Goldsboro Spine Center
605 N Spence Ave Goldsboro
NC 27534

GOLDSBORO™ SPINE CENTER

Phone: 919-751-0555
Fax: 919-751-3001
www.goldsborospinecenter.com

Date

First Name:	Last Name:	Date of Birth:
Home Phone:	Mobile Phone:	Work Phone:
@E-mail:	Preferred Communication: ☐H ☐M ☐W ☐E@	
Street Address:		Apt/Suite:
City:	Zip Code:	State:

SSN:	**Gender:** ☐♀ Female ☐♂ Male	**Preferred Language:** ☐ English ☐ _____

Race & Ethnicity:

☐ American Indian or Alaska Native
☐ Asian
☐ Black or African American
☐ White
☐ Hispanic or Latino
☐ Native Hawaiian or Other Pacific Islander
☐ Other: _____

Marital Status:

☐ Single ☐ Married
☐ Divorced ☐ Widowed
☐ Other: _____

Emergency Contact Name: Phone: Relationship:

Employer/Company Name:	Phone:
Street Address:	Apt/Suite:
City:	Zip Code: State:
Job Title/Position:	**Currently Working:** ☐ Yes ☐ No ► Date Stopped Working:

Reason For Your Visit

☐ Wellness & Health Maintenance
☐ Injury, Pain Complaint, or Ailment

Date Of Injury (When Did Your Pain Start?)

Please Provide Brief Details Of Your Injuries & Pain:

Are You A Smoker?	☐ Yes ☐ No	If Yes ► How Often? _____ / Day / Week
Do You Drink Alcohol?	☐ Yes ☐ No	If Yes ► How Often? _____ / Day / Week
Do You Exercise?	☐ Yes ☐ No	If Yes ► How Often? _____ / Day / Week

Medical Conditions: (Check all that apply to you)

☐ Arthritis ☐ Cancer ☐ Diabetes ☐ Heart Disease
☐ Hypertension ☐ Psychiatric Illness ☐ Skin Disorder ☐ Stroke
☐ Fibromyalgia ☐ Asthma ☐ Osteoporosis

Surgeries: (Check all that apply to you)

☐ Appendectomy ☐ Cardiovascular procedure ☐ Cervical spine ☐ Hysterectomy
☐ Joint Replacement ☐ Prostate ☐ Lumbar spine ☐ Gall Bladder
☐ Brain ☐ Shoulder ☐ Thoracic spine ☐ Knee
☐ Carpal Tunnel ☐ Gastro-intestinal ☐ Urogenital Hernia ☐ Breast Augmentation
☐ Other: _____

Allergies: (Check all that apply to you)

☐ Mold ☐ Seasonal ☐ Milk or Lactose Animal
☐ Sulfites ☐ Wheat/Glutens Other ☐ Chemical

Social History: (Check all that apply to you)

Caffeine use:	☐ occasional	☐ often	☐ never
Drink Water:	☐ <64 oz/day	☐ >64 oz/day	☐ never
Sleep:	☐ <8 hours/night	☐ >=8 hours/night	☐ Insomnia

Family History: (Check all that apply)

Arthritis:	☐ Parent	☐ Sibling Cancer:	☐ Parent	☐ Sibling
Diabetes:	☐ Parent	☐ Sibling Heart Disease	☐ Parent	☐ Sibling
Hypertension:	☐ Parent	☐ Sibling Stroke	☐ Parent	☐ Sibling
Thyroid:	☐ Parent	☐ Sibling	☐ Other _____	

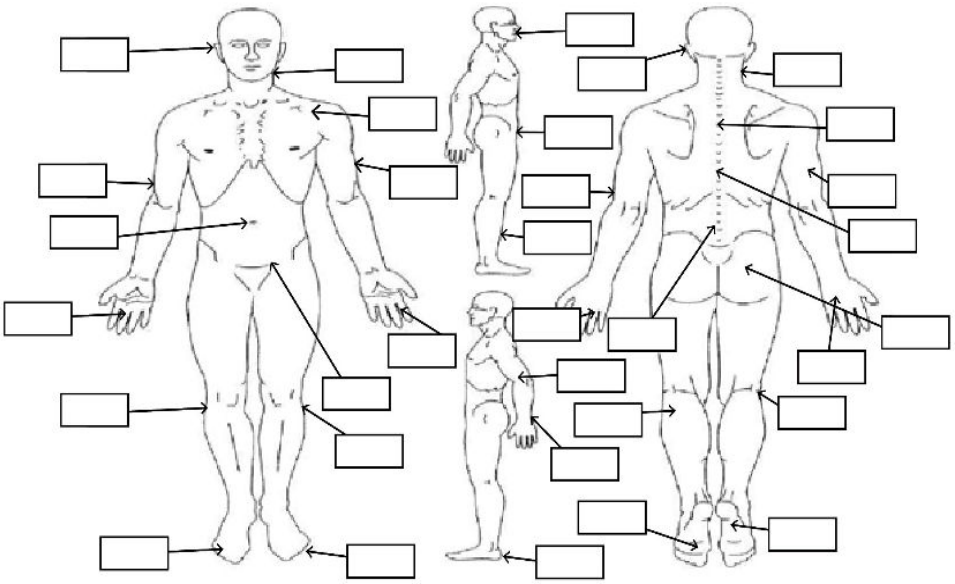
Are You Pregnant? (Check) No

At this time, to the best of my knowledge, I am not pregnant, and I consent to radiographic pictures if necessary.

Signature:_____ Date: _____

By using the key below, indicate on the body diagram where you are experiencing the following symptoms:

N=Numbness **B=Burning** **S=Sharp** **T=Tingling** **A=Dull Ache**



Average Pain Intensity:

Last 24 hours: ☐ no pain ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ worst pain

Past week: ☐ no pain ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ worst pain

Does anything improve your pain? ☐ Yes ☐ No

If Yes, please list: _____

When did your symptoms begin? _____

Are your symptoms a result of:

☐ Motor Vehicle Accident ☐ Work related Accident ☐ Other_____

How did your symptoms begin? _____

How are your symptoms changing?

☐ Getting better ☐ Not changing ☐ Getting worse

PAYMENT POLICY

Thank you for choosing Goldsboro Spine Center as your chiropractic provider. We are committed to providing you with quality and affordable health care. Due to some of the questions our patients have regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask any questions you may have, and sign in the space provided below. A copy will be provided to you upon request.

01 INSURANCE. We participate in most insurance plans, including Medicare. If you are not insured by a plan we participate with, payment in full is expected at each visit. If you are insured by a plan we do participate with, but do not have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility, please contact your insurance company with any questions you may have regarding your coverage. If your insurance company requires a referral it is your responsibility to provide us with a referral dated the day of your first visit from your primary care physician prior to your first visit. We are only able to provide a summary of your chiropractic benefits.

02 CO-PAYMENT AND DEDUCTIBLES. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help is in upholding the law by paying your co-payment at each visit.

03 PROOF OF INSURANCE. All patients must complete out patient information form before seeing the provider. We must obtain a copy of your most current insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

04 CLAIM SUBMISSION. We will submit your claims and assist you in any way we reasonably can to help get your claim paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance pays your claim. Your insurance benefits are a contract between you and your insurance company; we are not party to that contract.

05 COVERAGE CHANGES. If your insurance coverage changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 90 days, the balance will automatically be billed to you.

06 MISSED APPOINTMENT. Our policy is to charge $30.00 after one missed appointment not cancelled 24 hours in advance. The charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regular scheduled appointment.

07 RETURNED CHECK. There will be a $25.00 returned fee for any returned checks.

08 X-RAYS. X-rays remain property of this office and cannot be released.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. I have read and understood the payment policy and agree to abide by its guidelines. In order to maximize your treatment at Goldsboro Spine Center, group therapy is required as part of the treatment process. Disclosure of Private Health Information is required in order to carry out this procedure. A signature below states that you release the use of the information under HIPAA guidelines. A signature will also authorize consent to release your health information to your insurance company, which allows them to make any contributions to your care directly to Goldsboro Spine Center, and gives us limited power of attorney to endorse any check made out to you for services rendered by our office to you on your behalf.

ASSIGNMENT OF BENEFITS / ERISA AUTHORIZED REPRESENTATIVE FORM

FINANCIAL RESPONSIBILITY

I have requested professional services from Goldsboro Spine Center, 605 N. Spence Avenue Goldsboro, NC 27534 ("Provider") on behalf of myself and/or my dependents, and understand that by making this request, I am responsible for all charges incurred during the course of said services. I understand that all fees for said services are due and payable on the date services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement unless other arrangements have been made in advance.

Assignment of Insurance Benefits

I hereby assign all applicable health insurance benefits to which I and/or my dependents are entitled to Provider. I certify that the health insurance information that I provided to Provider is accurate as of the date set forth below and that I am responsible for keeping it updated.

I hereby authorize Provider to submit claims, on my and/or my dependent's behalf, to the benefit plan (or its administrator) listed on the current insurance card I provided to Provider, in good faith. I also hereby instruct my benefit plan (or its administrator) to pay Provider directly for services rendered to me or my dependents. To the extent that my current policy prohibits direct payment to Provider, I hereby instruct and direct my benefit plan (or its administrator) to provide documentation stating such non- assignment to myself and Provider upon request. Upon proof of such non-assignment, I instruct my benefit plan (or its administrator) to make out the check to me and mail it directly to Provider. 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 Provider to: (1) release any information necessary to my health benefit plan (or its administrator) regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (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 Provider to the full extent permissible under law and under any applicable insurance policy and/or employee health care benefit plan, as my Authorized Representative: (1) the right and ability to act on my behalf in connection with any claim, right, or cause in action that I may have under such insurance policy and/or benefit plan; and (2) the right and ability to act on my behalf 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 to act on my behalf in 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 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.

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

NOTICE OF PRIVACY PRACTICES

Purpose: This form, Notice of Privacy Practices, presents the information that federal law requires us to give our patients regarding our privacy practices.

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you. Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations.

Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement*

I, _____, have received and had the opportunity to review a copy of Goldsboro Spine Center's Notice of Privacy Practices. I understand that the Notice describes the uses and disclosures of my protected health information and informs me of my rights with respect to my protected health information.

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify) : _____

Signature:_____Date:_____

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. Record charges are as follows: $.75 pages 1-25, $.50 pages 26-100, $.25 pages 100+. If you request an alternative format, we will charge a cost- based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before September 12, 2016. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Dr. Wayne Wagner
Address: 605 N. Spence Avenue Goldsboro, NC 27534
Telephone: (919)751-0555
Fax: (919)751-3001
Email: records@goldsborospinecenter.com

INFORMED CONSENT TO TREATMENT

I hereby request and consent to the performance of chiropractic treatments (also known as chiropractic adjustments or chiropractic manipulative treatments) and any other associated procedures.

I understand, as with any health care procedures, that there are certain complications, which may arise during chiropractic treatments. Those complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, Horners' syndrome, diaphragmatic paralysis, cervical myelopathy and cost vertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to complications including stroke.

I do not expect the doctor to be able to anticipate all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure(s) which the doctor feels at the time, based upon the facts then known, that are in my best interest.

I have had an opportunity to discuss with the doctor(s) named above and/or with office personnel the nature, purpose and risks of chiropractic treatments and other recommended procedures. I have had my questions answered to my satisfaction. I also understand that specific results are not guaranteed.

I have read (or have had read to me) the above explanation of the chiropractic treatments.

By signing below, I state that I have been informed and weighed the risks involved in chiropractic treatment at this health care office. I have decided that it is in my best interest to receive chiropractic treatment. I hereby give my consent to that treatment. I intend for this consent to cover the entire course of treatment for my present condition(s) and for any future conditions(s) for which I seek treatment.

Signature:_____ Date: _____

PATIENT FINANCIAL RESPONSIBILITY FORM

Thank you for choosing Goldsboro Spine Center as your healthcare provider. We are committed to providing you with the highest quality healthcare. We ask that you read and sign this form to acknowledge your understanding of our patient financial policies.

Patient Financial Responsibilities:

The patient (or patient's guardian, if minor) is ultimately responsible for the payment for treatment and care. We will bill your insurance for you, however the patient is required to provide the most correct and updated information regarding insurance. Patients are responsible for payment of copays, coinsurance, deductibles and all other procedures or treatment not covered or approved by their insurance plan. Copays are due at the time of service. Coinsurance, deductibles and non-covered items are due 30 days from receipt of billing.

Signature:_____Date:_____

HIPAA COMPLIANT AUTHORIZATION FOR THE RELEASE OF PATIENT INFORMATION PURSUANT TO 45 CFR 164.508

TO:
Goldsboro Spine Center
605 N Spence Avenue Goldsboro, NC 27534

I authorize and request the disclosure of all protected information for the purpose of review and evaluation in connection with a legal claim. I expressly request that the designated record custodian of all covered entities under HIPAA identified above disclose full and complete protected medical information including the following:

- ☐ All medical records, meaning every page in my record, including but not limited to: office notes, face sheets, history and physical, consultation notes, inpatient, outpatient and emergency room treatment, all clinical charts, r ports, order sheets, progress notes, nurse's notes, social worker records, clinic records, treatment plans, admission records, discharge summaries, requests for and reports of consultations, documents, correspondence, test results, statements, questionnaires/histories, correspondence, photographs, videotapes, telephone messages, and records received by other medical providers.
- ☐ All physical, occupational and rehab requests, consultations and progress notes.
- ☐ All disability, Medicaid or Medicare records including claim forms and record of denial of benefits.
- ☐ All billing records including all statements, insurance claim forms, itemized bills, and records of billing to third party payers and payment or denial of benefits for the period _____ to_____.

I understand the information to be released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), and alcohol and drug abuse. I authorize the release or disclosure of this type of information.

This authorization is given in compliance with the federal consent requirements for release of alcohol or substance abuse records of 42 CFR 2.31, the restrictions of which have been specifically considered and expressly waived.

I understand the following: See CFR §164.508(c)(2)(i-iii)

a. I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization.

b. The information released in response to this authorization may be re-disclosed to other parties.

c. My treatment or payment for my treatment cannot be conditioned on the signing of this authorization.

Any facsimile, copy or photocopy of the authorization shall authorize you to release the records requested herein. This authorization shall be in force and effect until two years from date of execution at which time this authorization expires

Authorization, Release & Explanation

Goldsboro Spine Center
605 N Spence Ave
Goldsboro, NC 27534
Phone: 919-751-0555
Fax: 919-751-3001
HIPAA compliant email: records@goldsborospinecenter.com

Medical Notes and X-ray Release

I hereby acknowledge the release of any and all medical records and diagnostic testing to Goldsboro Spine Center and Dr. Wayne Wagner for the treatment of my condition.

Patient Name (printed): _____

Date of Birth: _____

Signature: _____

Date: _____

Witness Signature: _____

Date: _____