REDDING SPINE & SPORTS MEDICINE

Name: _____

DOB: _____

Today's Date: _____

What symptoms are you having?

□ Pain Where? _____
Does it Radiate? □ Yes – Where to? _____
□ No

□ Numbness / Tingling Where? _____ for how long? _____

□ Weakness Where? _____ for how long? _____

How did these symptoms begin? _____
_____

Do you have any of the following medical conditions/treatments?

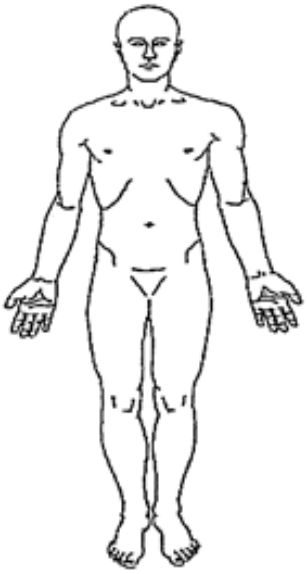
□ Diabetes
□ Hypothyroidism
□ Hyperthyroidism
□ Kidney disease
□ Current or previous alcoholism or heavy alcohol use
□ Current or previous exposure to industrial toxins
□ HIV / AIDS
□ Recent severe illness requiring hospitalization
□ Gastric Bypass
□ Cancer
□ Chemotherapy
□ Radiation Therapy

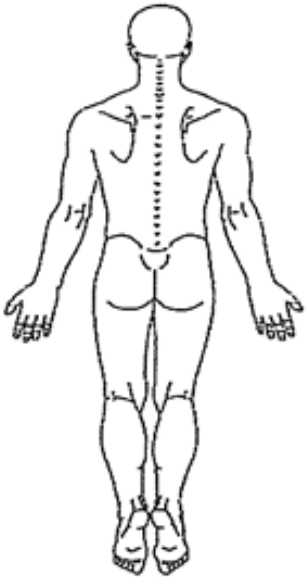
Please list any other medical problems:

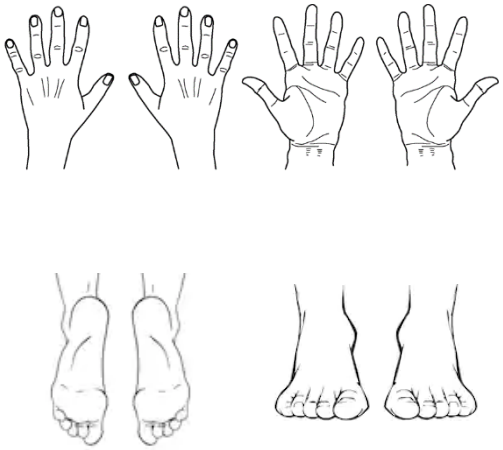
_____ _____
_____ _____
_____ _____
_____ _____

Please label the below diagrams with your symptoms:

Pain	Numbness	Tingling	Weakness
PPP	NNN	TTT	WWW







REDDING SPINE & SPORTS MEDICINE

DATE: _____ PRIMARY LANGUAGE SPOKEN: _____

PATIENT NAME: _____ Nick Name: _____

(Last) (First) (Middle)

CHECK ONE: SEX: M_____ F_____

CHECK ONE: MARRIED_____ SINGLE_____ WIDOWED_____ DIVORCED_____

RACE: _____

DATE OF BIRTH: _____ SOCIAL SECURITY: _____

PATIENT'S LOCAL ADDRESS: _____

(Street) (City) (Zip)

PERMANENT ADDRESS (IF DIFFERENT):

_____

HOME TELEPHONE #: (_____) _____ CELL #: (_____) _____

EMAIL: _____

EMPLOYED BY: _____ OCCUPATION: _____

WORK # (_____) _____

Work ADDRESS: _____

EMERGENCY CONTACT: _____ RELATIONSHIP: _____

PHONE #: (_____) _____

PRIMARY PHARMACY: _____ PHONE #: (_____) _____

LOCATION: _____

PRIMARY CARE PHYSICIAN: _____

CHECK ONE: ILLNESS/INJURY RELATED TO: WORK ____ AUTO ____ OTHER ____

DATE OF INCIDENT: _____

****Failure to disclose all insurance information could result in patient being responsible for balance****

REDDING SPINE & SPORTS MEDICINE

Redding Spine & Sports Medicine
Financial & Office Policies

Authorization for Medical Release of Information:
A form is attached in which you may allow family members and friends access to your medical information. Please fill this out if you would like anyone to have access to your information or participate in your care.

Consent for Medical Treatment:
I hereby authorize Redding Spine and Sports Medicine and all persons acting as agents thereof, as well as all medical personnel to whom I am referred, to furnish all forms of reasonable diagnostic, preventive, therapeutic and medical treatment to me.

_____
Signature

Missed Appointments:
Our office will try to do reminder calls as a courtesy but patients are ultimately responsible for keeping an appointment. 24 hours notice is required to reschedule or cancel a scheduled appointment. Our office receives referrals for many more patients than we are able to accommodate and we keep a waiting list of patients who are trying to be seen sooner. Please be advised that it is our office policy to no longer see patients who repeatedly miss scheduled appointments. A missed appointment fee of $50 may be applied (if allowed by your insurance carrier) if an appointment is missed after one warning is given. We understand unusual circumstances may arise. In order for our physicians to see patients in a timely manner your help in arriving promptly for your appointment is required. If you are late, our office may reschedule your appointment to a new date and time. We understand your time is valuable and will do our best to see you in a timely manner. Please be aware that sometimes certain situations and emergencies can occur and cause your provider to run late. Please be patient in these circumstances.

_____
(Initials)

Payment and Insurance Policy:
Payment is expected at time of service. Your co-pay, coinsurance, and/or deductible is due upon arrival for your visit. For your convenience we accept checks, cash, Visa, MasterCard or American Express as forms of payment. You will be responsible for payment of any remaining balances after insurance is billed. We will require a scan of your insurance card and we will bill your insurance company for you. For those plans that are not contracted with our office we will submit claims to your carrier as a courtesy. Any deductible, coinsurance or non-covered services will be your responsibility. Monthly statements will be sent to collect those balances. Please inform our staff immediately of any insurance, address or phone number changes.

_____
(Initials

REDDING SPINE & SPORTS MEDICINE

Non-Covered Service Policy:
Certain services performed by our office are NOT COVERED by all insurance plans. We suggest you contact your insurance carrier to verify your benefits and understand when any non-covered services will be your financial responsibility as payment will be required prior to your appointment. Our office will try to notify you of a non-covered service if we are aware. Medicare requires a signature on an Advanced Beneficiary Notice [ABN] for non-covered services.

_____
(Initials)

Delinquent Accounts Policy:
Delinquent accounts may be reported to our collection agency following normal collection procedures. If an account is reported to our collection agency a collection fee of 25% will be added to any outstanding balance. If a balance is over 61 days late, a 1.5% monthly interest fee will be added to the outstanding balance. Please inform our billing staff if you know your payment will be late in arriving or if payment arrangements are needed. Our office charges a $25.00 fee for all accounts closed, stop payments or checks returned for non-sufficient funds.

_____
(Initials)

Medical Records/Forms:
Should you request a copy of your medical records, please allow our office 7-10 business days for completion. There may be a fee for obtaining them, depending on the volume of medical records requested. The fee for medical records is .25 per page for anything beyond 10 pages. Should you request our office to complete forms on your behalf for disability, work status, jury duty, FMLA, etc., there will be a charge of $25.00 per form. Payment of this charge is expected at time of completion.

_____
(Initials)

Referrals & Authorizations:
If a referral is required by your insurance carrier you will be asked to obtain the referral prior to your appointment. If no referral exists on file or your referral has not been received, your appointment may be cancelled. Our office will obtain authorization for your procedure prior to scheduling your appointment. We suggest you contact your insurance carrier to verify your coverage, benefits and preauthorization requirements prior to having any procedures performed. Claims are paid based on medical necessity. Please be aware authorizations and referrals are not a guarantee of payment.

_____
(Initials)

Worker's Compensation:
Our office will require you to inform us of any changes regarding your workers compensation claim. The following information is required: Adjustors Name, claim status, (litigation, supportive care, claim closed, new injury), DOI, carrier, claim number and claims address. Please have this information available prior to your appointment time.

_____
(Initials)

REDDING SPINE & SPORTS MEDICINE

Please sign below to verify that you have reviewed and will follow the above office policies:

_____
(Patient/Guarantor Printed Name)

_____ Date_____
(Patient/Guarantor Signature)

Acknowledgment of Receipt of Privacy Notice
I acknowledge that I have been offered and/or received a copy of the office's Notice of the Privacy Practices.

- This handout will be available at the time of your office visit if you have received your paperwork by mail or online.

Patient or legally authorized individual signature Date

Printed Name if signed on behalf of the patient Date
Relationship to patient

REDDING SPINE & SPORTS MEDICINE

Personal Representative Authorization For Medical Release Form

I authorize this facility to speak to the following family members or my personal representative regarding:

- ☐ All medical information, including but not limited to records pertaining to examinations, treatments, consultations, billing records, radiological studies and reports, history, physical findings, laboratory findings, admissions and discharge reports, diagnosis, prognosis and records, nursing and physicians notes and any other non-medical information in my file.

- ☐ Only the following types of information:

_____

_____

_____

The above medical information may only be released to the following persons:

Family member/representative name	Relationship
_____	_____
_____	_____
_____	_____

I understand that I may terminate this medical authorization form. I must notify this facility in writing regarding termination and effective date.

This authorization to remain valid (check one)

- ☐ Until revoked in writing
- ☐ Until _____, 20____

I know that I am entitled to receive a copy of this agreement

Name_____

Signature_____

Signed this _____ day of _____, 20_____