Prestige Spinal Care

Registration & Account Information

If you need any assistance completing this paperwork, just ask. It is our pleasure to help you. We want your visit with us to be comfortable, helpful, and educational.

Confidential health information

File # / Clinic ID	Date

1 PATIENT INFORMATION

Last Name		First Name	M. I.
Age	Social Security #	Date of Birth	Gender ☐Male ☐ Female
Status ☐ single ☐ married ☐ partnered ☐ widowed ☐ separated ☐ divorced			
Street	City	State	Zip
Work Phone	Home Phone	Cell Phone	E-mail
Spouse or guardian last name	First Name	M.I.	Date of Birth

2 EMERGENCY CONTACT

Last Name	First Name	Relationship	Home Phone	Work Phone	Cell Phone
Last Name	First Name	Relationship	Home Phone	Work Phone	Cell Phone

3 PATIENT EMPLOYMENT

Employer Name		Occupation	
Address Street	City	State	Zip

4 QUESTIONS

Who referred you to us?	
How did you hear about our clinic?	
Are you here because you were involved in a vehicle collision? Date of Injury _____	☐Yes ☐ No
Are you here because you were injured at your place of employment? Date of Injury _____	☐Yes ☐ No
Are you here because you were involved in another type of accident? Date of Injury _____	☐Yes ☐ No
Will you be using health insurance to supplement payment to our office*? If YES, please complete the INSURANCE COVERAGE and INSURED INFORMATION sections of this form.	☐Yes ☐ No

5 INSURANCE COVERAGE

Types of Insurance

☐Employee Group Health Plan ☐ Personal Health Insurance ☐Health savings Account ☐ Medicare ☐Personal Injury ☐

Primary Insurance Company	Primary Ins. ID#	Primary Ins. Group#
Secondary Insurance Company	Secondary Ins. ID#	Secondary Ins. Group #

I understand and agree to the following:

- My case may not be accept of treatment at this clinic
- If the doctors believe that I may respond to their care, additional Services may be recommended and I will be advised of applicable costs
- There is no guarantee that my health insurance will pay for all or any Part of my care.
- As the patient or guardian of a patient, I am ultimately responsible For all charges incurred for services rendered
- All payments are due at the time services are rendered

Patient or guardian signature
Date

PRESTIGE SPINAL CARE **PATIENT CASE HISTORY**

We are glad you are here today. If you have any questions concerning our policies, forms, or procedures, just as. It is our pleasure to help you. We want your visit with us to be comfortable, helpful and educational.

PATIENT INFORMATION

LAST NAME	FIRST NAME	MIDDLE INITIAL
DATE OF BIRTH	AGE	SEX

CHIEF COMPLAINT

What is the reason for your visit?

Where did you chief complaint begin?

Are you here because you were injured at work, in a motor vehicle collision, or in another accident? ☐ Yes ☐ No

Mark the severity of your chief complaint as it is **right now**.

☐ 1. No Symptoms	☐ 2. Slight Discomfort	☐ 3. Does not Affect Activity	☐ 4. Affects Personal Activities	☐ 5. Prevents Personal Activities	☐ 6. Limits My Work Schedule	☐ 7. Prevents All Working Activity	☐ 8. Prevents All Activity	☐ 9. Keeps Me Bedridden	☐ 10. Causes Thoughts of Suicide

Mark the severity of your chief complaint as it is on **average**.

☐ 1. No Symptoms	☐ 2. Slight Discomfort	☐ 3. Does not Affect Activity	☐ 4. Affects Personal Activities	☐ 5. Prevents Personal Activities	☐ 6. Limits My Work Schedule	☐ 7. Prevents All Working Activity	☐ 8. Prevents All Activity	☐ 9. Keeps Me Bedridden	☐ 10. Causes Thoughts of Suicide

Mark the severity of your chief of your chief complaint as it is **at its best**.

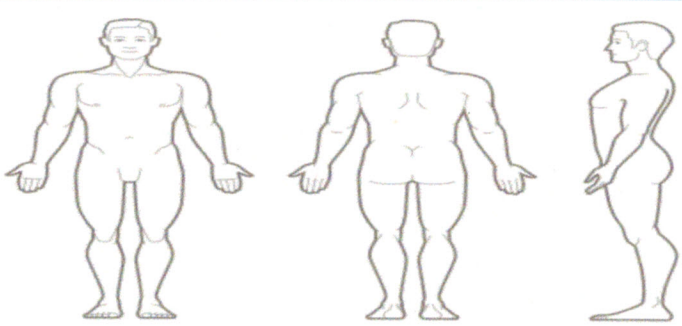
☐ 1. No Symptoms	☐ 2. Slight Discomfort	☐ 3. Does not Affect Activity	☐ 4. Affects Personal Activities	☐ 5. Prevents Personal Activities	☐ 6. Limits My Work Schedule	☐ 7. Prevents All Working Activity	☐ 8. Prevents All Activity	☐ 9. Keeps Me Bedridden	☐ 10. Causes Thoughts of Suicide

Mark the severity of your chief complaint as it is **at its worst**.

☐ 1. No Symptoms	☐ 2. Slight Discomfort	☐ 3. Does not Affect Activity	☐ 4. Affects Personal Activities	☐ 5. Prevents Personal Activities	☐ 6. Limits My Work Schedule	☐ 7. Prevents All Working Activity	☐ 8. Prevents All Activity	☐ 9. Keeps Me Bedridden	☐ 10. Causes Thoughts of Suicide

Mark the areas of your chief complaint on the diagrams to the right. Include any descriptors or comments that you feel are important.

If your symptoms travel to other areas of your body, mark the diagrams to reflect how the symptoms seem to move.



REVIEW OF SYSTEMS (COMPLETE) Mark all of the following conditions that you currently have:

CONSTITUTIONAL	MUSCULOSKELETAL	NEUROLOGICAL	CARDIOVASCULAR	RESPIRATORY
☐ Fever	☐ Back Pain	☐ Sudden Numbness	☐ High Blood Pressure	☐ Asthma
☐ Weight Loss	☐ Headaches	☐ Sudden Headache	☐ Heart Disease	☐ COPD
☐ Obesity	☐ Extremity Pain	☐ Loss of Sensation	☐ Arterial Aneurysm	☐ Common Cold
☐ Loss of Appetite	☐ Bone Demineralization	☐ Confusion	☐ Angina	☐ Emphysema
☐ Fatigue	☐ Unstable Fracture	☐ Dizziness	☐ Irregular Heart Beat	☐ Pneumonia
☐ Anxiety	☐ Spinal Infection	☐ Slurred Speech	☐ Bleeding Disorder	☐ Cancer
☐ Allergies	☐ Spinal Bone Tumors	☐ Loss of Balance	☐ Heart Attack	☐ Pneumothorax

EYES	E,N,M,T	GENITOURINARY	GASTROINTESTINAL	DISEASE HISTORY
☐ Vision Trouble	☐ Hearing Loss	☐ Kidney Infection	☐ Gerd	☐ Stroke
☐ Double Vision	☐ Tinnitus	☐ Loss Bladder Control	☐ IBS	☐ Heart Attack
☐ Night Blindness	☐ Vertigo	☐ Urine Color Change	☐ Crohns	☐ Diabetes
☐ Glaucoma	☐ Nose Bleeds	☐ Painful Urination	☐ Bleeding Disorder	☐ Cancer
☐ Cataracts	☐ Dry Mouth	☐ Urine Leakage	☐ Cramping	☐ HIV / AIDS
☐ Discharge	☐ Change in Taste	☐ Urgency		
☐ Droopy Eyelids	☐ Bleeding Gums	☐ Blood in Urine		

PAST FAMILY SOCIAL HISTORY

How often do you exercise?	☐ Never	☐1x / week	☐2x / week	☐3x / week	☐ 4x / week
How often do you use tobacco?	☐ Never	☐ Daily	☐ Weekly	☐ Monthly	☐ Yearly
How many alcoholic beverages do you drink each week?	☐ 0	☐ 1 - 2	☐ 3 - 4	☐ 5 - 7	☐ >7
How many coffee beverages do you drink each week?	☐ 0	☐ 1 - 2	☐ 3 - 4	☐ 5 - 7	☐ >7
How many soda or sugar beverages do you drink each week?	☐ 0	☐ 1 - 2	☐ 3 - 4	☐ 5 - 7	☐ >7
List all of the prescription medications you are currently taking.					
List all of the over-the-counter medications and nutritional supplements you are currently taking.					
List all of the surgical procedures that you have had.					
List all of the times you have been hospitalized.					
List all significant past traumas that you have had.					
Mark all the following that are in your family history.	☐ Heart Disease	☐ Stroke/TIA	☐ Diabetes	☐ Cancer	

Print Patient Name

Patient or Guardian Signature

Date

PRESTIGE SPINAL CARE

4810 W. Panther Creek Dr. Suite 105, The Woodlands, TX 77381

CONSENT TO X-RAY

I hereby authorize Prestige Spinal Care and whomever the clinician may designate as his assistant(s) to take x-rays of myself (or said minor).

Dated this _____ day of _____, 20_____.

Witness:

_____ _____

Printed Name Patient Printed Name

_____ _____

Signature Signature of Patient

_____

Signature of Parent or Guardian (If a minor)

CONSENT TO X-RAY

Pregnancy Realese*

Date of onset of patient's last menstrual period (LMP): _____.

I hereby release Prestige Spinal Care from any and all liability. I hereby affirm that I am not pregnant nor am I attempting to get pregnant as of this date. I have been informed adequately of the potential effects of radiation on a developing fetus. If a pregnancy test has been performed, I am also aware that this test is not 100% accurate and may yield false results.

Dated this _____ day of _____, 20_____.

Witness:

_____ _____

Printed Name Patient Printed Name

_____ _____

Signature Signature of Patient

_____

Signature of Parent or Guardian (If a minor)

*Must be completed for all females of childbearing age and signed in the patient's, parents or guardian's own handwriting.

Prestige Spinal Care, LLC
Dr. Dustin K. Etemadi, D.C.
4810 W. Panther Creek Dr. The Woodlands, TX 77381
Phone: (281) 292 - 7525 Fax: (281) 292 - 6119

Assignment of Benefits: Assignment of Cause of Action: Contractual Lien

The undersigned patient and/or responsible party, in consideration of treatment rendered or to be rendered and for deferred payment, irrevocably and exclusively assigns, grants and conveys, to Dustin Etemadi, DC, a lien and assignment of any and all claims, causes of action, and right to any proceeds and/or benefits, including any Personal Injury Protection proceeds and/or benefits that the patient may have against any other person, entity, and/or insurance company for reimbursement and/or payment of the medical charges incurred with all the following rights, power, and authority:

RELEASE OF INFORMATION: You are authorized to release information concerning my condition and treatment to my insurance company, attorney or insurance adjustor for purposes of processing my claim for benefits and payment for services rendered to me.

IRREVOCABLE ASSIGNMENT OF RIGHTS: You are assigned the exclusive, irrevocable right to any cause of action that exists in my favor against any insurance company for the terms of the policy, including the exclusive, irrevocable right to receive payment for such services, make demand in my name for payment, and prosecute and receive penalties, interest, court loss, or other legally compensable amounts owned by an insurance company in accordance with Article 21.55 of the Texas Insurance Code to cooperate, provide information as needed, and appear as needed, wherever to assist in the prosecution of such claims for benefits upon request.

DEMAND FOR PAYMENT: To any insurance company providing benefits of any kind to me/us for treatment rendered by the physician/facility named above within 5 days following your receipt of such bill for services to the extent of such bills are payable under the terms of the policy. This demand specifically conforms to Sec. 542.057 of the Texas Insurance Code, and Article 21.55 of the Texas Insurance Code, providing for attorney fees, 18% penalty, court cost, and interest from judgment, upon violation. I further instruct the provider to make all checks payable to **Prestige Spinal Care, and send to 4810 W. Panther Creek Dr., Ste. 105, The Woodlands, TX 77381**.

THIRD PARTY LIABILITY: If my injuries are the result of negligence from a third party, then I instruct the liability carrier to issue a separate draft to pay in full all services rendered, payable directly Prestige Spinal Care, and send to 4810 W. Panther Creek Dr., Ste. 105, The Woodlands, TX 77381.

STATUTE OF LIMITATIONS: I waive my rights to claim any statute of limitations regarding claims for services rendered or to be rendered by the physician/facility named above, in addition to reasonable cost of collection, including attorney fees and court cost incurred.

LIMITED POWER OF ATTORNEY: I hereby grant to the physician/facility named above power to endorse my name upon any checks, drafts, or other negotiable instrument representing payment from any insurance company representing payment for treatment and healthcare rendered by the physician/facility named above. I agree that any insurance payment representing an amount in excess of the charges for treatment rendered will be credited to my/our account or forwarded to my/our address upon request in writing to the physician/facility named above.

REJECTION IN WRITING: I hereby authorize the physician/clinic named above to establish a PIP or UM/UIM claim on my behalf. I also instruct my insurance carrier to provide upon request to the provider/clinic named above, any rejections in writing as they apply to my lack of PIP or UM/UIM coverage. I allege that electronic signatures are not adequate proof of rejection, and are invalid to establish rejection, and instruct my carrier to provide only copies of my original signature regarding rejection as evidence of rejection of PIP or UM/UIM.

TERMINATION OF CARE: I hereby acknowledge and understand that if I do not keep appointments as recommended to me by my caring doctor at this clinic, he/she has full and complete right to terminate responsibility for my care and relinquish any disability granted me within a reasonable period of time. If during the course of my care, my insurance company requires me to take an examination from any other doctor, I will notify this physician/facility immediately. I understand the failure to do so may jeopardize my case.

Signature of Patient and/or Responsible Parties:

_____ Date: _____

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4810 W. Panther Creek Dr. The Woodlands, TX 77381
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Prestige Spinal Care

H.I.P.A.A Open Door Policy & Group Insurance Disclaimer

It is the policy of this office to keep patient information confidential regarding care. We are required to transfer information regarding insurance related care to the carrier regarding patient diagnosis, history; exam findings care plans, prognosis, and patient status. It is our office policy to render our services for patients in an open room which may be visible to anyone in the reception area. This is both for patient/doctor safety. It is possible for others in the reception area to overhear your protected health information during administration of care. If you need to speak with the doctor about a matter which must be kept private, let us know in advance and we will make allowances for the discussion to be held behind a closed door.

The financial policy for Prestige Spinal Care is that all services must be paid at the time services rendered unless prior arrangement has been made. We strive to keep fees affordable. When we have to bill a third party and wait for payment, our fees must be adjusted for the added time & expense incurred for billing.

We only bill Auto P.I.P, Health insurance, and LOP (from attorney) Claims. Pre-Payment for advanced visits are ALWAYS accepted. I have read and understand the above stated policies and agree to abide by them and authorize the administration of my care to this facility.

Signed _____ Date _____