SPOKANE
SPINE CENTER
YOUR RECOVERY BEGINS HERE!

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
Phn (509)487-8000 Fax (509)487-6333

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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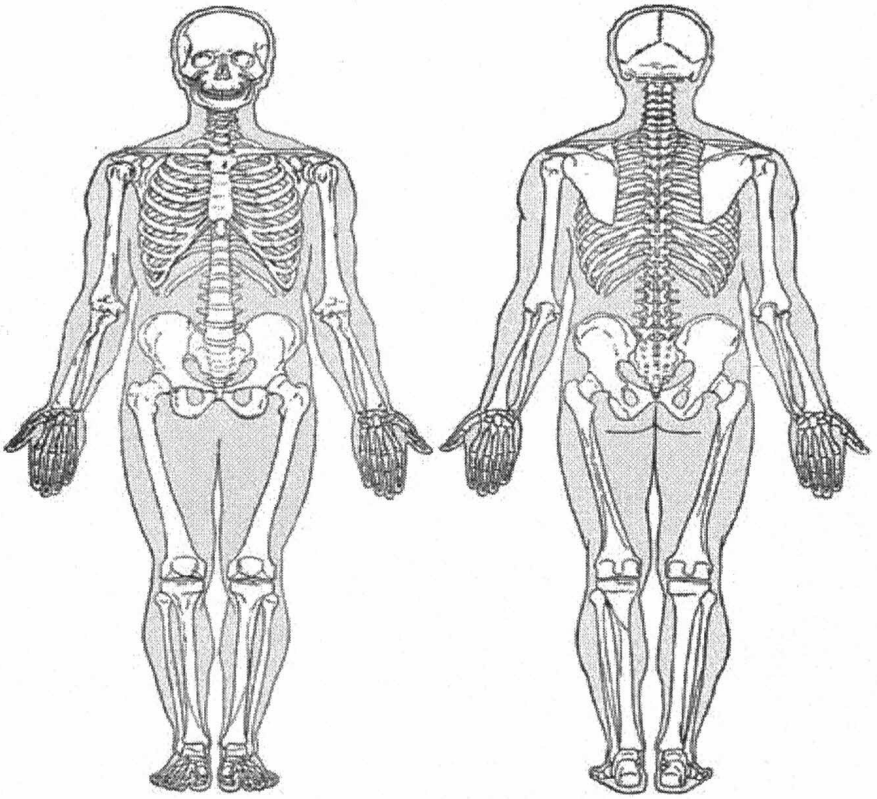
(509) 487-8000 (p)
(509) 487-6333 (f)

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

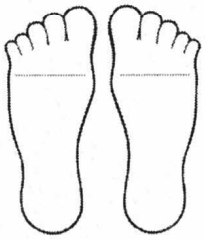
Right



Right

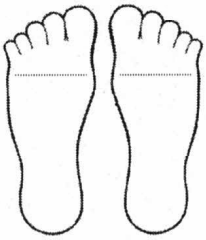
Foot Sole

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_____

Name:_____ Date of Birth:_____ Today's Date:_____

REASON FOR VISIT

_____

CURRENT MEDICAL PROBLEMS

_____

ALLERGIES

Iodine: yes no Latex: yes no List others: _____

_____

PREVIOUS SURGERIES

_____

_____

CURRENT MEDICATIONS

Medication Name	Dosage	Frequency	How Long

FAILED MEDICATIONS ***FOR THIS PAIN***

(i.e. anti-inflammatory, muscle relaxers, opioids, nerve pain medications, other pain medication)

Medication Name	Dosage	Frequency	How Long

CONSERVATIVE CARE TRIED ***FOR THIS PAIN***

Chiro: ____/wks Massage: ____/wks Physical Therapy: ____/wks Work Modification: _____/wks

Heat: ____ Ice: ____ Acupuncture: ____ Other: ____

Social History: ☐ Smoker pack per/day: ____ ☐ Former Smoker pack per/day quit: _____ ☐ Alcohol ____/day

Primary Care Provider_____

Pharmacy Name:_____ Address:_____

Confidential Review of Systems

Please place a check mark if you are experiencing the following symptoms or write "P" beside the box if you have experienced these symptoms in the past.

General

( ) Poor/Change in appetite
( ) Foreign bodies
( ) Weight gain
( ) Unexplained Weight loss
( ) Cancer
( ) Poor Sleep ( )Fatigue
( ) Recent Illness
( ) Chills and Fevers
( ) Night Sweats
( ) Sweat Easily
( ) Strong Thirst ( )Cravings
( ) Covid
( ) Hospitalized due to Covid
( ) None of the above

Skin

( ) Rash
( ) Ulcers
( ) Boils
( ) Other Skin Problem(s)
( ) None of the above

Eyes, Ears, Nose, Throat

( ) Problems swallowing
( ) Change in vision
( ) Nosebleeds
( ) Headaches
( ) Loss of taste/smell
( ) Eye Pain
( ) Blurry vision
( ) Vertigo
( ) Impaired vision
( ) Cataracts
( ) None of the above

Cardiovascular

( ) Blood Pressure: High Low (circle one)
( ) Congestive heart failure
( ) Heart Attack
( ) Phlebitis
( ) Stroke/cardiovascular accident
( ) Pacemaker or similar device
( ) Irregular heartbeat
( ) Fainting
( ) Chest pain at rest
( ) Chest pain with activity
( ) Swelling of limbs
( ) None of the above

Respiratory

( ) Difficulty breathing
( ) Asthma
( ) Emphysema
( ) Shortness of Breath
( ) Coughing blood
( ) None of the above

Muscle, Bone & Joints

( ) Neck pain
( ) Back pain
( ) Muscle pain
( ) Muscle weakness
( ) Arthritis
( ) Bursitis
( ) Other pain
( ) Artificial joint
( ) None of the above

Gastrointestinal

( ) Indigestion
( ) Stomach ulcer
( ) Constipation
( ) Diarrhea
( ) Incomplete bowel movements
( ) Abdominal pain/cramps
( ) Nausea
( ) Vomiting
( ) Chronic laxative use
( ) Rectal pain
( ) Hemorrhoids
( ) Blood in stool
( ) None of the above

Heme

( ) On blood thinners
( ) Blood disorder
( ) Blood clots
( ) None of the above

Thoughts and Emotions

( ) Irritable
( ) Poor memory
( ) Anxiety
( ) Depression
( ) Emotional problems
( ) Other psychological problem
( ) Nervousness
( ) None of the above

Neurological

( ) Loss of Balance
( ) Numbness
( ) Pins and Needles
( ) Falls
( ) Abnormal skin sensation
( ) Dizziness
( ) Lack of coordination
( ) Seizures/Epilepsy
( ) Concussion
( ) Loss of sensation
( ) None of the above

Endocrine

( ) Diabetes
( ) Thyroid problems
( ) Osteoporosis
( ) None of the above

Infections

( ) Hepatitis - Type:
( ) Tuberculosis
( ) HIV/AIDS
( ) Syphilis
( ) Herpes
( ) None of the above

Genito-Urinary

( ) Frequent urination
( ) Urgency to urinate
( ) Pain on urination
( ) Incontinence
( ) Kidney stones
( ) Kidney infection
( ) Blood in urine
( ) STD
( ) None of the above

Male

( ) Prostate problem
( ) Impotence
( ) None of the above

Female

( ) Irregular periods
  ( ) Heavy
  ( ) Light
  ( ) Clots
( ) Chance of Being Pregnant
( ) Sexually active
( ) None of the above

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Phn(509)487-8000 Fax(509)487-6333

Informed Consent for Treatment

John F. Long, D.O
Stacia Reagan, PA-C
Erin Schultz, PA-C, PhD

I understand that as part of my office visit, I may be examined in areas where I am currently having pain as part of the standard physical exam. This may cause increased pain.

I understand that results are not guaranteed. The provider will address injury complaints within the context of resolution of symptoms or until medically stable state is achieved. Treatment beyond maximum improvement will be referred. Narcotics will not be prescribed.

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.

24 HOUR CANCELLATION POLICY: Scheduled appointments that are skipped will be billed to you. Insurance will NOT pay the fine. Please make sure we have a good contact phone number for future appointment confirmation. For HIPAA compliance voicemail must indicate your name for a message to be left.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its contents. 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.

_____
Printed name of patient

x_____ _____
Signature of Patient Date

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

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Robert Haddad, D.C
John Long, D.O
Stacia Reagan, PA-C
Erin Schultz, 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:**_____