BAILEY SPINE & WELLNESS

224 Southpark Circle East
St. Augustine, FL 32086
904-342-4941

Name:	☐ Male ☐ Female	Today's Date:
Address:	City/State/Zip:	
Home Phone: ( )	Cell Phone: ( )	Work Phone: ( )
Age: Social Security#:	Date of Birth:	Marital: ☐ M ☐ S ☐ D ☐ W
Occupation:	Employer:	Name of Spouse:
Number of Children:	Ages of Children:	Email:
Insurance type: ☐ Health ☐ Medicare ☐ Medicaid ☐ Car accident ☐ Workers' Compensation ☐ Other		
Emergency Contact:	Phone:	
Who is your primary Care Physician?	Phys City:	
Who may we thank for referring you to our office?		

List medications you are currently taking (prescription and non-prescription:_____

_____

_____

List Previous Surgeries?_____

_____

Is there any chance you are pregnant? ☐ Yes ☐ No

Do you have allergies? ☐ Yes ☐ No If so, what to?_____

Are you allergic to: ☐ Eggs ☐ Chicken ☐ Feathers ☐ Iodine ☐ Lidocaine type products ☐ Latex

Family history

If any blood relative has had any of the following conditions, please check and indicate which relative(s):

□ Alcoholism □ Anemia □ Arteriosclerosis □ Arthritis □ Asthma □ Bleeds easily

□ Cancer □ Diabetes □ Emphysema □ Epilepsy □ Heart disease □ Thyroid

□ Multiple sclerosis □ Osteoporosis □ Stroke □ High Blood Pressure □ High Cholesterol

Name: _____

ARE YOU HERE FOR WELLNESS OR A SYMPTOM? ☐ Wellness ☐ Symptom

Where is your pain?	**Neck**	**Mid or Low back** (PLEASE CIRCLE ONE)	**Other** (SPECIFY)
Which **SIDE** of the body is your PAIN?	Right Left Both	Right Left Both	Right Left Both
Is Pain DULL or SHARP? Or is there a BETTER WORD to describe the pain? (PLEASE CIRCLE ONE or FILL IN)	Sharp Dull Burning Tightness	Sharp Dull Burning Tightness	Sharp Dull Burning Tightness
Rank your pain AT IT'S WORST. 10 = Most Severe Pain 1=Very Mild Pain (PLEASE CIRCLE ONE)	AT IT'S WORST? 1 2 3 4 5 6 7 8 9 10	AT IT'S WORST? 1 2 3 4 5 6 7 8 9 10	AT IT'S WORST? 1 2 3 4 5 6 7 8 9 10
Pain is CONSTANT or COMES & GOES? (PLEASE CIRCLE ONE)	constant comes & goes	constant comes & goes	constant comes & goes
Is there a TIME OF DAY when your pain is worse? (PLEASE CIRCLE ONE)	No Morning Afternoon Evening	No Morning Afternoon Evening	No Morning Afternoon Evening
HOW LONG have you had this condition?			
What CAUSED your condition or is the cause UNKNOWN?			
What makes your pain WORSE? Ex. (Sitting at computer, Standing)			
What makes your pain BETTER? Ex. (Medication, lying down)			
Does the pain RADIATE into your ARM? LEG? Or into another area?	Yes No	Yes No	Yes No

Do you have other complaints NOT listed above?

1._____

2._____

3._____

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PAST MEDICAL HISTORY: Do you, or, have you ever had any of these conditions/symptoms:

Musculoskeletal:
☐ Neck pain
☐ Middle back pain
☐ Lower back pain
☐ Hip Joint pain
☐ Knee pain
☐ Ankle pain
☐ Foot pain
☐ Shoulder pain
☐ Elbow pain
☐ Wrist pain
☐ Hand pain
☐ Jaw pain
☐ Tense/Painful muscles

Neurological:
☐ Radiating pain arm(s)
☐ Radiating pain leg(s)
☐ Weakness/tingling arms
☐ Weakness/tingling legs
☐ Loss of smell/taste
☐ Loss of memory
☐ Dizziness
☐ Fainting
☐ Depression
☐ Epilepsy
☐ Loss of Balance
☐ Ringing in the ears
☐ Blurred Vision
☐ Sensitivity to Light
☐ Numbness in hands
☐ Numbness in feet
☐ Mental disorders
☐ Dyslexia
☐ Anxiety

Head & ENT:
☐ Frequent sinus troubles
☐ Hay fever
☐ Frequent colds
☐ Frequent sore throats
☐ Chronic ear infections
☐ Swollen lymph nodes
☐ Inflammation in throat
☐ Eye or vision problems
☐ Allergies

Cardiovascular:
☐ High blood pressure
☐ Low blood pressure
☐ Heart attack
☐ Chest pain
☐ Coronary artery disease
☐ Leg pain upon walking
☐ Swollen legs/feet
☐ Varicose veins
☐ Shortness of breath
☐ Stroke

Respiratory:
☐ Apnea
☐ Asthma
☐ Pneumonia
☐ Emphysema
☐ Difficulty breathing
☐ Wheezing
☐ Tuberculosis
☐ Snoring issues
☐ Other_____

Gastrointestinal:
☐ Abdominal pain
☐ Gall bladder problems
☐ Black or bloody stool
☐ Liver disease
☐ Jaundice
☐ Bloating
☐ Changes in bowl habits
☐ Nausea
☐ Vomiting
☐ Pancreatitis
☐ Colitis
☐ Colon Cancer
☐ Colon Polyps
☐ Difficulty swallowing
☐ Severe diarrhea
☐ Food sensitivities
☐ Reflux
☐ Diabetes
☐ Heartburn

Genitourinary:
☐ Blood in urine
☐ Kidney stones
☐ Incontinence
☐ Painful urination
☐ Bladder infections
☐ Urinary tract infections
☐ Frequent urination
☐ Kidney disease
☐ Venereal disease
☐ Prostate problems
☐ Other_____

Endocrine:
☐ Diabetes
☐ Excessive thirst
☐ Increase in urination
☐ Adrenal problems
☐ Fatigue
☐ Heat/cold intolerance
☐ Thyroid problems
☐ Testosterone deficiency

Derm. and Hematopoietic:
☐ Bleeding tendency
☐ Hyper/hypo pigmentation
☐ Anemia
☐ Easy bruising
☐ Skin rashes
☐ Psoriasis
☐ Skin cancer
☐ Excessive acne
☐ Other_____

Immune:
☐ Allergies

Diseases:
☐ Measles
☐ Mumps
☐ Chicken Pox
☐ Small Pox
☐ Rheumatic Fever
☐ Scarlet Fever
☐ Diphtheria
☐ Polio

PATIENT SOCIAL:

Alcohol:	☐Daily	☐Weekly	☐Occasionally	☐Never	Drugs:	☐Daily	☐Weekly	☐Occasionally	☐Never
OTC Stimulants:	☐Daily	☐Weekly	☐Occasionally	☐Never	Exercise:	☐Daily	☐Weekly	☐Occasionally	☐Never
Homemade Food:	☐Daily	☐Weekly	☐Occasionally	☐Never	Processed Food:	☐Daily	☐Weekly	☐Occasionally	☐Never
Soft Drinks:	☐Daily	☐Weekly	☐Occasionally	☐Never	Tobacco:	☐Daily	☐Weekly	☐Occasionally	☐Never
Water:	☐Daily	☐Weekly	☐Occasionally	☐Never					
Caffiene:	☐Daily	☐Weekly	☐Occasionally	☐Never					

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

_____ _____

Signature of the Patient, Parent or Guardian Date

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HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been our practice for years. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.

6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.

7. We agree to provide patients with access to their records in accordance with state and federal laws.

8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.

9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, _____ (Full Name) hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

Signature _____ Date _____

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BAILEY SPINE& WELLNESS LLC.

224 South Park Circle East, Saint Augustine, FL, 32086

Ph: (904) 342-4941

ASSIGNMENT OF HEALTH PLAN BENEFITS AND RIGHTS
AS WELL AS AN APPOINTMENT AND/OR DESIGNATION AS MY PERSONAL REPRESENTATIVE
AND AN ERISA/PPACA REPRESENTATIVE AND BENEFICIARY

I understand and agree that (regardless of whatever health insurance or medical benefits I have), I am ultimately responsible to pay **Bailey Spine & Wellness LLC.** as well as all employees, employers, representatives, and agents thereof, (hereinafter collectively referred to as "Healthcare Provider") the balance due on my account for any professional services rendered and for any supplies, tests, or medications provided. I hereby authorize payment of, and assign my rights to, any health insurance or medical plan benefits directly to Healthcare Provider for any and all medical/healthcare services, supplies, tests, treatments, and/or medications that ***have been*** **or** ***will be*** rendered or provided; as well as designating and appointing Healthcare Provider as my beneficiary under all health insurance or medical plans which I may have benefits under. I hereby authorize the release of any health status, conditions, symptoms or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other remedies necessary in connection with same. I hereby assign directly to Healthcare Provider all rights to payment, benefits, and all other legal rights under, or pursuant to, any health plan (including, but not limited to, any ERISA governed plan/insurance contract, PPACA governed plan/insurance contract) rights that I (or my child, spouse, or dependent) may have under my/our applicable health plan(s) or health insurance policy(ies). I also hereby appoint and designate that Healthcare Provider can act on my/our behalf, as my/our Personal Representative, ERISA Representative, and PPACA Representative as to any claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals and/or legal action (including in my name and on my behalf) to obtain and/or protect benefits and/or payments that are due (or have been previously paid) to either Healthcare Provider, myself, and/or my family members as a result of services rendered by Healthcare Provider, and to pursue any and all remedies to which I/we may be entitled, including the use of legal action against the health plan, the insurer, or any administrator. I hereby also declare that Healthcare Provider is my/our beneficiary regarding my/our health plan as contemplated by both ERISA and PPACA, and that Healthcare Provider can pursue any and all rights that I/we may have under state and/or federal law regarding my/our health plan. This assignment, appointment, and designation will remain in effect unless revoked by me in writing. *It is my intent that the effective date of this document shall relate back to include all services, supplies, test, treatments, or medications that have been previously provided by Healthcare Provider.* A photocopy or scan or this document is to be considered as valid and as enforceable as the original.

Signed this _____ day of _____, 20 ____. X_____
(patient signature)

X_____ X_____
(signature of Guardian if applicable) (please print patient name)