VRC | VESTAVIA SPINE & REHABILITATION CENTER

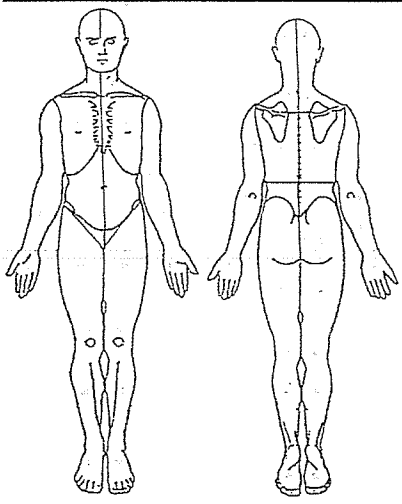
Full Legal Name: _____ Today's Date: _____
Occupation: _____ Male: ____ Female: ____
Address: _____ City: _____
State: _____ Zip: _____ Email (write legibly): _____
Phone (Primary): _____ Phone (Home): _____
Date of Birth: _____ Age: _____ Social Security #: _____

PLEASE FILL OUT INSURANCE INFORMATION BELOW EVEN IF YOUR CARDS WERE TURNED IN

Primary Insurance: _____ Contract #: _____
Insured Name: _____ If not you, *Insured* Date of Birth: _____
Secondary Insurance: _____ Contract #: _____
Primary Care Physician (Address & Phone if known): _____

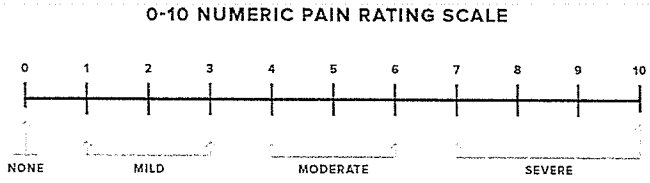
PATIENT QUESTIONAIRE:

Reason for seeking care? _____
Who might we ask referred you to us? _____
When was your X-Ray or MRI? _____
If pain is present, how long has it been occurring? _____
If pain is present, what alleviates the pain? _____
If pain is present, what worsens the pain? _____
Height? _____feet _____inches Weight? _____pounds
Do you smoke? Y/N _____
Alcohol? Y/N _____ Daily? _____ Weekly? _____ Social Occasions? _____
Caffeinated drinks per day? _____



PLEASE MARK WHERE YOU FEEL PAIN ON THE FIGURE/S TO THE ← LEFT

PLEASE CIRCLE THE DEGREE OF PAIN YOU CURRENTLY HAVE BELOW WHERE "0" IS NO PAIN AND "10" IS WORST PAIN:



Social History Information Sheet

Name _____ Today's Date _____

DOB _____ Height ____ ft ____ in Weight _____

Reason for Today's Exam _____

Past Medical History: Please check any illnesses/conditions which YOU have had.

☐High Blood Pressure	☐DVT	☐Lung Disease	☐Stroke
☐High Cholesterol	☐Pulmonary Embolus	☐Asthma	☐Diabetes
☐Vein Trouble	☐Tuberculosis	☐Heart Trouble	☐Pneumonia
☐Kidney Disease	☐Nervous Disorder	☐Seasonal Allergies	☐HIV
☐Thyroid Problems	☐Sinus	☐Arthritis	☐Hepatitis
☐Drug Abuse/Alcoholism	☐Tonsillitis	☐Gastrointestinal	☐Osteoporosis
☐Joint Replacement	☐Bleeding Disorder	☐Cancer: If yes, what type _____	

Other: _____

Surgical History and or Surgical Complications: _____

_____

Family Medical History: Please check any illnesses/conditions immediate FAMILY has had.

☐High Blood Pressure	☐DVT	☐Lung Disease	☐Stroke
☐High Cholesterol	☐Pulmonary Embolus	☐Asthma	☐Diabetes
☐Vein Trouble	☐Tuberculosis	☐Heart Trouble	☐Pneumonia
☐Kidney Disease	☐Nervous Disorder	☐Seasonal Allergies	☐HIV
☐Thyroid Problems	☐Sinus	☐Arthritis	☐Hepatitis
☐Drug Abuse/Alcoholism	☐Tonsillitis	☐Gastrointestinal	☐Osteoporosis
☐Joint Replacement	☐Bleeding Disorder	☐Cancer: If yes, what type _____	

Other: _____

Social History

Occupation _____ Marital Status _____ Children: Yes ___ No ___

Tobacco Use ☐Never ☐In the Past ☐Presently How Much _____ How Long _____

Alcohol Use ☐Daily ☐Occasional ☐None Other substance use or abuse ☐Yes ☐No

System Review: Please describe any active problem or symptom

General Symptoms (i.e. fever, weight gain/loss, fatigue) _____

Eyes/Ears/Nose/Throat _____ Heart _____

Lung _____ Allergies/Rashes _____ Nerves _____

Muscles/Bones/Joints _____ Bleeding/Lymph Nodes _____

Psychiatric _____ Abdomen _____ Skin and/or Breasts _____

OB/Genital/Urinary _____ Endocrine (diabetes/thyroid) _____

Allergic to Latex ☐Yes ☐No Allergic to Medications ☐Yes ☐No

Please list _____

Current Medications _____

_____

Medical Information Release Form (HIPAA Release Form)

Name: _____ Date of Birth: ____/____/____

Release of Information

I authorize the release of information including the diagnosis, records, examination results, medication dose changes, and claims information.
This information may be released to:

☐ - Spouse _____

☐ - Child(ren) _____

☐ - Other _____

☐ - Information is not to be released to anyone other than me.

Messages

Please call ☐ my home phone is _____ ☐ my cell phone is _____

If unable to reach me:

☐ - You may leave a detailed message

OR

☐ - Please leave a message asking me to return your call

☐ - Do not leave messages on my phone mailbox.

The best time to reach me is (day of week)_____ between (time)_____

E-mail Messages

☐ - Use my e-mail address to send messages for me to contact the nurse for information OR
☐ - Use my e-mail to leave detailed messages and information.

☐ Attach lab results to the e-mail message.

My e-mail address is _____

This Release of Information will remain in effect until terminated by me in writing.
This release ***specifically excludes*** any psychiatry and psychology evaluations/records which are further restricted by HIPAA regulations.

Patient Signature: _____ Date: ____/____/____

Witness Signature:_____ Date: ____/____/____

INFORMED CONSENT

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risk associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care

We may conduct some diagnostic or examination procedures, if indicated. Any examinations or tests conducted will be carefully performed, but may be uncomfortable

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including, but not limited to, hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an arterial dissection that involves an abnormal change in the wall of an artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. This occurs in 1 of every 1, 000, 000 people, whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately, a percentage of these patients will experience a stroke. As chiropractic can involve manually and/or mechanically adjusting the cervical spine, it has been reported that chiropractic care may be a risk of developing this type of stroke. The association with stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinion about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office

Patient/ Guardian

Date

Vestavia Spine & Rehabilitation Center

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION: By signing, I authorize Vestavia Spine & Rehabilitation Center to use and/or disclose certain protected health information (PHI) about me to any participating hospitals or clinics that I want my records sent to. This authorization permits Vestavia Spine & Rehabilitation Center to use and/or disclose the following individually identifiable health information about me. Things include: patient demographics, MRI or X-Ray reports, doctor's notes, prescriptions or medical history. The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information. This authorization will expire on June 1, 2027. The practice will not receive payment or other remuneration from a third party in exchange for using or disclosing the PHI. I do not have to sign this authorization in order to receive treatment from Vestavia Spine & Rehabilitation Center. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the privacy officer at Vestavia Spine & Rehabilitation Center. I acknowledge my Notice of Privacy Practices.

CONSENT FOR TREATMENT & AUTHORIZATION: I do hereby consent for treatment at Vestavia Spine & Rehabilitation Center (VSRC), and I authorize VSRC to release medical and supporting documentation of the same as compiled in my medical record during this treatment or subsequent treatments for purposes as to benefit payment. I further authorize my insurance benefits to be paid directly by VSRC when indicated on a claim. I understand I am financially responsible for the charges for services rendered. All cancellations must be received 24 hours in advance of your scheduled appointment or may be subject to a cancellation fee. All accounts over 60 days past due are subject to an interest charge of 1.5% per month of the unpaid balance. All accounts over 90 days past due are subject to be turned over to collections.

Scheduling for Physical Therapy Guidelines: If late for a scheduled appointment, 20 minutes or greater, the appointment will be canceled and the patient will have to reschedule the appointment. Patient understands that if patient misses 3 consecutive scheduled visits in a row or if patient misses 2 consecutive scheduled weeks of physical therapy, without the physical therapist's consent, patient may be automatically discharged from physical therapy.

Signed by:_____ Date:_____

Signature of Patient or Legal Guardian