reviewed for completeness

<<staff initials

Welcome

North Shore Spine & Rehab

500 West Cummings Park Suite 6400
Woburn, MA 01801

ph# 781-938-9400 fax# 781-938-9323

★ this section-mandatory Tell us about You

if there is anything you are not comfortable completing, please leave it blank & discuss with the staff

Today's Date _____

Patient Name _____
last first mi nickname?

Birthdate age **gender>** ☐ **male** ☐ **female**

Guardian Name if Minor _____

relationship

Mailing Address _____

City _____ state _____ zip _____

Home Ph# _____

Cell Ph# _____

Work Ph# _____ ext# _____

Other Ph# _____

E-Mail Address _____

It helps to get to know you & what you do & if any of it impacts the reasons you're here today...

Where do you work? _____

what do you do? _____

how long have you been doing that? _____

ARE YOU >> ☐ minor ☐ single ☐ married ☐ divorced ☐ widowed

Spouse's Name _____

Do you have kids? ☐ no ☐ yes If yes, how many?

☐ **I DO NOT HAVE HEALTH INSURAI** ☐ **I HAVE HEALTH INSURANC**

Insurance Info

circle ALL that applies to you

>>>continue if you have health insurance>>>

BCBS UNITED AETNA HPHC TUFTS CIGNA other _____

MEDICARE MEDEX AARP other SR plan(s) _____

MASSHEALTH NETWORK HEALTH other state plan(s) _____

Are you the Policy Holder ? YES NO

if you aren't the policy holder, please complete this section

★ Policy Holder Name _____

★ Relation _____ ★ their DOB / /

★ different address?

Is Visit related to *(circle if appl)* **Car Accident** **Work Injury**

If so, please be sure to present any insurance or attorney info you may have upon your first visit... thanks

Please be sure to present any ins cards you hold at your visit-copy required for file

Please fill out everything that applies Reason for Visit

if the questions below do not apply, you are not sure of the answers or you are uncomfortable answering any of them, please leave it blank & discuss with the staff

The reason for this visit is a result of (please circle) work sports auto trauma chronic other

Explain what happened _____

since onset, have you experienced any of the following: check all that apply...

☐ loss of range of motion if checked, what body part? _____

☐ visual disturbance if checked, please explain _____

☐ dizziness if checked, how often? _____

☐ anxiety if checked, how often? _____

☐ depression if checked, how often? _____

☐ difficulty sleeping if checked, how often? _____

If auto - did you go to ER? If YES, on your own or by ambulance?

When did condition begin? / /

Is this condition getting worse? ☐ yes ☐ no ☐ constant ☐ comes & goes

Is this condition interfering with your (please circle) work sleep daily routine

If so, please explain _____

Have you had this or similar conditions in the past? ☐ yes ☐ no

If so, please explain _____

Have you been treated for this condition? ☐ yes ☐ no

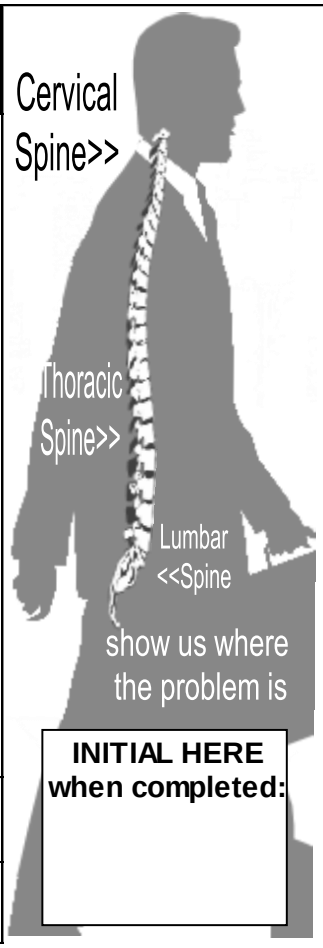
If so, where? how long?

I have participated in the following treatments/therapies(circle all that apply)

chiropractic accupuncture physical therapy pain clinic orthopedic surgery massage therapy other_____

I would be interested in the following treatments/therapies in this facility (circle any that apply)

chiropractic accupuncture spinal decompression NutriMost



INITIAL HERE when completed:

ALL PATIENTS MUST COMPLETE A MEDICAL HISTORY

PERSONAL MEDICAL HISTORY

please check all that apply (up to and including today)

- Alcohol/Drug Abuse
- Allergies
- Anemia
- Arthritis
- Artificial Bones/Joints
- Artificial Valves
- Asthma
- Blood Pressure-high/low
- Cancer
- Chemotherapy
- Colitis
- Congenital Heart Defect
- COPD
- Diabetes
- Difficulty Breathing
- Digestive Issues
- Earaches
- Emphysema
- Epiliepsy/Seizures
- Fainting/Dizziness
- Headaches
  - *migraine*
  - *tension*
  - *other*
- Heart Attack/Stroke
- Heart Murmur
- Heart Surgery
- Hepatitis
- HIV / AIDS
- Kidney Issues
- Mitral Valve Prolapse
- Pacemaker
- Pain- Arms/Hands
- Pain- Back
- Pain - Legs/Feet
- Pain- Neck
- Pain- Other
- Pain- Other
- Psychiatric Condition(s)
- Rheumatic Fever
- Shingles
- Sinus Problems
- Skin Condition(s)
- Tuberculosis
- Ulcers
- Venereal Diseases
- other
- other

MEDICATIONS that I am taking…

☐ muscle relaxers	☐ blood pressure meds
☐ stimulants	☐ insulin / diabetes meds
☐ tranquilizers	☐ inhalers / oxygen
☐ psychiatric meds	☐ vitamins
☐ seizure medication	☐ herbal / natural supplements
☐ other	☐ other
☐ other	☐ other
☐ other	☐ other

do you exercise? ☐ yes ☐ no

do you smoke? ☐ yes ☐ no

do you wear contacts? ☐ yes ☐ no

do you have dentures? ☐ yes ☐ no

do you use hearing aids? ☐ yes ☐ no

do you use cane / other? ☐ yes ☐ no

do you use heel/arch supports? ☐ yes ☐ no

how old is your mattress?

Primary Care Physician or Group

Address

Phone#

Fax#

Emergency Contact Info

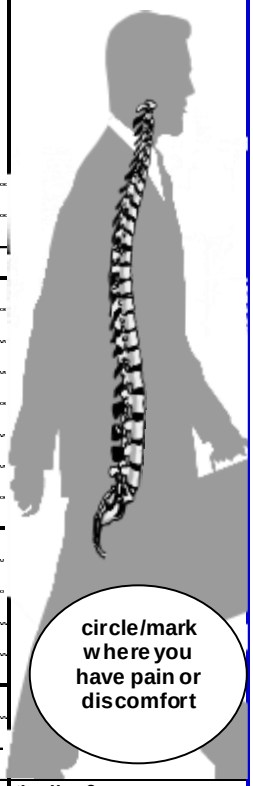
Name

Phone#

relationship

Have you had any surgeries?if yes, give approx dates & outcome

Have you had any serious accidents in the past? (when?)



tingling?

numbness?

tightness?

stiffness?

other?

WOMEN ONLY

are you/could you be pregnant? ☐ yes ☐ no any concerns you'd like to address?

have you recently given birth? ☐ yes ☐ no

if yes, are you nursing? ☐ yes ☐ no

are you menopausal? ☐ yes ☐ no

are you on hormones or meds? ☐ yes ☐ no

menopausal alternatives? ie;herbs,etc ☐ yes ☐ no

FAMILY MEDICAL HISTORY-please tell us about any illnesses in your family

condition_____relative_____year_____

condition_____relative_____year_____

condition_____relative_____year_____

condition_____relative_____year_____

if you've answered yes to anything above, or checked 'OTHER' please feel free to provide more detail in this section…

I have completed my health information and history to the best of my knowledge/ability.

Should I experience any changes in my health, medications or conditions, I realize that it is my responsibility to inform my health care provider(s)

PRINT patient NAME & _____ SIGN patient name _____ date

COMPLETE ALL SHADED AREA on ALL PAGES IF PATIENT IS A MINOR or UNABLE TO COMPLETE ON THEIR OWN (incapacitated, impaired)

parent/guardian/ rep print _____ parent/guardian/ rep sign _____

North Shore Spine & Rehab

500 West Cummings Park / Suite 6400 / Woburn, MA 01801 781-938-9400

AOB - ASSIGNMENT OF BENEFITS BY A PATIENT TO A PHYSICIAN

Complete only 1 of the top 2 boxes ~ BCBS patients & patients involved in an accident - complete box 3 as well

If minor child or unable to complete paperwork a Parent, Guardian or Representative's Signature is required

In accordance with Chapter 272 of the Acts of 1988, we are now required to obtain information regarding other health benefits (HMO, Medicare, Health Ins, etc.) available to you before we can process your claim for personal injury benefits (P.I.P.) Any medical expenses in excess of $2,000.00 will not be paid under P.I.P. If those expenses will be compensated, paid or indemnified by an outside carrier (HMO, Medicare, Health Ins, etc.). Bills submitted for Payment over the $2,000.00 limit must be accompanied by a statement from your health carrier as to their reason for non-payment.

I DID NOT HAVE AN ACCIDENT

Only check one below

❑I have Health Ins. **Chiropractic Care is a covered benefit**. A copy of my ins card(s) will be taken for my file. I hereby assign to my physician in this facility, all benefits for such services, which I may be entitled to under any insurance policy. I request all benefits be paid directly to my physician in this facility upon submission of an appropriately completed claim form.

❑I have Health Ins. My benefits **do not include** chiropractic care. **I am responsible** for cost of services.

❑**I do not have any health ins**. **I am responsible** for cost of services.

PRINT NAME & DOB SIGN NAME DATE

COMPLETE SHADED AREA IF PATIENT IS A MINOR or PATIENT IS UNABLE TO COMPLETE ON THEIR OWN

parent/guardian/rep print name _____ parent/guardian/rep sign name _____ Date _____

I HAD AN ACCIDENT

date of my accident: Mo _____ day_____ year_____

I will be treating in this facility for injuries sustained in the accident. A copy of any ins cards I hold will be taken for my file. I hereby assign to my physician in this facility, all benefits for such services, which I may be entitled to under any insurance policy. I request all benefits be paid directly to my physician in this facility upon submission of an appropriately completed claim form.

Only check one below

❑I have health ins. **Chiropractic Care is a covered benefit.** A copy of my card was taken for my file

❑My health ins **does not include** chiropractic care. A copy of my card will be taken for my file.

❑**I do NOT have any health ins**

PI WAIVER / Medical Practitioner's Lien - NOTICE OF MEDICAL LIEN – MASS GENERAL LAW – Chapter 111 – Section 70B-70D
On Behalf of North Shore Spine (Dr. Michael Pendolino) – 500 West Cummings Park – Suite 6400 - Woburn, MA 01801

I acknowledge that I have read, understand, attest and agree to the contents of this section and this page… I am aware that if/when the P.I.P. benefits are exhausted, my care/treatment will be billed through any other health insurance that I may carry, which is usual. In the event that my insurance fails to cover costs of services/care rendered and billed, I understand that I will be held responsible for the expenses of my care in this facility and that any/all unpaid charges will be my responsibility. As well, I understand that if I have an open/pending or settled/unsettled case (related to my injuries) that a medical provider's lien is appropriate and that this document shall serve as such. Pursuant to the forgoing statute, notice is herby given that the provider of medical services, North Shore Spine & Rehab (Dr. Michael Pendolino) has a lien for services furnished to the injured person, whose name, address and date of injury are set forth herein, signed and agreed with pertinent information including injured person/patient, other responsible persons (alleged-liable persons), insurance companies, entities, legal representatives, etc(when available/applicable).

PRINT patient name / address/ dob / ph#_____

Ins Co / Claim # / Date of Injury_____

Attorney Name / Ph# _____

Ins Co / Claim# of alleged liable person(s)_____

PRINT NAME & DOB SIGN NAME DATE

COMPLETE SHADED AREA IF PATIENT IS A MINOR or PATIENT IS UNABLE TO COMPLETE ON THEIR OWN

parent/guardian/rep print name _____ parent/guardian/rep sign name _____ Date _____

I HAVE BCBS and/or I had an accident (waiver of non-covered services of my health insurance)

I have been in an accident … I have read this section… Some Insurance plans are limited or specific regarding your available benefits.

It has been brought to my attention that my health insurance may not cover all chiropractic services that will be performed and billed by North Shore Spine & Rehab. I have been informed that should any/all non-covered services fail to be covered/paid by my health insurance, it will be my responsibility, specifically procedure codes 97010, 57014 and 99070 may/can be billed back to my PIP carrier for re-imbursement or may be subject to a doctor's lien.

PRINT NAME & DOB SIGN NAME DATE

COMPLETE SHADED AREA IF PATIENT IS A MINOR or PATIENT IS UNABLE TO COMPLETE ON THEIR OWN

parent/guardian/rep print name _____ parent/guardian/rep sign name _____ Date _____

I am a BCBS MEMBER... I have read this section…. Specifically in regards to Blue Cross Blue Shield (typically policies beginning with the prefix MTN or MTP, but not limited to) it is required to obtain authorization for treatment beyond 12 visits. I am aware that *Healthways Whole Health Network* may not authorize further treatment and I have been notified prior to the service being rendered that I am responsible for payment of said services and if my injury/condition is the result of an accident and/or that these services may/can be billed back to my PIP carrier for re-imbursement as well.

PRINT NAME & DOB SIGN NAME DATE

COMPLETE SHADED AREA IF PATIENT IS A MINOR or PATIENT IS UNABLE TO COMPLETE ON THEIR OWN

parent/guardian/rep print name _____ parent/guardian/rep sign name _____ Date _____

Account Info

Person responsible for account-In the event ins terminates or you opt for non-covered services & acknowledge costs of same

Please Print Name _____ Relationship(ie; self, spouse, child) _____ **initial here**

Address _____

phone# _____ work or other ph _____

by signing this page below, I authorize assignment of my insurance benefits to this provider. If I have no coverage of these services through my health insurance or have no health insurance at all, I acknowledge that I am responsible for the cost of services provided to me. I agree to compensate this facility for care and will make payments per visit or arrangements with the administrative staff for payment options and plans.

Consent to Contact

Please let us know the best way to contact you if we need to reach you for anything

I prefer that you use the following number(s)…. | is there a bad time of day to call you? | **initial here**

☐ home phone ☐ cell phone ☐ work phone

please do not call me… use the following… ☐ email ☐ mail ☐ other

Consent to Share Information with Facility Staff/Providers

According to HIPAA privacy act, you're entitled to restrict communication and use of your information within this facility if you so choose. Should you decide to initiate care/treatment/visits with any providers, herein, of the other services available (such as decompression, weight loss program(s) or acupuncture) in this facility and would like your files shared among the providers herein, please authorize these actions by initialing this section. **initial here**

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE INVOLVES YOUR PRIVACY RIGHTS & DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED/DISCLOSED & HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION-REVIEW CAREFULLY – Full text version of these regulations is available/posted in the waiting area. As a rule NORTH SHORE SPINE & REHAB dba Woburn Family Chiropractic (heretofore represented as NSSR) will not disclose your information obtained from your contacts, your file/records here, or the fact that you are my patient, except with your written consent. However, there are some important exceptions to this rule of confidentiality - some exceptions created voluntarily by policies in this office, and some required by law. Only in cases of dire emergency when your medical information may be critical to your care elsewhere (ie; E.R.) and you are unable to communicate any information, only then will your medical information be released in order to benefit your care elsewhere in an emergency or critical care situation. If you wish to receive services in this facility, under Federal HIPAA regulations, you must sign this form indicating that you understand and accept NSSR policies about confidentiality and its limits. NSSR will discuss these issues with you now. As well, you may reopen the conversation at any time during treatment. In general, no persons are privileged to review your medical information without written permission.

By signing below, I acknowledge that I give permission to those listed above to receive/provide information regarding my care. I also acknowledge that I understand my HIPAA rights as described above and posted in the waiting area of this facility.

PRINT> patient name & dob _____ SIGN > patient name _____ date _____

COMPLETE SHADED AREA IF PATIENT IS A MINOR or PATIENT IS UNABLE TO COMPLETE ON THEIR OWN

parent/guardian/rep print name _____ parent/guardian/rep sign name _____

RECORD OF DISCLOSURE OF PROTECTED HEALTH INFORMATION

All persons listed below are privileged to receive and/or provide (as specified) information regarding this patient, their records, reports, notes, films and any other information requested. By adding names and facilities below, you are allowing them and us to view and share that information regarding your care as specified.

*(1) Check box one if you are authorizing this person / facility/ provider to receive/provide/share information for this patient

*(2) Type of info Requested:"T"/treatment records "P"/payment records "O"/healthcare operations

*(3) Enter method preferred or used for the disclosure requested, received or sent (ie; fax / mail / e-mail / any/all acceptable, etc)

date	disclosure/request TO/FROM (name/ph/fax/etc)	purpose	by whom	*(1)	*(2)	*(3)

PRINT> patient NAME & _____ SIGN > patient name _____ date _____

COMPLETE SHADED AREA IF PATIENT IS A MINOR or PATIENT IS UNABLE TO COMPLETE ON THEIR OWN

parent/guardian/rep print name _____ parent/guardian/rep sign name _____