PHENIX CITY JOINT & REHAB, LLC :3700 SOUTH RAILROAD STREET, SUITE D PHENIX CITY, AL 36867 : 334.298.7700 WWW.PCSPINE.COM
CMG1 DBA South Atlanta Joint & Rehab: 547 Forest Parkway, Suite 14 Forest Park GA 30297,

RICHARD CUNNINGHAM, DO : MEDICAL DIRECTOR
SHELBY SMITH, F-NP
DEVEANE ATKINSON, F-NP

South Atlanta PHENIX CITY Joint & Rehab CENTER

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: _____

Name of Medication	Dosage/Strength	Frequency	Date started/stopped

Known Allergies	

EMERGENCY CONTACT INFORMATION

NAME: _____RELATIONSHIP_____
PHONE: _____RELATIONSHIP_____-
NAME: _____RELATIONSHIP_____-
PHONE: _____RELATIONSHIP_____
INITIAL HERE IF YOU WANT THEM TO HAVE ACCESS TO IN-FORMATION ABOUT YOUR PRESENCE IN THE CLINIC

I,_____(Print Name), do hereby authorize Dr. Richard Cunningham 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. 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 any insurance company, and that any amount billed is assigned and authorized to be paid and sent directly to this office will be credited to my account upon re-ceipt. 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 Joint & Rehab, LLC, Dr. Richard Cunningham 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.

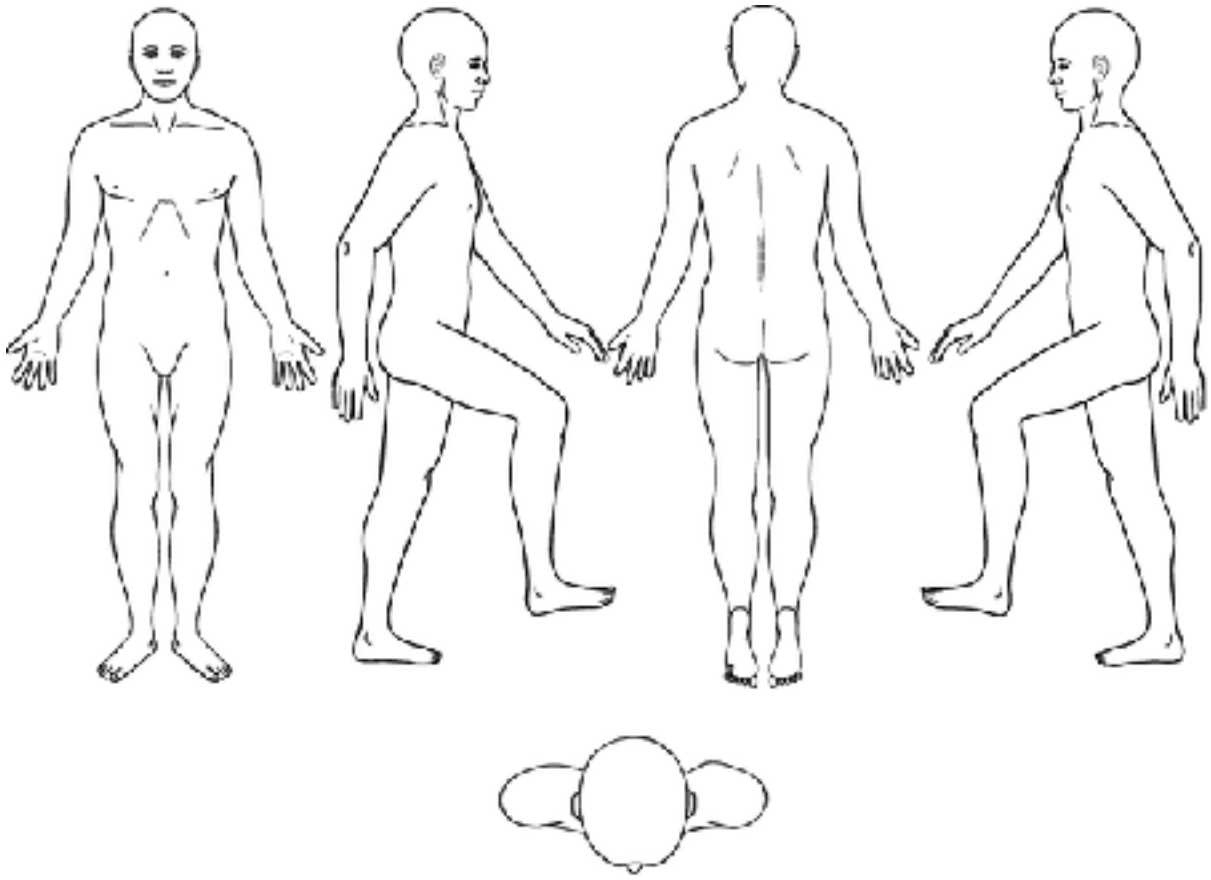
GUARDIAN PRINTED NAME: _____ **SIGNED** _____ **DATE:**_____

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 ARROWS TO SHOW SHOOTING PAIN AND NUMBERING 1 THROUGH 6 TO SHOW THE MOST SIGNIFICANT AREAS

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

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 South Atlanta 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. This Assigns all financial benefits of treatment billed from listed companies and any other insurance company determined to be liable after care is issued. Theses companies may be added after original signature as the claim number, responsible party or insurance carrier may change or not be known at time of care.

PATIENT PRINTED NAME: _____ **SIGNED** _____ **DATE:**_____

WITNESS PRINTED NAME: _____ **SIGNED** _____ **DATE:**_____

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RICHARD CUNNINGHAM, DO- MEDICAL DIRECTOR
SHELBY SMITH, F-NP
DEVEANE ATKINSON, F-NP

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

PHENIX CITY OR SOUTH ATLANTA JOINT & REHAB CENTER TO THE ABOVE ADDRESS OR FAXED TO: 866.537.1711

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 JOINT & REHAB CENTER of PHENIX CITY AND SOUTH ATLANTA!

HIPAA PRIVACY Statement for the Phenix City Joint & Rehab

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 ofyour 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 actual- ly provided
- ◊ A tool in educating health care providers
- ◊ A source of date for medical research
- ◊ A tool we utilize to assess, analyze and improve the care we render and the out- comes 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 infor- mation
- ◊ Make a more informed decision when signing disclosure statements to autho- rize 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 infor- mation 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 de- scribed 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”)