SPOKANE
SPINE CENTER
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Patient Registration

Name:(*First Last*)______________________________ **Middle:** __________

Address: ______________________ **City:** ______________ **State:** _____ **Zip:** ___________

Date of Birth: ______________ **Age:** _____ **Sex:** ☐ *F* ☐ *M* **SSN:** __________________

Email: ______________________**Marital status (circle one**) Single / Mar / Div / Sep / Wid

Home #: (_____)______________ **Cell #: (_____)**______________

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

Employer:______________________**Address:**______________________

Work #: (_____)______________ **Position/title:**______________________

Please briefly list your symptoms: ______________________________

Accident Billing Information

Date of Accident: ____/_____/______ **Which State did this occur in?** _______ **Please provide accident report**

Did this occur while working? ☐ *Yes* ☐ *No* **If yes, L & I Claim #**______________ **Case mgr:**______________

Location of accident, intersection, mile marker:______________________________

Do you have an attorney representing you? ☐ *Yes* ☐ *No* **Attorney Name:** ______________________

Attorney Address: ______________________ **City:** ______________ **State:** _____ **Zip:** _______

Attorney phone number______________________ **Have you consulted with your attorney yet?** ☐ *Yes* ☐ *No*

Have you seen another doctor since the MVA (related treatment)? ☐ *Yes* ☐ *No*

Did you have X-Rays taken? ☐ *Yes* ☐ *No* **If so, where?**______________________________

Do you have Medical Coverage or PIP (Personal Injury Protection) on your Auto Policy ? ☐ *Yes* ☐ *No*

** Your insurance will pay medical bills initially and will be reimbursed if another party is at fault. **

Your Auto Insurance Company: ______________________ **Policyholder Name:**______________________

Ins Address: ______________________ **City:** ______________ **State:** _____ **Zip:** _______

Your relationship to policyholder: ☐ **self** ☐ **spouse** ☐ **family member** ☐ **friend**

Ins Policy #______________________ **Insurance broker name:**______________________

Claim #: ______________________ **Claim Adjuster's Name:** ______________________

Adjuster's Phone #: (____)____________**x**_______

Claims billing Address: ______________________ **City:** ______________ **State:** _____ **Zip:** ________

Patient/Guardian Signature: ______________________________ **Date:** _____/____/______

Your signature on this document indicates that the above information is true and correct.

If there is no personal injury protection (PIP) on your auto insurance,

please provide the 3rd party (other driver) insurance information, but this does not insure payment to us.

Please also provide your private medical insurance information.

Please provide copies of any documentation, ie: ins cards, letter from insurance co.

Other driver's (3rd party) Auto Insurance Company: ____

Driver name and address____

Policyholder Name:____ **Policyholder phone #**__________________________

Policyholder Address: ______________________________________ **City:** _________________ **State:** _____ **Zip:** _______

Policy or Claim #: _________________________________

Claim Adjuster's Name: ______________________________**Adjuster's Phone #: (**____**)**________________**x**_______

Claims billing Address: _________________________________**City:** _____________________ **State:** _____ **Zip:** _______

Private Insurance Health Plan

Please provide Receptionist your health insurance card to copy

Primary Insurance Co.: ______________________ **Member ID#:** ___________________ **Group #:** _______________

Ins Address: ____ **City:** _____________________ **State:** _____ **Zip:** _______

Policy holder name: ____ **Policy holder birth date:**_____________________

Relationship to policy holder: ______________________ **Ins Phone #** _________________________

Patient/Guardian Signature: ____ **Date:** _____/____/______

Your signature on this document indicates that the above information is true and correct.

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124 E. Rowan Ave., Suite 101 & 202
Spokane, WA 99207-1214
(509)487-8000 t (509)487-6333 f

Auto Accident Form

Name:_______________________ **Date of Accident:**__________ **Time of Day:**______ ☐ Daylight ☐ Dark

Road conditions: ☐ Dry ☐ Damp ☐ Wet ☐ Icy ☐ Snowy ☐ Other ____________________________________

Your vehicle: Year: __________ Make: ______________________ Model: ____________________________

Your estimated speed at time of accident: ______ mph ☐ Accelerating ☐ Slowing ☐ Stopped

Other vehicle: Year: __________ Make: ______________________ Model: ____________________________

Other vehicle's estimated speed at time of accident ______ mph ☐ Accelerating ☐ Slowing ☐ Stopped

You were: ☐ Driver ☐ Front Seat Passenger ☐ Back Seat Passenger ☐ Other __________________________

Were you wearing a seatbelt? ☐ Yes, shoulder & lap-belt ☐ Yes, lap belt only ☐ Don't know ☐ No seatbelt

Were you braced for impact? ☐ Yes ☐ No **Were you applying your brakes?** ☐ Yes ☐ No

Was your seat broken? ☐ No ☐ Yes **Was the position of your seat altered by the accident?** ☐ No ☐ Yes

Did your airbag deploy? ☐ No ☐ Yes **If yes, were you struck by it?** ☐ Yes ☐ No Injuries:____________________

Head position: ☐ Forward ☐ Looking left ☐ Looking right ☐ Looking up ☐ Looking down

Did you have a head rest? ☐ Yes ☐ No **Was it centered behind your ears?** ☐ Yes ☐ No **Did it break?** ☐ Yes ☐ No

Brief description of the accident*:____

____

____

* You may draw an accident diagram on the back of this page to help explain the situation.

During the crash:

Did you strike any parts of the vehicle? ☐ Yes ☐ No **Please describe:** ____________________________________

Did your vehicle strike any objects after the initial collision? ☐ Yes ☐ No **Please describe:** __________________

Were you wearing a hat or glasses during the crash? ☐ Yes ☐ No **Still on after the crash?** ☐ Yes ☐ No

Did you lose consciousness? ☐ Yes ☐ No **If yes, for how long?** __________

What was the estimated property damage to your vehicle? _______________

What was the estimated property damage to the other vehicle? ☐ Major ☐ Moderate ☐ Minimal ☐ None

After the crash:

Were the police called to the scene? ☐ Yes ☐ No **Was a police report filed?** ☐ Yes ☐ No

Was an ambulance called to the scene of the accident? ☐ Yes ☐ No **Did you go to the hospital?** ☐ Yes ☐ No

If yes, how did you get to the hospital? ☐ Ambulance ☐ Car **If by car, were you driven by:** ☐ Self ☐ Other

If no, did you see another doctor? ☐ Yes ☐ No **Name of Doctor:** ____________ **Location:** _______________

What treatment did you receive? ☐ Exam ☐ Neck brace ☐ X-rays ☐ Medication ☐ Other:_______________

Have you lost any days of work due to the accident? ☐ Yes ☐ No If yes, dates:_____________________________

Were you unable to do housework, yard work, regular daily activities due to pain from the accident? ☐ Yes ☐ No

Have you been in other accidents? ☐ Yes ☐ No If yes, dates:____

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(509) 487-8000

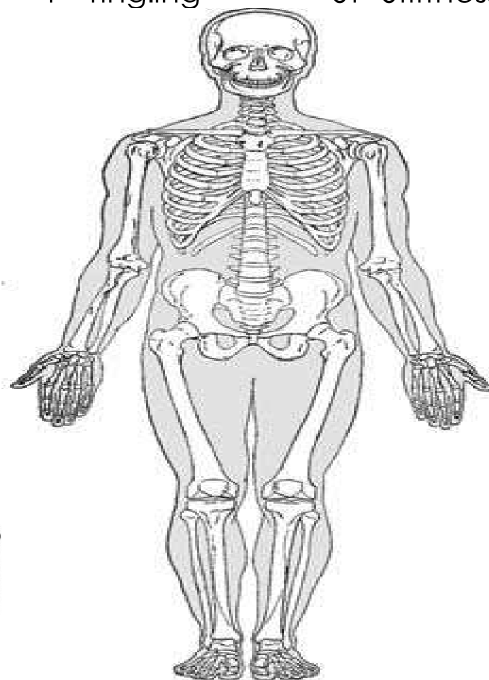
PAIN SCALE

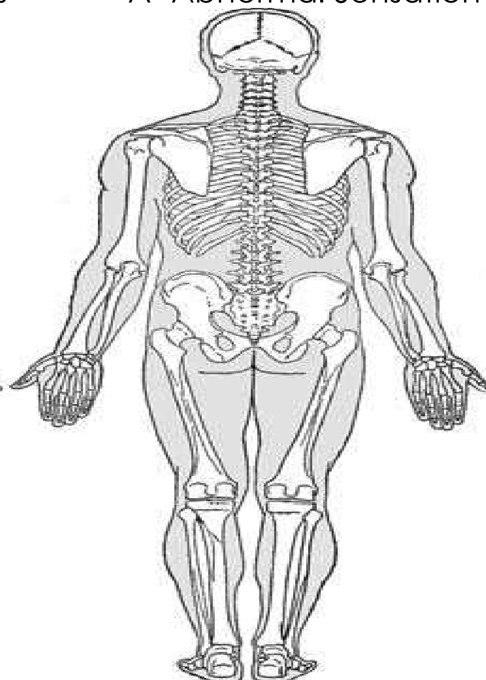
If you are experiencing pain (sharp, dull burning, stinging) or abnormal feelings (numbness, tingling, stiffness, abnormal sensation), please mark the area on the diagram below and label accordingly.

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

T= Tingling ST=Stiffness A=Abnormal Sensation

Right

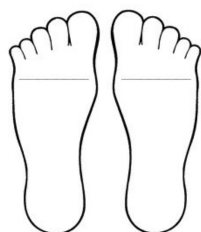




Right

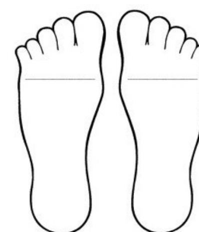
Foot Sole

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____________________________________

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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

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Robert Haddad, D.C
John Long, D.O
Stacia Reagan, PA-C
124 E. Rowan Ave., Spokane, WA 99207-1214

Patient Health Information Consent (Notice of HIPAA Privacy Practices)

We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. Before we will begin any health care, we must require you to read and sign this consent form stating that you understand and agree with how your records will be used.

If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information, we encourage you to read the HIPAA PRIVACY POLICY NOTICE that is available to you at the front desk before signing this consent.

- The patient understands and agrees to allow the Spokane Spine Center to use their Patient Health Information for the purpose of treatment, payment, and coordination of care.
- The patient has the right to examine and obtain a copy of her/his own health records at any time and request corrections.
- A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
- The patient may provide a written request to revoke consent at any time during care, which would apply to any care given after the request has been presented.
- For your security and right to privacy, the Spokane Spine Center staff has been trained in patient record privacy and will assure that your records are not readily available to those who do not need them.
- If the patient refuses to sign this consent for the purpose of treatment, payment, and health care operations, the physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used, I agree to these policies and procedures, and I have been offered a paper copy of the Spokane Spine Center HIPAA Privacy Policy Notice.

Signature on File Authorization of Assignment Release of Information Authorization

Be assured that this office will limit and protect the release of all Personal Health Information to the minimum needed for what insurance companies require for payment.

As a patient of Spokane Spine Center:

- I authorize Spokane Spine Center to **obtain AND release** any medical information necessary to process my claim, including but not limited to, the use of my signature on all insurance submissions and attorney requests.
- I authorize Spokane Spine Center to act as my agent in helping me obtain payment from my insurance companies, third party claims, and attorney liens.
- I authorize and assign the payment of medical benefits to be paid directly to the Spokane Spine Center on my behalf for services rendered.

As per the HIPAA Privacy Policy Notice, I have the right to terminate this Authorization to Release my Personal Health Information to other health care providers, insurance companies, or attorneys in writing at any time.

I have read and understand that by signing below, I agree to:

1. *Allow Spokane Spine Center to use my "Signature on File" for collection purposes,*
2. *Assign my insurance benefits and/or reimbursement to the Spokane Spine Center for services rendered, and*
3. *Give my permission and request that Spokane Spine Center obtain and release my Personal Health Information for the purpose of discussing or determining appropriate care and/or medical payment for my condition.*

Please sign and date this page indicating that you have read, fully understand, and agree to the above statements. Your signature also indicates that you have had the opportunity to have any questions answered to your satisfaction, have freely decided to undergo the recommended treatment, and accept chiropractic care from Spokane Spine Center on this basis.

Printed Name of Patient:________________________ **Signature:**________________________ **Date:**____________