SPOKANE
SPINE CENTER
YOUR RECOVERY BEGINS HERE!

124 E. Rowan Ave., Suite 101 & 202 (509)487-6222(t)
Spokane, WA 99207-1214 (509)487-6333(f)

PATIENT REGISTRATION

(Please Print)

PATIENT INFORMATION

Patient's Last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Social Security no.:	Home phone no.: ( )

P.O. box:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.: ( )

Other family members seen here:

Appointment reminders via call or text permitted at the above given phone numbers and email? ❑ Yes ❑No

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Is this person a patient here? ❑ Yes ❑ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance	❑ Premera	❑ Aetna	❑ CIGNA	❑ Asuris	❑ L & I
❑ Blue Cross/Blue Shield	❑ Regence	❑ United Health Care	❑First Choice Health Network	❑ Medicare	❑ Other

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:	
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Spokane Spine Center, PC or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

SPOKANE
SPINE CENTER
YOUR RECOVERY BEGINS HERE!

124 E. Rowan Ave., Suite 101 & 202
Spokane, WA 99207-1214

(509) 487-8000

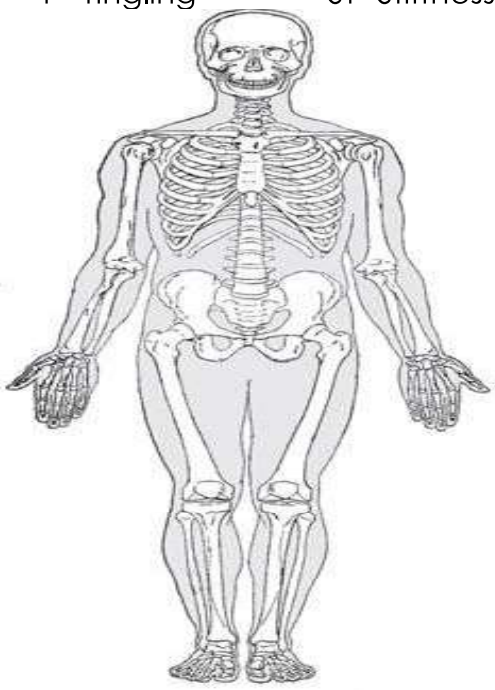
PAIN SCALE

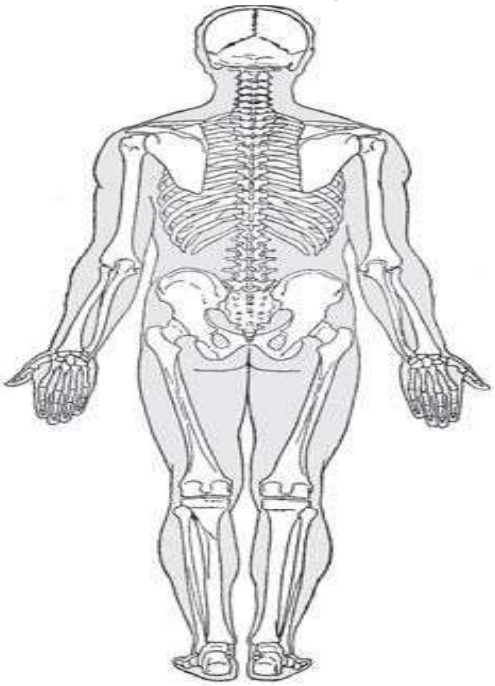
If you are experiencing pain (sharp, dull burning, stinging) or abnormal feelings (numbness, tingling, stiffness, abnormal sensation), please mark the area on the diagram below and label accordingly.

SP = Sharp pain DP=Dull Pain B=Burning S=Stinging N=Numbness

T= Tingling ST=Stiffness A=Abnormal Sensation

Right

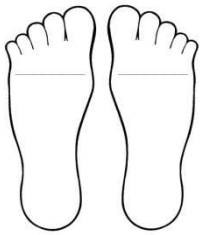




Right

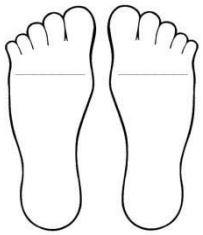
Foot Sole

Right Left



Foot top

Left Right



What was your highest level of pain in the last week?

0 1 2 3 4 5 6 7 8 9 10

What was your lowest level of pain in the last week?

0 1 2 3 4 5 6 7 8 9 10

What is your current level of pain today?

0 1 2 3 4 5 6 7 8 9 10

How much does this interfere with your weekly activities?

0 1 2 3 4 5 6 7 8 9 10

Patient's signature_____ Date_____

Printed name_____

SPOKANE
SPINE CENTER
YOUR RECOVERY BEGINS HERE!

Robert G. Haddad, DC, Rph
124 E. Rowan Ave., Suite 202
Spokane, WA 99207-1214
(509) **487-8000** tel (509) **487-6333** fax

Informed Consent for Chiropractic Treatment and Massage Therapy

I have read and understand the foregoing explanation of chiropractic care, have evaluated the risks and benefits, and hereby give my consent for the doctor and other licensed practitioners to render care to me.

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including various modes of physical therapy by the chiropractic physician and/or anyone working in this office authorized by the chiropractic physician. I further understand that such chiropractic services may be performed by Dr. Robert Haddad and/or other licensed doctors and/or therapists who may treat me now or in the future at this office.

The doctor may use his hands or mechanical device in order to move your spinal joints. Your may feel a "click" or "pop" such as the noise when a knuckle is "cracked" and you may feel movement of the joint.

I have had an opportunity to discuss with Dr. Robert Haddad and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine and all healthcare, the practice of chiropractic carries some risks to treatment; including, but not limited to: fractures, disc injuries, strokes (CVA), dislocations, and sprains. I do not expect the physician to be able to anticipate and explain all risks and complications. Further, I wish to rely on the physician to exercise judgment during the course of the procedure which the physician feels are in my best interests at the time, based upon the facts then known.

_____ (please initial) Cupping and other tools may cause bruising. Essential oils may be used. Heat or ice packs may be used. We do not massage breasts or torsos. Please discuss with your therapist any questions you may have about ANY part of massage therapy.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its contents, and by signing below, I agree to the treatment recommended by my physician. I intend this consent form to cover the entire course of treatment for my present condition(s) and for any condition(s) for which I seek treatment at this facility.

X_____
Dr Sign: Consent was discussed verbally

x_____ _____
Signature of Patient or Representative (if minor or handicapped) Date

_____
Printed name of patient

SPOKANE
SPINE CENTER
YOUR RECOVERY BEGINS HERE!

124 E. Rowan Ave, Spokane, WA
99207-1214
509-487-8000
509-487-6333 fax

HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information:

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse of Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ

Donation: Research: Criminal Activity: Military Activity and National Security: Worker's Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164-500.

Other Permitted and Required Uses and Disclosures Will Be Made Only with Your Consent, Authorization or Opportunity to object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in the Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.