

PHENIX CITY SPINE & JOINT CENTER, LLC :3700 SOUTH RAILROAD STREET, SUITE B PHENIX CITY, AL 36867 : 877-495-7773
SOUTH ATLANTA SPINE & JOINT CENTER, LLC: 541 FOREST PARKWAY, FOREST PARK GA 30297:

STEPHEN B. COOPER, D.C.: LICENSED IN ALABAMA AND GEORGIA. MUA CERTIFIED. PALMER GRADUATE
SEAN LAURAITIS, D.C.: LICENSED IN ALABAMA. LIFE GRADUATE
JAMES WADDELL, DC : LICENSED IN GEORGIA, LIFE GRADUATE



DATE: _____

NAME: _____

ADDRESS: _____

CITY: _____ **STATE :** _____ **ZIP:** _____

CELL#: _____ **HOME #:** _____

CELL PHONE CARRIER: _____ **RACE:** _____ **ETHNICITY :** _____ **HISPANIC** _____ **NON-HISPANIC**

DOB: _____ **AGE:** _____ **SSN:** _____

EMPLOYER : _____ **OCCUPATION:** _____ **WK_PHONE:** _____

EMAIL (USED FOR PATIENT RECORDS AND OFFICE COMMUNICATION) _____

MARITAL STATUS: M S D W _____ **SPOUSE NAME:** _____

INSURANCE INFORMATION : PLEASE GIVE COPY OF ALL INSURANCE CARDS AND DRIVERS LICENSE/ID TO FRONT DESK

NAME OF HEALTH INSURER: _____ **PRIMARY CARE PROVIDER:** _____ **NONE**

POLICY #: _____ **GROUP#:** _____ **PHONE#:** _____

IF INSURANCE IN ANOTHER'S NAME: _____

DOB: _____ **SSN:** _____

IF MINOR, GUARDIAN NAME: _____ **DOB:** _____ **SSN:** _____

HOW DID YOU HEAR ABOUT THIS OFFICE: _____

PHENIX CITY SPINE & JOINT CENTER, LLC :3700 SOUTH RAILROAD STREET, SUITE B PHENIX CITY, AL 36867 : 877.495.7773

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| Name of Medication | Dosage/Strength | Frequency | Date started/stopped | Known Allergies |
|--------------------|-----------------|-----------|----------------------|-----------------|
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EMERGENCY CONTACT INFORMATION

NAME: _____ RELATIONSHIP _____
PHONE: _____ RELATIONSHIP _____
NAME: _____ RELATIONSHIP _____
PHONE: _____ RELATIONSHIP _____
INITIAL HERE IF YOU WANT THEM TO HAVE ACCESS TO INFORMATION ABOUT YOUR PRESENCE IN THE CLINIC

I, _____ (Print Name), do hereby authorize Dr. Stephen B. Cooper, Dr. Lynne Lofton and Dr. Sean Lauraitis and whomever he may designate as his assistants to perform diagnostic tests, including but not limited to radiographs, physical examination and administer treatment as directed, indicated or deemed necessary. This includes emergency actions that may need to be performed should I be physically incapacitated. Complications to chiropractic care may include rib fracture and stroke, however, specific tests designed to minimize these risks are employed and do minimize these outcomes. I ALSO CERTIFY THAT IN NO WAY HAS ANY GUARANTEE OR ASSURANCES AS TO THE RESULTS THAT MAY BE OBTAINED. I understand and agree that health and medical insurance policies are an arrangement between an insurance carrier and myself (patient). Furthermore, I understand and agree that this office and contracted representatives may prepare or receive any necessary reports and forms to assist me in making collection from the insurance company, and that any amount authorized to be paid and sent directly to this office will be credited to my account upon receipt. I permit this office to endorse remittances for the conveyance of credit to my account. However, I clearly understand and agree that I have sought treatment, received treatment, and am directly responsible for the bills that accumulate from this treatment.

NAME (PRINTED): _____ SIGNED: _____ DATE: _____

WITNESS (PRINTED): _____ SIGNED: _____ DATE: _____

Consent for Treatment of a Minor

I hereby authorize the Phenix City Spine & Joint Center, LLC, Dr. Stephen B. Cooper, Dr. Lynne Lofton and Dr. Sean Lauraitis and whomever they may designate as an associate or contractor of this clinic to perform diagnostic tests, radiographic studies, physical evaluations, and to administer treatment as he deems necessary to, a minor child under my guardianship. I also accept all terms and conditions named herein with regards to payment of the account and lien arrangements and am responsible for the execution of these agreements on this minors behalf.

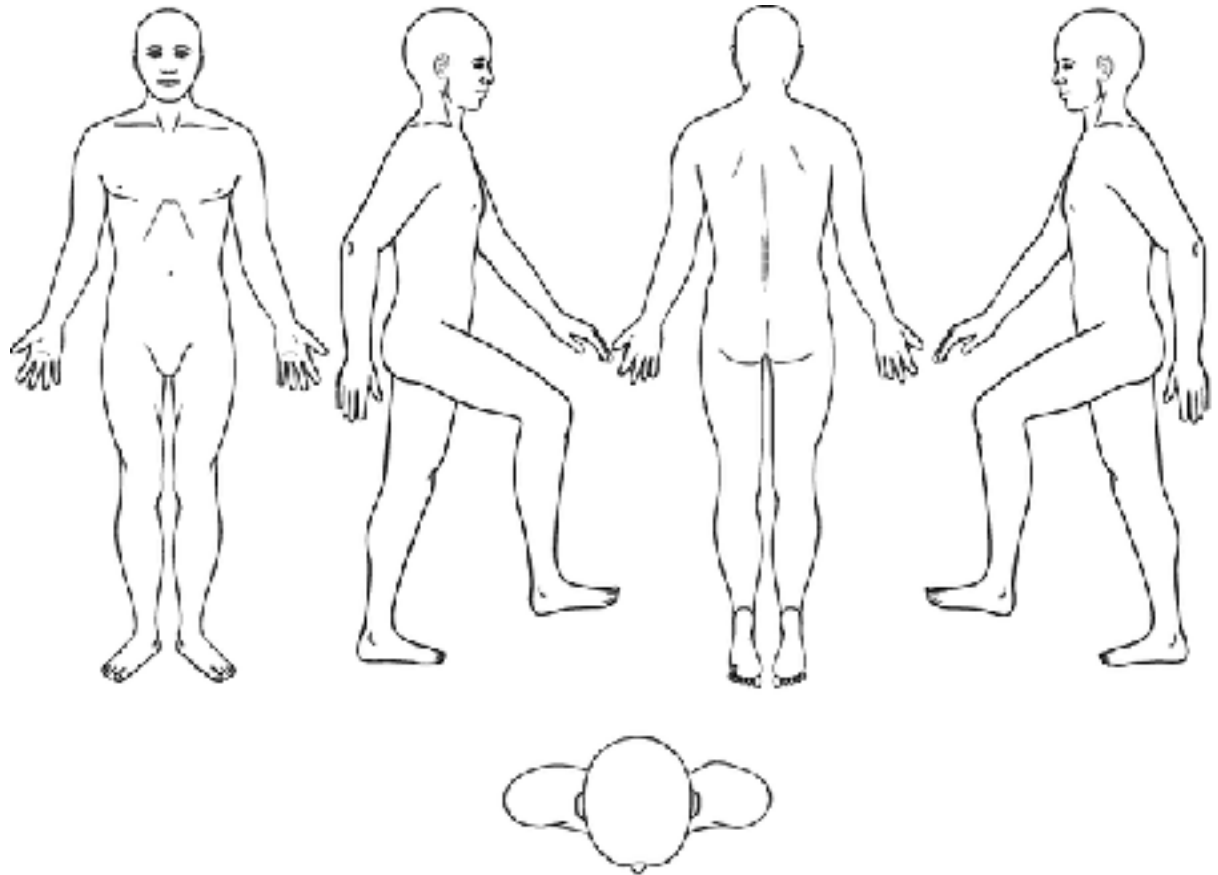
GUARDIAN PRINTED NAME: _____ SIGNED _____ DATE: _____

WITNESS PRINTED NAME: _____ SIGNED _____ DATE: _____

**IT HELPS US TO HELP YOU IF YOU CAN BE VERY THOROUGH AND COMPLETE,
FEEL FREE TO ASK FOR HELP, CIRCLE ALL OF THE FOLLOWING THAT APPLY**

**PLEASE MARK EVERY AREA USING
THE KEY BELOW. YOU CAN USE AR-
ROWS TO SHOW SHOOTING PAIN
AND NUMBERING 1 THROUGH 6 TO
SHOW THE MOST SIGNIFICANT AR-
EAS**

**B = BURNING
S = SHOOTING
X = PAIN
V = SEVERE PAIN
D = DULL PAIN
N = NUMBNESS
W = WEAKNESS**



PLEASE DETAIL ANY OTHER FACTS ABOUT YOUR HEALTH WE DON'T KNOW:

PAST HEALTH HISTORY: IF YES LIST IN ADJACENT BOX

HAVE YOU BEEN INVOLVED IN AN AUTO ACCIDENT PRIOR TO THIS ONE Y N

ARE YOU PREGNANT Y N

HAVE YOU HAD PREVIOUS HOSPITALIZATIONS Y N

HAVE YOU HAD ANY PRIOR SURGERIES Y N

HOSPITALIZATIONS/SURGERIES PREVIOUS ACCIDENTS AND OTHER MEDICAL HISTORY:

| REVIEW OF SYSTEMS | | | | | | | | |
|-------------------------|------------------|-------------------------|-------------------------------|----------------------|---------------------------------------|----------------------------|--------------------------|--------------------------------------|
| CONSTITUTIONAL | ALCOHOLISM | DIZZINESS | CHEMICAL DEPENDENCY | HISTORY OF DIABETES | FEVER / NIGHT SWEATS | HISTORY OF CHRONIC FATIGUE | NUTRITION PROBLEMS | UNEXPLAINED WEIGHT CHANGE |
| EENT | CATARACT | GLAUCOMA | COLOR BLINDNESS | MOTION SICKNESS | NIGHT BLINDNESS | BLURRY VISION | EPISTAXIS / NOSE BLEEDS | SEVERE SINUS |
| RESPIRATORY | ASTHMA | BRONCHITIS | EMPHYSEMA | INFLUENZA | PLEURISY | PNEUMONIA | TUBERCULOSIS | |
| CARDIOVASCULAR | HEART ATTACK | HEART DISEASE | HEART MURMURS | HIGH CHOLESTEROL | HBP | IRREGULAR HEART BEAT | CHEST PAIN / DISCOMFORT | SHORTNESS OF BREATH |
| GENITOURINARY | BLADDER PROBLEMS | CYSTITIS | GALL BLADDER DISEASE | KIDNEY DISEASE | KIDNEY STONES | NEPHRITIS | PROSTATE PROBLEMS | VAGINAL INFECTIONS, VENEREAL DISEASE |
| MUSCULO SKELETAL | ARTHRITIS | GOUT | OSTEOPOROSIS | JOINT DEFORMITY | BONE & JOINT DISEASE | MULTIPLE SCLEROSIS | HERNIATED DISC | POSTURAL PROBLEMS - SCOLIOSIS |
| NEUROLOGICAL | FACIAL WEAKNESS | EQUILIBRIUM DISTURBANCE | DYSPHAGIA - DIFFICULTY EATING | HEARING DISTURBANCES | SPEECH - SWALLOWING OR TASTE PROBLEMS | EPILEPSY | BLACKOUTS OR MEMORY LOSS | VERTIGO |
| HEMATOLOGIC / LYMPHATIC | ANEMIA | HEPATITIS | HIV | LYMPHATIC MALIGNANCY | BLEEDING SKIN | SWOLLEN LYMPH NODES | SICKLE CELL | HISTORY OF MUMPS |
| INTEGUMENT | BRUISING | COLOR CHANGE | DRY SKIN | EDEMA / SWELLING | ITCHING | LESIONS | RASH | SKIN CANCER |

ASSIGNMENT OF BENEFITS: I HEREBY AUTHORIZE THE FOLLOWING INSURANCE COMPANIES OR LIABLE DIRECT PAY PARTIES:

1. _____
2. _____
3. _____
4. _____

to pay by check or credit card through either mailing the check payable to Phenix City Spine & Joint Center—P.O. Box 1611 Phenix City, AL 36867. or Forest Park Spine & Joint Center — P.O. Box 1601 Phenix City AL, 36867 This covers the expense benefits allowable and otherwise payable to me under my current policy, as payment towards the total charges for professional services rendered I have agreed to pay, in a current manner, any balance of said applicable charges. I further state and agree that this office is given a limited power of attorney to endorse / sign my name on any and all drafts directed for the payment of my bill.

PATIENT PRINTED NAME: _____ SIGNED _____ DATE: _____

WITNESS PRINTED NAME: _____ SIGNED _____ DATE: _____

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THIS IS A FORMAL REQUEST FOR MEDICAL RECORDS, X-RAY'S, MRI'S, LAB TESTS AND REPORTS BE SENT TO

___ PHENIX CITY SPINE AND JOINT CENTER TO THE ABOVE ADDRESS OR FAXED TO: 866.537.1711

___ FOREST PARK SPINE AND JOINT CENTER TO THE ABOVE ADDRESS OR FAXED TO: 877.292.4848

REGARDING THE PATIENT: _____

SOCIAL SECURITY NUMBER _____ BIRTH DATE _____

PLEASE SEND RECORDS BY THIS DATE: _____

PATIENTS SIGNATURE FOR RELEASE:

PATIENT'S SIGNATURE

TODAY'S DATE
(REQUEST EXPIRES 30 DAYS FROM THIS DATE)

IF YOU HAVE ANY QUESTIONS, PLEASE CALL US. WE APPRECIATE YOUR PROMPTNESS FOR THIS REQUEST.

THANK YOU, THE SPINE & JOINT CENTERS OF PHENIX CITY AND FOREST PARK

HIPAA PRIVACY Statement for the PHENIX CITY SPINE & JOINT CENTER

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

Understanding your health record information

Each time you visit a hospital, physician or other health care provider, a record of your visit is made. Typically this record contains your symptoms, examination, test results, diagnosis, treatment and a plan for future care and treatment. This information is often referred to as your health and medical record and serves as, but not limited to the following:

- ◇ A basis for planning your care and treatment
- ◇ Means of communication along the many health professionals who contribute to your care
- ◇ Legal documentation describing the care you received
- ◇ Means by which your third party payer can verify that services billed were actually provided
- ◇ A tool in educating health care providers
- ◇ A source of data for medical research
- ◇ A tool we utilize to assess, analyze and improve the care we render and the outcomes we have achieved.

This Information is shared with you to help you:

- ◇ Ensure its accuracy
- ◇ Understand who and under what circumstances they may access your health information
- ◇ Make a more informed decision when signing disclosure statements to authorize access by others.

Your Health Information Rights

Although your health record is the physical property of the health care provider or the facility who compiled it, the information belongs to you. You have the right to:

- ◇ Request a restriction on certain uses and disclosures of your information as provided by CFR 164.522
- ◇ Obtain a paper copy of notice of information practices upon request
- ◇ Inspect and copy your health record as provided in 45 CFR 164.524

- ◇ Obtain an account of the disclosures of your health record
- ◇ Revoke authorization for future disclosure except that which has already been provided

Our Responsibilities:

- ◇ Maintain privacy of your health information
- ◇ Provide you with notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- ◇ Abide by all the terms of this notice
- ◇ Notify you if we are unable to agree to a requested restriction
- ◇ Accommodate reasonable requests you may have to communicate health information by alternative means to alternative locations

We reserve the right to change our practices and make new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you have supplied to us.

We will not use or disclose your health information without your authorization, except as described in this notice.

For more information, questions, or to report a problem, you may contact our HIPAA Privacy Officer at (412) 446-9100. If you believe your privacy rights have been violated, you may file a complaint with our HIPAA Privacy Officer. There will be no retaliation for filing a complaint.

I have read the HIPAA PRIVACY STATEMENT and Understand: _

Initial (HIPAA stands for the "health insurance portability and accountability act")