SOUTHWORTH
Active
SPINE & REHAB

Always Active, Always Improving

Nicholas Southworth, D.C.

PATIENT INFO

Patient Name: _____ Male [] Female []

Birthdate: _____/_____/_____Age: _____ SS#: _____-_____-_____DL #_____

Home Address_____City/State/ZIP_____

Home Phone: (_____)_____ Cell Phone: (_____)_____

Would you like a text or email reminder for your scheduled appointments? YES [] NO []

Cell phone carrier: _____ Email Address: _____

Employer& Occupation: _____ Work Phone: (_____)_____

Marital Status: S M D W Spouse's Name: _____ Do You have Children? YES/NO How many? _____

Who Can We Thank for Referring You: _____

INSURANCE INFO

Primary Insurance Name: _____ Insured's Name_____

INS Address: _____ Phone:
(_____)_____

Insured's ID#: _____ Group# (Plan, Local, or Policy #): _____

DOB: ____/____/_____ Subscribers SS#: _____-_____-_____ Relation: _____

Secondary Insurance Name: _____Insured's Name_____

INS Address: _____ Phone:
(_____)_____

Insured's ID#: _____ Group# (Plan, Local, or Policy #): _____

DOB: ____/_____/_____ Subscribers SS#: _____-_____-_____ Relation: _____

I clearly understand that all insurance coverage, whether accident, work related, or general coverage is an arrangement between my insurance carrier and myself. If this office chooses to bill any services to my insurance carrier that they are performing, these services are strictly as a convenience to me. The office will provide any necessary reports or required information to aid in insurance reimbursement of services. I understand that insurance carriers may deny my claims and that I am ultimately responsible for any unpaid balances. Any monies received will be credited to my account.

Signature of Patient or Guardian of Minor_____ Date: _____

Health History

Who is your **primary care** physician? _____

Are you **currently** pregnant? Yes [] No []

Please list any medications you are currently taking including vitamins, minerals, herbs:

_____

Are you on any blood thinners? Yes [] No [] What type? _____

Please list any previous surgeries or hospitalizations including date:

_____

Please check any of the following that apply:

Symptoms	**Yes**	**No**	**Have you EVER had Any of the following:**	**Yes**	**No**	**Contd.**	**Yes**	**No**
Neck Pain or stiffness			Aids/HIV			Psychiatric Care		
Back Pain or stiffness			Arthritis			Rheumatoid Arthritis		
Arm or Hand Pain			Bleeding disorders			Stroke		
Leg or Knee Pain			Breast Lump			Suicide Attempt		
Headaches Migraines			Cancer			Tumors or Growths		
Pins and Needles in extremities			COPD or Asthma			Hip replacement		
Jaw Problems			Diabetes			Knee Replacement		
Dizziness, Fainting or Shortness of Breath			Fractures			Anesthetic Allergy		
Asthma, Allergies, or chest pain			Gout			Suffer from blood clots		
Sleeping difficulties			Herniated Disc			Do you exercise? Yes [] No [] How often? _____ What do your activities include? _____ Do your employment activities include mostly: Standing [] Sitting [] Light Labor [] Heavy Labor [] Do you Smoke? Yes [] No [] Drink? Yes [] No[] How many a week? _____ Do you use illicit drugs? Yes [] No []		
Nervousness/ Tension			Manipulation/Adjustments					
Constipation/stomach problems			Miscarriage					
Cold Feet			Multiple Sclerosis					
Light Bothers Eyes or blurred vision			Osteoporosis					
Sudden Weight Loss			Pacemaker					
Loss of Memory			Prosthesis					
Loss of Smell or Taste			Pinched Nerve _____ Epilepsy					

I hereby certify that the above questions were answered accurately. I understand that providing false information is dangerous to my health.

Patient/Guardian's Signature _____Date_____

Physician's Signature _____Date _____

Radiograph Consent

Our consultation and examination may indicate that x-rays are necessary to adequately diagnose and analyze your condition. By signing below, you give your consent to allow Southworth Active Spine and Rehab and its representatives, as deemed by the examining physician to take radiographs of your spine and/or extremities.

Signature of Patient or Guardian of Minor_____Date_____

I also hereby declare that to my knowledge I am NOT Pregnant _____ (Initials)

Authorization of Care

This clinic will attempt to identify and diagnose any ailments you may have that may be corrected through physical medicine, massage therapy, chiropractic care, and/or active/passive rehabilitation. If any condition or disease appears to be present out of our scope of practice, we will refer you to an appropriate physician to diagnose and/or treat that condition. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare cases, underlying birth defects, deformities, or pathologies may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare if he/she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known these things which otherwise might not come to the attention of the physician (i.e. Deformities, Illnesses, etc.). I agree to settle any claim or dispute I may have against or with any of these persons or entities, whether related to the prescribed care or not, by binding arbitration under the current malpractice terms which can be obtained by written request.

I also clearly understand that if I do not follow the doctor's specific recommendations at this clinic that I will not receive the full benefit from these programs, and that if I terminate my care prematurely that all fees incurred will be due and payable at that time. I authorize the assignment of all insurance benefits be directed to the doctor for all services rendered. I understand that in the event my account goes to collections, I am responsible for any and all collections fees.

I understand that I am financially responsible for all fees incurred for the services provided, regardless of any applicable insurance or benefit payments, and I agree to ensure full payment. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer, and my attorney to release to such doctor and clinic and any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

The assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have fully read and I fully understand this agreement.

For guardians: I hereby authorize Southworth Active Spine and Rehab to administer care as deemed necessary to my child, a minor under the age of 18.

_____ _____ _____

Patient's Printed Name Patient or Guardian Signature Date

Emergency Contact

Name:_____ Phone number:(_____)_____

Relationship:_____ Workplace:_____\

Notice of Privacy Practices Acknowledgement & Consent to use PHI

Use and Disclosure of your Protected Heath Information
Your protected health information will be used by Southworth Active Spine and Rehab or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations at this office.

Notice of Privacy Policies
You should review the Notice of Privacy Practices for a more complete description of how your protected health information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by the office. You may review the notice prior to signing this consent. You may request a copy of the notice at the front desk.

Requesting a Restriction on the Use or Disclosure of your Information

1. You may request a restriction on the use or disclosure of your Protected Health Information
2. This office may or may not agree to restrict the use or disclosure of your Protected Health Information
3. If we agree to your request, the restriction will be binding with the office. Use or disclosure of protected health information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent
You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

By my signature below, I give my permission to use and disclose my health information as stated in the notice of privacy practices.

_____ _____
Patient's Complete Printed Name Date

_____ _____
Patient or Legally Authorized Individual Signature Date

_____ _____
Witness Signature Date

Insurance Company Payment Policy

I _____, Have been advised that the doctors and therapists at Southworth Active Spine and Rehab will bill my insurance company directly for my treatment. I have been further advised that the payment may be sent to me by my insurance company. By signing below, I affirm and attest that I am in no way entitled to this reimbursement for my treatment, and I understand that this money is intended to pay the above mentioned companies and physicians.

Accordingly, it is hereby understood and agreed to again that I have no right, implied or otherwise to said funds as they do not belong to me, and/or the insured party and are intended to pay for my medical care and procedures performed with me informed consent.

Furthermore, in the event that I receive a check or checks from the responsible insurance company as payment for my treatment/procedures or the insureds procedures, I will immediately or within fourty eight hours contact the appropriate party (the office or the billing department) about the check and return these funds to the appropriate parties. I understand that I am ultimately responsible for all medical bills if my insurance company fails to pay, and I will assist Southworth Active Spine and Rehab with the collection of any funds.

In the event that a check or multiple checks are made payable to me or the insured and is received by Southworth Active Spine and Rehab or its physicians, I hereby grant the facility and above providers the express permission and limited power of attorney solely and exclusively for the purpose of endorsing said checks, so that I do not need to return to the facility with the express intent to endorse the funds to the facility or providers.

If either party defaults in the performance of any of these terms, provisions, covenants, and conditions and by reason thereof, the other party employs the services of an attorney to enforce performance of the covenants, or to perform any service based upon defaults, regardless of initiation of court proceedings, there in any of said events, the prevailing party shall be entitled to recover from the non-prevailing party all of the prevailing party's reasonable attorney's fees and all expenses and costs incurred by the prevailing party pertaining thereto (including costs and fees relating to any appeal) and in the enforcement of any remedy. By signing below, I agree that the sole and exclusive venue for a litigation arising from or related to this Lease shall be in the state courts in Franklin County.

_____ _____

Patient or Guardian Signature Date

Southworth Active Spine & Rehab
8076 E Broad Street
Reynoldsburg, Ohio 43068

Assignment of Benefits/ ERISA Authorized Representative Form

Assignment of Insurance Benefits- Appointment as Legal Authorized Representative

I hereby assign all applicable insurance benefits and all rights and obligations that I and my dependents have under my health plan to the provider and the Force of Law Firm PC and their affiliated law firms (hereinafter, "My Authorized Representative") and I appoint them as my authorized representative with the power to:

1. File Medical Claims with the health plan
2. File appeals and grievances with the health plan
3. Institute and necessary litigation and/or complaints against my health plan naming me as plaintiff in such lawsuits and actions if necessary.
4. Discuss or divulge any of my personal health information or that of my dependents with any third party including the health plan

I certify that the health insurance information that I provided to the provider s accurate as of the date set forth below and that I am responsible for keeping it updated.

I am fully aware that having health insurance does not absolve me of my responsibility to ensure that my bills for professional services from provider are paid in full. I also understand that I am responsible for all amounts not covered by my health insurance, including co-payments, co-insurance, and deductibles.

Authorization to Release Information

I hereby authorize my authorized representatives to:

1. Release any information necessary to my health benefit plan (or its administrator) regarding my illness and treatments
2. 2.Process insurance claims generated in the course of examination or treatment.
3. Allow a photocopy of my signature to be used to process insurance claims. This order will remain in effect until revoked by me in writing.

ERISA Authorization

I hereby designate, authorize, and convey to my authorized representatives to the full extent permissible under law and under any applicable insurance policy and/or employee health care benefit plan:

1. The right and ability to act as my authorized representative in connection with any claim, right, or causes of action including litigation against my health plan (even to name me as plaintiff in such action) that I may have under such insurance policy and/or benefit plan.
2. The right and ability to act as my authorized representative to pursue such claim, right, or cause of action in connection with said insurance policy and/or benefit plan (Including, but not limited to, the right and ability to act as my authorized representative with respect to a benefit plan governed by the provisions of ERISA as provided in 29 C.F.R. 2560.5031(b)(4) with respect to any healthcare expense incurred as a result of the services I received from the provider and to the extent permissible under the law, to claim on my behalf, such benefits, claims, or reimbursement, and any other applicable remedy, including fines. I authorize communication with the provider and his authorized representatives by email and my email address is _____@_____. I understand I can revoke this authorization in writing at any time.

A photocopy of this Assignment/Authorization shall be as effective and valid as the original.

_____ _____

Patient or Guardian's Signature Date

Southworth Active Spine & Rehab
8076 E Broad Street
Reynoldsburg, Ohio 43068