Signe Spine & Rehab
New Patient Information

Please give any XR, CT, or MRI Discs to Front Desk Upon Check-In

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Patient Demographic Information

Name: _____ **DOB**: _____ **Gender**: _____

Address: _____ **City**: _____ **State**: _____ **Zip**: _____

Social Security Number: _____ **Marital Status (Circle): Single☐ Divorced☐ Widowed☐ Married☐**

Home Phone: _____ **Cell Phone**: _____ **Email**: _____

May we leave a message? YES☐NO☐ **May we email? YES☐NO☐**

Race: _____ **Language**: _____ **Circle: Hispanic☐ Non-Hispanic☐**

Emergency Contact: _____ **Relation**: _____ **Phone**: _____

Preferred Pharmacy: _____ **Address**; _____

How Did You Hear About Us? _____

Insurance Information: ***Please provide copy of Insurance Card(s)***

Primary Insurance

Company: _____ **Policy #**: _____ **Group #**: _____

If you are not Policy Holder: **Subscriber Name**: _____ **Birthdate**: _____

Secondary Insurance

Company: _____ **Policy #**: _____ **Group #**: _____

If you are not Policy Holder: **Subscriber Name**: _____ **Birthdate**: _____

If you have Medicare, are you working? YES☐NO☐ If you have Medicare, are you disabled? YES☐NO☐

Are you at a Skilled Nursing Facility? YES☐NO☐ If yes, Name of Facility _____

Please Fill Out This Section About Your Illness or Injury.

What is the Reason for Your Visit Today? _____

Date of Injury/When did the Pain Start? _____ **What side (Circle): LEFT☐RIGHT☐**

Where Did it Happen? (Circle):

School	Work	Home	Auto Crash	Other: _____

Are You Currently Working? YES ☐ NO☐

Is this a Worker's Compensation Injury? YES☐ NO☐ Was an Incident Report Filed with Supervisor? YES☐NO☐

Is there Legal Action or An Attorney Concerning this Injury? YES☐ NO☐ Name of Attorney: _____

ONLY fill this section out if the patient is a CHILD or FULL TIME STUDENT

Mother's Name _____ **Father's Name**_____

Guardian's Name _____ **Relation to Patient** _____

I acknowledge that by providing insurance information, I have asked and promised to pay for services provided in exchange for this information. I assign to Signe Spine & Rehab, LLC, all health insurance benefits available for services provided to me. I understand that fees for service provided by Signe Spine & Rehab, LLC are my responsibility and I agree to pay any balance left unpaid by any insurance company or third-party entity immediately upon notification of said balance. If I do not have insurance, I understand that I am responsible for any incurred expenses in their entirety.

Patient/Guardian Signature_____ Date_____

OFFICE & FINANCIAL POLICIES FOR SIGNE SPINE & REHAB, LLC

Payment for Services
Copays will be collected at check-in, as well as any balance due on the account. We will pre-collect the estimated patient responsibility amounts for any procedures and/or imaging services.

Insurance
Insurance information will be updated once a year and we may request your card at each visit. Please notify of any change in carrier, coverage, or cards. Failure to disclose policy changes may result in claim denial and financial charges will become the patient's responsibility. The patient is responsible for knowing the benefits and limitations of their insurance plan.

Referrals
Signe Spine & Rehab, LLC is a specialty practice. If your plan(s) require a referral from your primary care physician (family or regular doctor) for specialty services to be covered, please make sure one has been provided prior to your appointment. Patients who do not have a required referral can either reschedule or be self-pay.

Copays, Deductibles, Co-Insurance, and Payment for Services
Any outstanding account balances will be collected at check-in. Many insurance plans require that we collect copays, deductibles, and coinsurances, and if these are unable to be paid at the time of service, a $10 processing fee will be added. In addition, we will collect payments for any services that insurance does not cover at the time of service. Prepayment is required for any estimated costs for procedures, and/or imaging. Signe Spine & Rehab, LLC does not take secondary payer adjustments. If you have a Health Savings Account, Health Reimbursement Account, or Flexible Spending Account, we will provide documentation to receive reimbursement; however, payment is still required at the time of service. The patient is responsible for any copays, deductibles, coinsurances, and any other services that are not covered, including Durable Medical Equipment (braces, etc.) and drug screening.

Uninsured Patients
Payment is due at the time of service unless a pre-arranged payment plan has been agreed upon between patient and practice, at which time a $200 down payment will be required.

Past Due Balances
Balances that are not paid within 30 days are considered in default. If your insurance company has not responded within 30 days, we may request your assistance in obtaining payment or request that you make payment. Balances not paid within 90 days will be forwarded to a collection's agency, and any associated fees will be added to your account. Any balances must be paid in full or subject to a payment plan before any additional services will be rendered.

No Show and Late Cancellation Fees
If you cannot keep an office appointment, **cancellation must be made within 24 hours** or a **$25 fee will be charged.**
Other fees for late cancellations/no shows include: **Office Visit No Show Fee: $25** and **Injection/Procedure No Show Fee: $150**.

Disability or FMLA Forms
A **$25 fee** will be charged for **EACH** form completed by our legal department and may take **up to 15 days** to process. Payment must be made, and the Claimant Information for Disability Benefits form must be submitted before any request is processed.

Electronic Prescribing
Signe Spine & Rehab, LLC uses e-scribing and may access my prescription history to provide the most accurate medication list.

I understand that I am financially responsible for account balances, copays, deductibles, coinsurances, and any services that are not covered, including DME, and drug screening. I understand that I will be charged a fee for any missed appointments or late cancellations. I understand there is a fee for medical records, imaging, disability or FMLA forms.

Patient/Guardian Signature_____ **Date** ____/____/_____

NOTICE OF PRIVACY PRACTICES AND HIPAA PRIVACY AUTHORIZATION

The privacy rights and practices of Signe Spine & Rehab, LLC were established to protect the privacy of our patient's medical records as required by Section 164.520 of the Health Insurance Portability and Accountability Act of 1996. This restricts the release of your medical information to the purpose of treatment, payment, and healthcare operations. This law allows the types of agencies listed below to disclose your medical records.

The release of healthcare information to any other source is prohibited without written consent of the patient or guardian.

- Hospital
- Coroner/Funeral Director
- Surgical Facility
- Judicial Proceeding
- Law Enforcement
- Public Health or Safety Threat
- Report Abuse or Neglect
- Physician Training
- Physical Therapy
- Pharmacy
- Worker's Compensation
- Health Insurance Company
- Physician Consultant
- Lab Testing Facilities
- Health Inspection
- Military/Veteran's Affair

You have the right to:

- Request restrictions on certain uses and disclosures of your medical records
- Inspect and request changes to your medical records.
- Obtain a copy of your medical record.
- Find out what disclosures of your records have been made.
- Receive confidential communications.
- Ask questions about the privacy policy or file a complaint with the Practice Manager without fear of any reprisals if you believe your privacy rights have been violated.

Please indicate the following to assist us in ensuring the privacy of your medical records.

1. I give my permission for Signe Spine & Rehab, LLC to leave messages concerning my medical records and appointment reminders on the following (please check all that apply):

	YES	NO		YES	NO
Text Message	☐	☐	**With Family Members**	☐	☐
Cell/Home Voicemail	☐	☐	**Work Voicemail**	☐	☐
Email	☐	☐	**Chart Sharing**	☐	☐

2. I consent to receive calls from Signe Spine & Rehab, LLC concerning healthcare information at the phone numbers provided. I accept financial responsibility for charges by my phone carrier for these calls. I understand this consent is not required to be a patient, and I may revoke it at any time. **YES☐ NO☐**

3. Can you be contacted at your place of employment? **YES☐ NO☐**

4. The following people have my permission to speak with Signe Spine & Rehab, LLC regarding my medical records and financial account.

   Name_____ Relationship_____
   Name_____ Relationship_____
   Name_____ Relationship_____

5. Electronic prescribing shows all medications a patient has received within the last 13 months, which enhances safety and reduces errors. This service is permitted and protected by HIPAA.

Signe Spine & Rehab, LLC is required by law to abide by the terms outlined in this notice. However, Signe Spine & Rehab reserves the right to change the terms of this Privacy Notice and make the new provisions effective for all protected health information that we maintain. Any changes to this notice will be posted and distributed. For additional questions or to report a problem, please contact our Practice Manager at 843-730-4124.

Patient/Guardian Signature_____ **Date** ____/____/____

Patient Name: _____
DOB: _____

Medical Questionnaire

Height: _____ **Weight**: _____ **Allergies**: _____

Current Medications: _____

_____

List Surgeries & Year: _____

Family History: ***Please list any medical problems involving relatives.***

Father: _____
Mother: _____
Other: _____

Please List Any Conditions You Have Been Diagnosed With (Heart Disease, Kidney Disease, Stomach Ulcer, etc.):

_____

_____

Social History: ***Please circle answers that apply to you & complete.***

Smoking Status	**Never** ☐		**Former Smoker** ☐	**Current Smoker** ☐			**Packs Per Day**: _____	
Cigar/Pipe Use	**YES** ☐	**NO** ☐	**Chewing Tobacco**	**YES** ☐	**NO** ☐	**Hand Dominance**	**Right-handed** ☐	**Left-Handed** ☐
Alcohol Use	**None** ☐	**1-4 drinks per week** ☐		**5-9 drinks/week** ☐		**>10 drinks/week** ☐		
Work History	**Disabled** ☐	**Student** ☐	**Homemaker** ☐	**Retired** ☐	**Unemployed** ☐			
Current Job			**Employer**					

Review of Systems: ***Please Circle Any Problem You are Currently Having.***

Constitutional	Fever ☐ Night sweats ☐ Weight gain ☐	Weight loss ☐ Difficulty exercising ☐	**Genitourinary**	Incontinence ☐ Difficulty urinating ☐ Painful urination ☐	Blood in urine ☐ Increased urinary frequency ☐
Eyes	Dry eyes ☐ Irritation ☐	Changes in vision ☐	**Musculoskeletal**	Muscle aches ☐ Muscle weakness ☐ Joint pain ☐	Back pain ☐ Swelling in extremities ☐
Ears	Difficult hearing ☐	Ear pain ☐	**Psychiatric**	Depression ☐ Sleep disturbance ☐	Alcohol abuse ☐ Drug abuse ☐
Nose	Frequent nosebleeds ☐	Nose/sinus problems ☐	**Neurologic**	Loss of consciousness ☐ Weakness ☐ Numbness ☐ Seizures ☐	Dizziness ☐ Headaches ☐ Migraines ☐ Restless legs ☐
Mouth/Throat	Sore throat ☐ Bleeding gums ☐ Snoring ☐ Dry mouth ☐	Ulcers ☐ Oral abnormalities ☐ Teeth problems ☐	**Skin**	Abnormal mole ☐ Jaundice rash ☐ Itching ☐	Dry skin ☐ Growth/lesion ☐
Cardiovascular	Chest pain ☐ Shortness of breath when walking or ☐ when lying down	Arm pain on exertion ☐ Palpitations ☐ Heart murmur ☐	**Endocrine**	Fatigue ☐ Increased thirst ☐ Hair loss ☐	Increased hair growth ☐ Cold intolerance ☐
Respiratory	Coughing ☐ Wheezing ☐	Shortness of breath ☐ Coughing up blood ☐	**Hematologic/ Lymphatic**	Swollen glands ☐ Easy bruising ☐	Excessive bleeding ☐
Gastrointestinal	Abdominal pain ☐ Vomiting ☐ Loss of appetite ☐	Diarrhea ☐ Vomiting blood ☐	**Allergic/ Immunologic**	Runny nose ☐ Sinus pressure ☐ Itching ☐	Hives ☐ Frequent sneezing ☐

Date: _____
Patient Name: _____
DOB: _____

Pain Questionnaire

Primary Care Provider		**Work Related?**	☐ YES ☐ NO
Referring Provider		**Date of Injury/Incident**	
When Did Your Pain Begin?		**Are You Working Now?**	

Chief Complaints: ***Check Which Side or Both***

Body Part	Right	Left	Body Part	Right	Left	Body Part	Right	Left
Neck	☐	☐	Shoulder	☐	☐	Hip	☐	☐
Mid Back	☐	☐	Elbow	☐	☐	Knee	☐	☐
Low Back	☐	☐	Wrist/Hand	☐	☐	Ankle/Foot	☐	☐

Does Your Pain Radiate (spread to your extremities?) YES☐ NO☐ **If yes, where?** _____

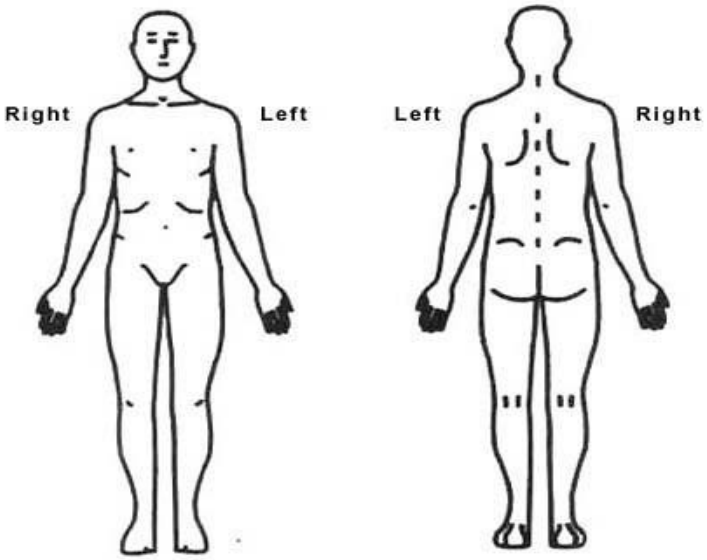
Visual Pain Scale: ***NONE (0☐ 1☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ 8☐ 9☐ 10☐ SEVERE***

What number would you rate your pain today? _____/10
What number would you rate your pain on average? _____/10
What number would you rate your pain at its worse? _____/10

Instructions:

Show areas of Pain in or around the Body using the "Type of Pain" Symbols

Aching	XXXXX
Burning	11111
Stabbing	=====
Numbing	OOOOO
Pins & Needles	/////



Please Circle ALL That Describe Your Pain:

Burning☐	Sharp Stabbing☐	Tingling☐	Aching☐
Shooting☐	Pulling/Tearing☐	Cramping☐	Throbbing☐

My Pain Is	Sudden☐	Gradual☐	Constant☐	Intermittent☐
My Pain is Worse:	Morning☐	Day☐	Afternoon☐	Night☐

My Pain is Worse with:	Walking☐	Running☐	Standing☐	Sitting☐	Bending☐	Lifting☐	Driving☐	Applying Heat☐
	Applying Ice☐	Exercising☐	Lying☐	Changing Positions☐	Sports☐	Overhead activity☐	Nothing☐	Other: _____
My Pain is Better with:	Walking☐	Running☐	Standing☐	Sitting☐	Bending☐	Lifting☐	Driving☐	Applying Heat☐
	Applying Ice☐	Exercising☐	Changing Positions☐	Sports☐	Lying on back/ stomach☐	Lying on side☐	Recliner☐	Other: _____

Because of my Pain, I am unable to:	**Walk over _____ miles or _____ blocks**	**Sit longer than _____ minutes/hours**	**Stand longer than _____ minutes/hours**	**Lift over _____ lbs.**

Patient Name: _____
DOB: _____

Pain Questionnaire Part 2

Do you feel Numbness or Tingling? YES ☐ NO ☐ If yes, where? _____
Do you have a Curve/Mass Near Your Spine? **YES ☐ NO ☐**
Are you experiencing difficulty walking or increased falls? **YES ☐ NO ☐**
Are you experiencing bladder/bowel incontinence/retention? YES ☐ NO ☐

Please indicate if you have had any of the following tests in the last year for your Problem.

Type of Test	Where	When	Body Part
X-Ray			
MRI			
CT Scan			
EMG/NCS			
Other			

Previous Treatment History

Type of Treatment	When/Where & Number of Sessions/Injections	Condition Improved? (Please Circle)		
Physical Therapy		YES ☐	NO ☐	WORSE ☐
Massage		YES ☐	NO ☐	WORSE ☐
Home Health Exercise		YES ☐	NO ☐	WORSE ☐
Chiropractor		YES ☐	NO ☐	WORSE ☐
Epidural Steroid		YES ☐	NO ☐	WORSE ☐
Facet Injection		YES ☐	NO ☐	WORSE ☐
Trigger Point		YES ☐	NO ☐	WORSE ☐
Brace		YES ☐	NO ☐	WORSE ☐
Acupuncture		YES ☐	NO ☐	WORSE ☐
Joint Injection		YES ☐	NO ☐	WORSE ☐

Please list all Medications Used to Treat Problem.

Medication: _____ **Relief? YES ☐ NO ☐**
Medication: _____ **Relief? YES ☐ NO ☐**
Medication: _____ **Relief? YES ☐ NO ☐**
Medication: _____ **Relief? YES ☐ NO ☐**
Medication: _____ **Relief? YES ☐ NO ☐**

Have you had previous surgery for this problem? YES ☐ NO ☐
What procedure was performed? _____
When was the procedure performed? _____
What physician performed the procedure? _____
What percentage (%) relief did you have? _____
Is there anything else you would like the doctor to know? _____
_____
_____

IN OFFICE USE ONLY:

Height (HT)	
Weight (WT)	
Blood Pressure (BP)	
Pulse (P)	
Respiration Rate (RR)	