Integrated Spinal Solutions
Patient Information

Patient Name:	**Today's Date:**
Address:	Home Telephone:
City/State/Zip:	Work Telephone:
Birth Date: Age:	Employer's Name:
Height: Weight:	Employer's Address:
Social Security Number:	
E-Mail:	Primary MD Name & Address
Marital Status: __ Single __ Married __Divorced __Widowed	

Emergency Contact Information

Nearest Adult Relative:	Relation to Patient:
Address:	Phone #:

Insurance Information

Does your insurance cover Chiropractic treatment?	☐ Yes ☐ No If yes, we need a copy of your card
If yes, indicate Insurance Company Name. **If you are being seen for a work related or car accident injury we need the Claim Number and the Claims Adjusters Name.**	Carrier Name: Address: Telephone Number: Claim Number: Claim Adjusters Name:
Are you the insured person or a dependent?	☐ Insured ☐ Dependent (wife/husband/child)
If you are the insured persons dependent (spouse or child), we need the insured persons name, date of birth, social security number, name of the insured employers business and the address of the business.	Name of Insured Person: Social Security Number: Insured Date of Birth: Name of Insured Company Insured Company Address:

As a courtesy, our office will provide insurance billing services for you if you so desire. Please remember that you are ultimately responsible for any charges incurred in this office. ***It is your responsibility to pay any deductible amount, co-pay and or any other balances not paid by your insurance carrier (except for contracted discounts). Your signature on this document indicates that you agree to pay for any outstanding bills incurred in this office.***

IN ORDER TO KEEP OUR OFFICE OVERHEAD DOWN AND KEEP OUR PATIENT FEES REASONABLE, WE REQUIRE PAYMENT AT THE CONCLUSION OF EACH TREATMENT FOR CASH PATIENTS AND THE CO-PAYMENT FOR INSURANCE PATIENTS.

Patient Signature (Parent or responsible party):_____ **Date:** _____

Patient History

Integrated Spinal Solutions
1000 Caughlin Crossing #55 Reno, NV 89519

Date:_____

Patient Name:_____ Age:_____ Height:_____ Weight:_____

ONSET: ☐ This form is for vehicle accident history only. If your injury resulted from something else please let the receptionist know.

☐ **Accident Date**:_____ ☐ Your Occupation: _____

Have you missed time from work? ☐ No ☐ Yes _____

Accident Details: Your position in the vehicle:	☐ I was the Driver ☐ Motorcycle Operator	☐ I was a Passenger: ☐ Front ☐ Rear left ☐ Rear Right ☐ Rear Middle

Impact Details:……	☐ My vehicle was struck		☐ My vehicle struck the other vehicle	
Type of Impact:……	☐ Front End	☐ Rear	☐ Drivers Side Impact	☐ Passenger Side Impact
Seat Belts Used:……	☐ Yes	☐ No		
Did your head or body hit:……	☐ Steering wheel	☐ Door	☐ Windshield	☐ Other: _____
Did you brace for the impact?.....	☐ Yes ☐ No			
Did you lose consciousness?	☐ Yes ☐ No	☐ Not sure		

Your body position when struck?	☐ Looking up. ☐ Looking straight ahead ☐ Both hands in lap ☐ Both hands on steering wheel ☐ Left hand on steering wheel ☐ Right hand on steering wheel ☐ Right hand on gear shift ☐ Head turned right ☐ Head turned left	☐ Body twisted to the left looking at back seat ☐ Body twisted to the right looking at back seat ☐ Body leaning to the right ☐ Body leaning to the left ☐ looking up and right at rear view mirror ☐ Sitting straight up ☐ Slouched in the seat ☐ Head against the head restraint ☐ Leaning forward away from the head restraint

Your Estimated Speed at impact:……....	☐ Stopped ☐ Slow ☐ Slowing ☐ Accelerating ☐ Highway Speed ☐ Other: _____
Other Vehicle's Estimated Speed at impact:...	☐ Slow ☐ Slowing ☐ Posted speed ☐ Excessive ☐ Highway Speed ☐ Other: _____
Head Restraints / Head Rest……	☐ None ☐ Integral Type ☐ Adjustable Type ☐ Up ☐ Down ☐ Don't Know If Adjustable, was the position altered by the crash? ☐ Yes ☐ No
Air Bags: ……	Did the Air Bag Deploy? ☐ Yes ☐ No ☐ Vehicle not equipped with Air Bags.
Seats: ……..	Was the seat back adjustment altered by the crash? ☐ Yes ☐ No Was it Broken? ☐ Yes ☐ No
Estimated property damage to **YOUR** vehicle?	$ _____ ☐ Totaled
Estimated property damage to **OTHER** vehicle?	☐ None ☐ Minimal ☐ Moderate ☐ Major ☐ Totaled

Year Make & Model: …….....	**YOUR** Vehicle: _____	**OTHER** Vehicle: _____

Patient History

Integrated Spinal Solutions

1000 Caughlin Crossing #55 Reno, NV 89519

Prior treatment:	☐ Paramedics / REMSA ☐ ER Visits ☐ Primary MD ☐ Surgeries ☐ Physical Therapy ☐ Specialist ☐ Other:	
	☐ Location of facilities:	☐ Urgent Care ☐ Renown ER ☐ Saint Mary's ER ☐ Northern Nevada Hosp ☐ Other:
Imaging Relating to this complaint:	☐ X-Ray ☐ CT Scan ☐ MRI ☐ Ultrasound ☐ Other_____ ☐ Urgent Care ☐ Renown ER ☐ Saint Mary's ER ☐ Northern Nevada Hosp ☐ Other:	

		Me	Family		Me	Family		Me	Family
Medical History:	☐ Heart Disease ☐ Diabetes ☐ Thyroid Disorder ☐ Liver Disease ☐ Kidney Disease ☐ Tuberculosis ☐ History of Malaria	☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ Herpes Eye Infection ☐ High Blood Pressure ☐ Ulcers ☐ Nerve Disease ☐ Psychiatric Disorders ☐ Depression ☐ Cataracts / Glaucoma	☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ Lung Disease ☐ Seizures ☐ Arthritis ☐ Osteoporosis ☐ Toxin Exposure	☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐

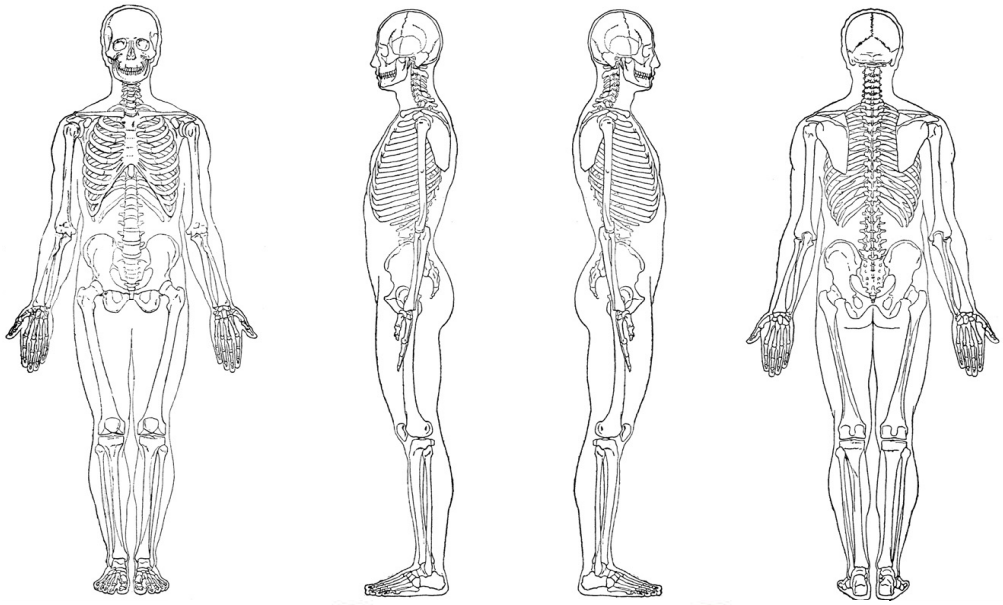
List <u>All</u> Past	☐ Work related Injuries:	
	☐ Car Accidents:	
	☐ Hospitalization:	
	☐ Severe Illnesses:	
	☐ Surgeries:	

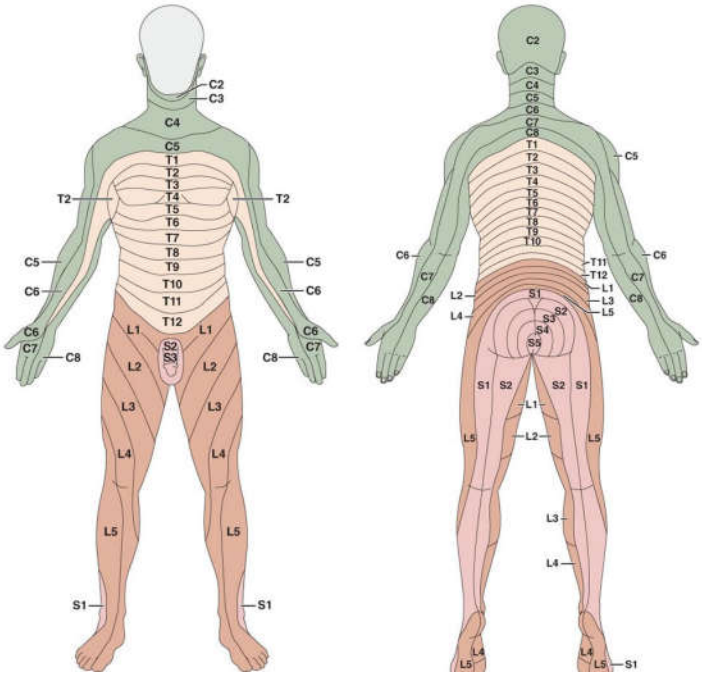
Medications you are currently taking: **Please Initial**	☐ **NSAIDS** ☐ Aspirin ☐ Ibuprofen ☐ Advil ☐ Motrin ☐ Midol ☐ **Naproxen** ☐ Aleve ☐ Naprosyn ☐ **Acetaminophen** ☐ Tylenol ☐ Coedine ☐ Morphine ☐ Fentanyl ☐ Oxycodone ☐ Hydrocodone	☐ **Antidepressants** ☐ Celexa ☐ Prozac ☐ Paxil ☐ Zoloft ☐ **Tricyclic Antidepressants** ☐ Norpramin ☐ Silenor ☐ Trofranill ☐ Pamelor ☐ **Rifampin** ☐ Rifadin ☐ **Seizure Medications** ☐ Dilantin ☐ Phenobarbital ☐ Luminal ☐ Solfoton	Aspirin Diuretics **Warfarin** Coumadin Jantoven **Cyclosporine** Restasis Gengraf Neoral Sandimmune **Insulin** **Ketoconazole** Nizoral Meloxacam Naprosyn	☐ **Muscle Relaxers** ☐ Baclofen ☐ Chloroxazone ☐ Lorzone ☐ Parafone ☐ Soma ☐ Cyclobenzaprine ☐ (Diazepam) Valium Robaxin ☐ _____ ☐ _____ ☐ _____ ☐ _____	

Patient History
Integrated Spinal Solutions
1000 Caughlin Crossing #55 Reno, NV 89519

Please complete the Symptom Diagram below

Mark all areas that you currently have pain:	**Severity** 0 = No pain 10 = Most Severe Pain Ever	**Frequency** 0% = Absent 100% = Constant





☐ Prior episodes of the above complaints?: ☐ No: ☐ : Yes

If Yes then indicate Pain level **BEFORE** crash **0** **1** **2** **3** **4** **5** **6** **7** **8** **9** **10**

Impact on daily Activities

What activities seem to make your pain WORSE?	☐ Standing ☐ Sitting ☐ Walking ☐ Walk up hill ☐ Walk down hill ☐ Bending ☐ Climbing stairs	☐ Stooping ☐ Lay Down ☐ Lifting ☐ Sleeping ☐ Sneezing ☐ Coughing ☐ Exercise	☐ Straining ☐ Reaching ☐ Twisting ☐ Looking up ☐ Looking down ☐ Changing positions ☐ Getting adjusted	☐ Rest ☐ Lying on back ☐ Lying on stomach ☐ Driving ☐ Household chores _____ _____ _____
What activities make you feel BETTER?	☐ Standing ☐ Sitting ☐ Walking ☐ Walk up hill ☐ Walk down hill ☐ Bending ☐ Climbing stairs	☐ Stooping ☐ Lay Down ☐ Lifting ☐ Sleeping ☐ Sneezing ☐ Coughing ☐ Exercise	☐ Straining ☐ Reaching ☐ Twisting ☐ Looking up ☐ Looking down ☐ Changing positions ☐ Getting adjusted	☐ Rest ☐ Lying on back ☐ Lying on stomach ☐ Driving ☐ Household chores _____ _____ _____
Please check all the words that describe your pain:	☐ Local ☐ Radiates ☐ Shoots to legs ☐ Shoots to arms	☐ Shock ☐ Sharp ☐ Dull ☐ Burning	☐ Ache ☐ Tingle ☐ Cramping ☐ Stinging	☐ Stabbing ☐ Throbbing

Mark any of the boxes that apply

☐ I prefer being alone now (not socializing)
☐ I am sleepy, tired during the day or doze off easily
☐ Upset stomach, nausea, heartburn or vomiting
☐ Difficulty concentrating, mind wanders easily
☐ I get overwhelmed easily
☐ Mood swings, happy one moment then sad
☐ Agitation (can't sit still, need to move around)
☐ Sadness, tearful episodes, crying easily
☐ Blurry vision, had to get or change glasses
☐ Asking people to repeat things or hearing problems
☐ I make wrong turns driving or can't remember time
☐ I get confused easily and cannot multi-task anymore
☐ I have difficulty finding some words when talking
☐ Bright lights bother me
☐ I cannot pay attention as long as before
☐ I am eating more or less than normal
☐ Room spins, lightheaded or woozy feeling
☐ Balance problems
☐ I feel like my head is "foggy"
☐ I have forgotten computer passwords or ATM / PIN
☐ I have to re-read things to understand what I read
☐ My thinking is slowed down
☐ Difficulty with adding / subtracting numbers

☐ Difficulty learning new things
☐ Difficulty understanding what people say to me
☐ Difficulty remembering or memory problems
☐ Cannot take on any more responsibilities
☐ I can't make decisions as fast as before
☐ Loss of libido or lack of sexual desire
☐ I do not feel as confident in my abilities
☐ I get panic attacks, fast heartbeat, nervous
☐ I am more irritable than usual
☐ Some food or drink tastes "funny" to me now
☐ I get frustrated very easily
☐ Difficulty planning my life or organizing my work
☐ Flashbacks or frightening thoughts about the accident
☐ I have had bad dreams about the accident
☐ I avoid places and objects that remind me about it
☐ I feel emotionally numb – no interest in my hobbies
☐ I'm feeling strong guilt, worry or depression
☐ I am having trouble remembering the accident
☐ I am easily startled since the accident – "Jumpy"
☐ I feel tense or "on edge" most of the time
☐ I am having difficulty sleeping
☐ I get angry easily or even yell at people now
☐ Fear I will never be the same again

Patient Name (please print): _____

Patient Signature: _____ Date:_____

TERMS OF ACCEPTANCE

Agreement to Financial Policy

I agree to be charged a **missed appointment fee of $30.00** if I miss an appointment without giving at least **24 hours** advance notice. I understand that as the parent or guardian, I am responsible for full payment of my child's care. I further understand that for unaccompanied minors, payment in full is still required at time of service. If I have insurance coverage I hereby assign directly to Integrated Spinal Solutions, pc all medical benefits, if any, payable to me for services rendered. I also understand that there is a 1.5% monthly interest charge on any unpaid balance over one (1) month old. It is at the discretion of the doctor to collect or waive said fee and will depend upon the payment history of the account. By signing below, I agree that should my account be referred to a collection agency or an attorney for collections, I will be directly responsible for paying all reasonable attorney's fees, other legal fees and/or any and all collection expenses.

Patient Accepts Responsibility for Insurance Reimbursements and Approvals

I accept responsibility to know my policy limits and requirements. I further accept responsibility to seek pre-authorization, bill and collect reimbursement from my insurance carrier if applicable. I understand that my insurance policy is a contract between the insurance carriers and myself. I further understand that Integrated Spinal Solutions, pc is in no way a guarantee of coverage or reimbursement from my insurance carrier. I further understand that my health insurance will be billed as a courtesy but that I am ultimately responsible for payment. I understand that some or perhaps all of the services that I receive may not be considered reasonable and necessary under the Medicare program and/or other insurance plans. I understand that insurance claims that are over 90 days old and unpaid, will become my responsibility. By my presence and continuation of appointments, I consent and elect care provided by Integrated Spinal Solutions.

Patient Will Truthfully and Fully Disclose Health Status and History

I hereby state that all information that I hereby give Integrated Spinal Solutions/DiMuro Pain Management, and/or its staff will be complete and truthful. I will not misrepresent my presence, nature, severity or cause of my injuries. I further state that I will fully disclose my health history and authorize the release of all past medical records to Integrated Spinal Solutions/DiMuro Pain Management,. I present myself for health reasons only and it is not my intent to mislead, defraud or coerce this office or any third party or misrepresent myself in any manner. I agree and herby give consent to Integrated Spinal Solutions/DiMuro Pain Management, to release and share any information as it relates to the settlement of my case or payment of a claim.

Patient Consents to Care and Accepts Responsibility

I consent to recommendations and care by the Doctor(s) and other Providers of Integrated Spinal Solutions/DiMuro Pain Management, for myself (or my children if minors) including, but not limited to examinations, x-rays, chiropractic adjustments, rehabilitative and physical therapy Pain Management and or Behavioral Health. I understand that my care will be individualized to me and therefore may not be comparable to standards or guidelines used or required by insurance companies, professional associates, and/or consensus groups. I understand that my treatment will comply with the inherent risks. These risks, though rare, could occur ranging from minor aggravation of current condition to serious conditions such as cerebral vascular accident or death. I am signing this consent after having been fully informed to my satisfaction by the Doctor(s) and Providers of Integrated Spinal Solutions/DiMuro Pain Management, and/or its staff of the risks and benefits of the care and the risks and benefits of not having the recommended treatment. I have been informed and fully understand that there are no guarantees of treatment success. By my presence and continuation of appointments, I consent and elect to care provided by Doctor(s) and Providers of Integrated Spinal Solutions/DiMuro Pain Management, and/or its staff.

Medicare Limits and Responsibilities Advance Notice

The only charge for Chiropractic that is covered by Medicare is manual manipulation of the spine. **I also understand that Medicare requires an initial Examination be preformed but provides no payment for such.** I accept responsibility to pay for all covered, non-covered or denied services. I accept responsibility to know the current Medicare guidelines and limits for covered services. I have been notified by my physician that he believes that in my case Medicare is likely to deny payment for some services. If Medicare denies payment, I agree to be personally and fully responsible for payment. I understand that I must pay for services at the time of treatment. I also understand that Integrated Spinal Solutions/DiMuro Pain Management, will bill all charges directly to Medicare as required by law. I authorize the release of my records as necessary for Medicare Billing.

I have read, understand and agree to the provisions and terms of acceptance. This agreement shall become effective upon signing and be irrevocable for the full extent of my treatment by the doctor.

Patient Name (please print): _____

Patient Signature: _____ Date:_____

LOW BACK PAIN QUESTIONNAIRE (OSWESTRY)

Please read: This questionnaire is designed to enable us to understand how much your **LOW BACK PAIN** has affected your ability to manage your everyday activities. Please answer each section by circling the ONE CHOICE that most applies to you. We realize that you may feel that more than one statement may relate to you, but PLEASE, JUST MARK THE ONE CHOICE WHICH MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.

SECTION 1 - Pain Intensity

- ☐ 0 The pain comes and goes and is very mild.
- ☐ 1 The pain is mild and does not vary much.
- ☐ 2 The pain comes and goes and is moderate.
- ☐ 3 The pain is moderate and does not vary much.
- ☐ 4 The pain comes and goes and is severe.
- ☐ 5 The pain is severe and does not vary much.

SECTION 2 - Personal Care

- ☐ 0 I do not have to change my way of washing or dressing in order to avoid pain.
- ☐ 1 I do not normally change my way of washing or dressing even though it causes some pain.
- ☐ 2 Washing and dressing increases the pain but I manage not to change my way of doing it.
- ☐ 3 Washing and dressing increases the pain and I find it necessary to change my way of doing it.
- ☐ 4 Because of the pain I am unable to do some washing and dressing without help.
- ☐ 5 Because of the pain I am unable to do any washing and dressing without help.

SECTION 3 - Lifting

- ☐ 0 I can lift heavy weights without extra pain.
- ☐ 1 I can lift heavy weights but it causes extra pain
- ☐ 2 Pain prevents me from lifting heavy weights off the floor.
- ☐ 3 Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g., on a table
- ☐ 4 Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ☐ 5 I can only lift very light weights at the most.

SECTION 4 - Walking

- ☐ 0 I have no pain on walking.
- ☐ 1 I have some pain on walking but it does not increase with distance.
- ☐ 2 I cannot walk more than one mile without increasing pain.
- ☐ 3 I cannot walk more than 1/2 mile without increasing pain.
- ☐ 4 I cannot walk more than 1/4 mile without increasing pain.
- ☐ 5 I cannot walk at all without increasing pain.

SECTION 5 -Sitting

- ☐ 0 I can sit in any chair as long as I like.
- ☐ 1 I can sit only in my favorite chair as long as I like.
- ☐ 2 Pain prevents me from sitting more than one hour.
- ☐ 3 Pain prevents me from sitting more than 1/2 hour.
- ☐ 4 Pain prevents me from sitting more than 10 minutes.
- ☐ 5 I avoid sitting because it increase the pain right away.

SECTION 6 -Standing

- ☐ 0 I can stand as long as I want without pain.
- ☐ 1 I have some pain on standing but it does not increase with time.
- ☐ 2 I cannot stand for longer than one hour without increasing pain.
- ☐ 3 I cannot stand for longer than 1/2 hour without increasing pain.
- ☐ 4 I cannot stand for longer than 10 minutes without increasing pain.
- ☐ 5 I avoid standing because it increases the pain immediately.

SECTION 7 -Sleeping

- ☐ 0 I get no pain in bed.
- ☐ 1 I get pain in bed but it does not prevent me from sleeping well.
- ☐ 2 Because of pain my normal night's sleep is reduced by less than 1/4.
- ☐ 3 Because of pain my normal night's sleep is reduced by less than 1/2.
- ☐ 4 Because of pain, my normal night's sleep is reduced by less than 3/4.
- ☐ 5 Pain prevents me from sleeping at all.

SECTION 8 - Social Life

- ☐ 0 My social life is normal and gives me no pain.
- ☐ 1 My social life is normal but increases the degree of my pain.
- ☐ 2Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.
- ☐ 3 Pain has restricted my social life, and I do not go out very often.
- ☐ 4 Pain has restricted my social life to my home.
- ☐ 5 I have hardly any social life because of the pain.

SECTION 9 - Travel

- ☐ 0 I get no pain while traveling.
- ☐ 1 I get some pain while traveling, but none of my usual forms of travel make it any worse.
- ☐ 2 I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
- ☐ 3 I get extra pain while traveling, which compels me to seek alternative forms of travel.
- ☐ 4 Pain restricts all forms of travel.
- ☐ 5 Pain prevents all forms of travel except that done lying down.

SECTION 10 - Changing degree of pain

- ☐ 0 My pain is rapidly getting better.
- ☐ 1 My pain fluctuates but overall is definitely getting better.
- ☐ 2 My pain seems to be getting better but improvement is slow
- ☐ 3 My pain is neither getting better nor worse.
- ☐ 4 My pain is gradually worsening.
- ☐ 5 My pain is rapidly worsening.

PATIENT NAME (PRINT): _____ **DATE**: _____

Patient Signature: _____ **LOW BACK PAIN**

NECK PAIN DISABILITY INDEX QUESTIONAIRE

Please read: This questionnaire is designed to enable us to understand how much your **NECK PAIN** has affected your ability to manage your everyday activities. Please answer each section by circling the ONE CHOICE that most applies to you. We realize that you may feel that more than one statement may relate to you, but PLEASE, JUST MARK THE ONE CHOICE WHICH MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.

SECTION 1 - Pain Intensity

- ☐ 0 I have no pain at the moment.
- ☐ 1 The pain is very mild at the moment.
- ☐ 2 The pain is moderate at the moment.
- ☐ 3 The pain is fairly severe at the moment.
- ☐ 4 The pain is very severe at the moment.
- ☐ 5 The pain is the worst imaginable at the moment.

SECTION 2 - Personal Care (washing, dressing, etc)

- ☐ 0 I can look after myself normally without causing extra pain.
- ☐ 1 I can look after myself normally, but it causes extra pain.
- ☐ 2 It is painful to look after myself; I am slow and careful.
- ☐ 3 I need some help but manage most of my personal care.
- ☐ 4 I need help every day in most aspects of self-care.
- ☐ 5 I do not get dressed; I wash with difficulty and stay in bed.

SECTION 3 - Lifting

- ☐ 0 I can lift heavy weights without extra pain.
- ☐ 1 I can lift heavy weights, but it gives me extra pain.
- ☐ 2 pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned for example on a table.
- ☐ 3 pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ☐ 4 I can with only very light weights.
- ☐ 5 I cannot lift or carry anything at all.

SECTION 4 - Reading

- ☐ 0 I can read as much as I want to with no pain in my neck.
- ☐ 1 I can read as much as I want to with slight pain in my neck.
- ☐ 2 I can read as much as I want with moderate neck pain.
- ☐ 3 I can't read as much as I want because of moderate neck pain.
- ☐ 4 I can hardly read at all because of severe pain in my neck.
- ☐ 5 I cannot read at all.

SECTION 5 -Headaches

- ☐ 0 I have no headaches at all.
- ☐ 1 I have slight headaches that come infrequently.
- ☐ 2 I have slight headaches that come frequently.
- ☐ 3 I have moderate headaches that come infrequently.
- ☐ 4 I have moderate headaches that come frequently.
- ☐ 5 I have headaches almost all the time.

SECTION 6 -Concentration

- ☐ 0 I can concentrate fully when I want to with no difficulty.
- ☐ 1 I can concentrate fully when I want to with slight difficulty.
- ☐ 2 I have a fair degree of difficulty in concentrating when I want to.
- ☐ 3 I have a lot of difficulty in concentrating when I want to.
- ☐ 4 I have a great deal of difficulty in concentrating when I want to.
- ☐ 5 I cannot concentrate at all.

SECTION 7 -Work

- ☐ 0 I can do as much work as I want to.
- ☐ 1 I can only do my usual work, but no more.
- ☐ 2 I can do most of my usual work, but no more.
- ☐ 3 I cannot do my usual work.
- ☐ 4 I can hardly do any work at all.
- ☐ 5 I can't do any work at all.

SECTION 8 - Driving

- ☐ 0 I can drive my car without any neck pain.
- ☐ 1 I can drive my car as long as I want with slight pain in my neck.
- ☐ 2 I can drive my car as long as I want with moderate pain in my neck.
- ☐ 3 I can't drive my car as long as I want because of moderate pain in my neck.
- ☐ 4 I can hardly drive at all because of severe pain in my neck.
- ☐ 5 I can't drive my car at all.

SECTION 9 - Sleeping

- ☐ 0 I have no trouble sleeping.
- ☐ 1 My sleep is slightly disturbed (less than one hour sleeplessness).
- ☐ 2 My sleep is mildly disturbed (1-2 hours sleepless).
- ☐ 3 My sleep is moderately disturbed (2-3 hours sleepless).
- ☐ 4 My sleep is greatly disturbed (3-5 hours sleepless).
- ☐ 5 My sleep is completely disturbed (5-7 hours sleepless).

SECTION 10 -Recreation

- ☐ 0 I am able to engage in all my recreation activities with no neck pain at all.
- ☐ 1 I am able to engage in all my recreational activities, with some pain in my neck.
- ☐ 2 I am able to engage in most, but not all of my usual of recreational activities because of pain in my neck.
- ☐ 3 I am able to engage in a few of my recreational activities because of pain in my neck.
- ☐ 4 I can hardly do any recreational activities because of pain in my neck.
- ☐ 5 I can't do any recreational activities at all.

PATIENT NAME (PRINT): _____ **DATE**: _____

Patient Signature: _____ **NECK PAIN**

Personal Injury Financing Options

Accidents happen and dealing with the pain of an injury can be stressful enough without the headache of figuring out how to pay for your care. We will make ever reasonable effort to ease you through this process and deal with the insurance to the extent possible. Please select which payment option works best for you. Our staff will provide you with the appropriate paperwork once it is clear how you wish to proceed.

At Fault

____ **Cash**
I wish to pay for each visit as I come in.

_____**Med Pay**
My car insurance has coverage I wish to utilize.
Med Pay may be utilized regardless of fault.
Covers 100% of your care up to policy max.
Utilizing will not affect your insurance rate.

_____**Group Health**
I do not want to file an accident claim.
I elect to have you bill my Health Ins.
I understand I must pay my deductible and cop-pay at time of service.
I understand that I may be giving up rights to file a claim later.

Not At Fault

_____**Cash**
I wish to pay for each visit as I come in.

_____**Med Pay and a Lien**
My car insurance has coverage I wish to utilize.
Can be used regardless of fault.
Covers 100% of your care up to policy max.
Utilizing will not affect your insurance rate.
I am willing to sign a lien against my settlement to receive the care that I require.

_____**Lien with representation**
I have or soon will be represented by an Attorney.
I am willing to sign a lien against my settlement to receive the care that I require.
My Attorney will pay my medical bills from my settlement.

_____**Lien without representation**
I do not wish to be represented by an Attorney.
I am willing to provide a credit card as security for my payment.
I will pay for my care once my case is settled.
I understand my credit card will be billed in the event I do not keep my account current.

_____**Group Health**
I do not want to file an accident claim.
I elect to have you bill my Health Ins.
I understand I must pay my deductible and cop-pay at time of service.
I understand that I may be giving up rights to file a claim later.

Patient Signature: _____ Date: _____

POINTS TO KEEP IN MIND WHEN DEALING WITH INSURANCE

1. Language takes on a different context when dealing with insurance companies.
2. It is best **NOT TO** discuss the state of your health with any insurance representative.
3. Respectfully direct the insurance representative to contact your doctors' office for updates.