worsening.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Back
Index
Score

Patient's Comments _____

Patient's Signature

Date

Doctor's Comments _____

Doctor's Signature

Date