The Center for Total Back Care
Patient Registration Form

Date: ___________________

TELL US ABOUT YOU

Name: Preferred Name:	(Circle One)	SSN#:
Address:	Male Female	Date of Birth:
City: State: Zip:	Marital Status	Married / Never Married / Divorced / Domestic Partner / Widowed
Home Phone:	Referred source:	☐ Doctor ☐ Internet ☐ Friend ☐ Other:
Work Phone:	Referral Name:	
Cell Phone:	Employer:	
Email:	Type of work:	

EMERGENCY INFORMATION

Person to Contact in Emergency:	Relation:
Address:	
City: State: Zip:	
Home Phone:	Cell Phone:

REASON FOR VISIT

Visit is a result of (Check one) ☐ Auto Accident ☐ Work Injury ☐ Trauma ☐ Sports ☐ Gradual Onset ☐ Chronic Pain

Area of complaint:	Date Condition Began:
Please explain what happened:	Is this interfering with work, sleep, daily routine? Yes No
	If yes, please explain:

Tell us about your past care

Check all that apply:	Helpful?
☐ Physical Therapy	Y N
☐ Surgery	Y N
☐ Epidural	Y N
☐ Injections	Y N
☐ Nerve Block	Y N
☐ Bio Feedback	Y N
☐ Chronic Care	Y N
☐ Supervised Exercise	Y N
☐ Back School	Y N
☐ Acupuncture	Y N
☐ Chiropractic	Y N
☐ Other: ____________	Y N
☐	Y N
☐	Y N
☐	Y N

Medical History

Have you ever had any of the following diseases/medical conditions?

☐ Frequent Neck Pain	☐ Cancer
☐ Lower Back Pain	☐ Chemotherapy
☐ Severe Frequent Headaches	☐ Anemia
☐ Fainting /Seizures /Epilepsy	☐ Difficulty Breathing
☐ Arm /Leg Pain	☐ Heart Attack
☐ Arthritis	☐ Stroke
☐ Artificial Bones /Joints	☐ Heart Surgery
☐ Asthma / Emphysema	☐ Heart Murmur
☐ Ulcers /Colitis	☐ Congenital Heart Defect
☐ Kidney Problems	☐ Mitral Valve Prolapse
☐ Alcohol /Drug Abuse	☐ Artificial Valves
☐ Hepatitis	☐ Rheumatic Fever
☐ HIV /AIDS	☐ High /Low Blood Pressure
☐ Shingles	☐ Diabetes
☐ Psychiatric Problems	☐ Tuberculosis

*** Please fill out other side ***

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Are you taking any medications? Yes No If Yes, please list:		
Please list any other serious medical condition(s) you have ever had:		
Please list anything that you may be allergic to:		
List past serious accidents:		
Family health history: ☐ Diabetes ☐ Cancer ☐ Heart Disease ☐ Stroke ☐ Other:		
Do you smoke? Yes No How Much?: How Long?:		
Do you wear? ☐ Heel Lifts ☐ Sole Lifts ☐ Inner soles ☐ Arch supports ☐ Other:		
What is the age of your mattress?: Is it comfortable?: **Yes No**		
Do you sleep on your: ☐ Back ☐ Side ☐ Stomach ☐ At an Incline ☐ Other:		
For Women:	Do you take birth control? **Yes No If Yes, how long?:**	
	Are you pregnant? **Yes No If Yes, how Long?:**	Are you nursing?: **Yes No**
	Other conditions/complications? **Yes No If Yes, Please list:**	

FINANCIAL RESPONSIBILITY

Person Responsible:	**Insured's Name:**
Address:	**Insured's ID#:**
City: State: Zip:	**Insured's DOB:**
Phone:	**Group Policy #:**
Relationship to Patient:	**Insured's Employer:**
Insurance Company:	**Employers Phone:**

PLEASE READ AND SIGN

We invite you to discuss with us any questions regarding our services and/or fees. The best health services are based on a friendly, mutual understanding between the provider and patient.

Our Policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made. As a courtesy to you, we will usually bill your insurance for you, however, insurance is a contract between you and your insurance company and you are ultimately responsible for all fees incurred as a result of any treatment you receive in this office.

If your account is **not paid within 90 days** of the date service, and no financial arrangements have been made, **a service fee of 25% of the outstanding balance will be added to your account** for collection agency fees, and any other expenses incurred collecting your account.

If this was a result of a motor vehicle accident, your insurance may not cover specific treatments that may be beneficial in your case. We reserve the right to collect our usual and customary fees for services rendered during your treatment in this office.

I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims or collect on my account.
I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered.

I understand the above information, and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my medical status.

Patient's Signature: ______________________________ Date: ____________________

*** Please fill out other side ***

Financial Policies and Patient Responsibilities

Please Read This Document Completely

* The Center for Total Back Care will bill my insurance as a courtesy. Billing of my insurance company does not guarantee reimbursement from my insurance company.

* The patient/guardian is responsible for all charges incurred in the course of treatment.

* The patient/guardian may request a copy of charges at any time.

* Insurance company reimbursement policies for chiropractic and/or physical therapy vary. This depends upon the policy you and/or your employer have purchased. A call will be placed in an attempt to determine your insurance benefits from your carrier before treatment is rendered. An estimation of benefits by the insurance company is not a guarantee of payment. **It is the patient's responsibility to know what their benefits are. The course of therapy developed for you by your therapist may include procedures that are not covered by your policy. You will be responsible to pay for those procedures not covered by your policy. Please consult your policy if you are unsure.**

* **Pertaining to liens/auto accident injuries/personal injuries:** The patient understands and agrees that as a condition of treatment, that The Center For Total Back Care may have a written contract with the patient's health plan, PPO, HMO, or other Insurer, permitting The Center For Total Back Care, if the medical expenses are accident related, to balance bill the amount of it's normal or customary charges over and above that allowed by the health plan against the patient's Third Party Liability, Uninsured/Underinsured/Medical Payments, or similar no fault insurance. By signing below, the patient reasonably expects to be responsible to pay the amount of the above balance billing from the insurance proceeds. **In these cases, we will file a medical lien as allowed by Arizona state law. Further, the patient consents and agrees to our filing such a lien and will be responsible for all administrative costs associated with the filing of this lien. Because of the risks associated with accepting a lien only arrangement, we do not reduce our bills at the time of settlement**

* Patient co-pays, co-insurance, deductible, and fees for supplies are due and must be paid at the time of service.

* Patient/Guardian grants Power of Attorney to The Center For Total Back Care to deposit check payments issued by my insurer written in two party payee formats.

I understand and have had my questions answered regarding these policies and responsibilities. I acknowledge and agree that I am responsible for any and all portion of my bill not paid by insurance. If under 18 years old, a guardian must be present to sign this agreement before the patient can be seen.

________________________________ Patient Name

____________________ Date

________________________________ Patient/guardian Signature

____________________ Relationship to Patient

2220 S. Country Club Drive, Suite 102 Mesa, Arizona 85210 (480) 633-8293 Fax (480) 926-1564

THE CENTER FOR TOTAL BACK CARE

Authorization to Release Information

I understand that under the Health Insurance Portability and Accountability Act (HIPAA) I have certain rights to privacy regarding my protected health information. I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my healthcare information. I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

I understand that you are required to have authorization to leave a message at my home or on my answering machine, regarding appointments, labs, imaging, and billing and insurance information.

____ It is ok to leave a message on my answering machine with information regarding my health care.

____ It is **NOT** ok to leave any messages on my answering machine.

Patient Signature ____ Date ____________

I understand that my signing this consent form, I am giving The Center For Total Back Care permission to disclose all medical treatment and billing information, unless otherwise indicated, to the following person or persons.

Authorized Person ___________________________________ Relationship to Patient _______

Authorized Person ___________________________________ Relationship to Patient _______

Authorized Person ___________________________________ Relationship to Patient _______

Authorized Person ___________________________________ Relationship to Patient _______

Acknowledgment of Privacy Practices

I have read a copy, and understand the Privacy Practices of The Center For Total Back Care.

___________________________________ ___________________________________

Patient Parent or Legally Authorized Individual

___________________________________ ___________________________________

Date Relationship to Patient