PATIENT INFORMATION

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

E-mail _____

City _____

State _____ Zip _____

Sex ☐ M ☐ F Age _____

Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Patient Employer/School _____

Occupation _____

Employer/School Address _____

_____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

INSURANCE INFORMATION

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with

_____ and assign directly to
Name of Insurance Company(ies)

Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____
Date Relationship to Patient

PHONE NUMBERS

Cell Phone (_____) _____ Home Phone (_____) _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship _____

Home Phone (_____)_____ Work Phone (_____) _____

ACCIDENT INFORMATION

Is condition due to an accident? ☐ Yes ☐ No Date _____

Type of accident ☐ Auto ☐ Work ☐ Home ☐ Other

To whom have you made a report of your accident?
☐ Auto Insurance ☐ Employer ☐ Worker Comp. ☐ Other

Attorney Name (if applicable) _____

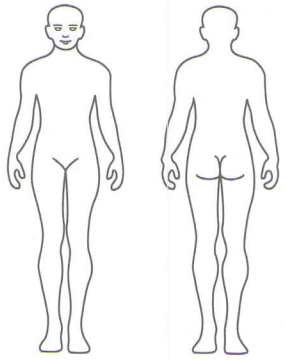
PATIENT CONDITION

Reason for Visit _____

When did your symptoms appear? _____

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.



Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

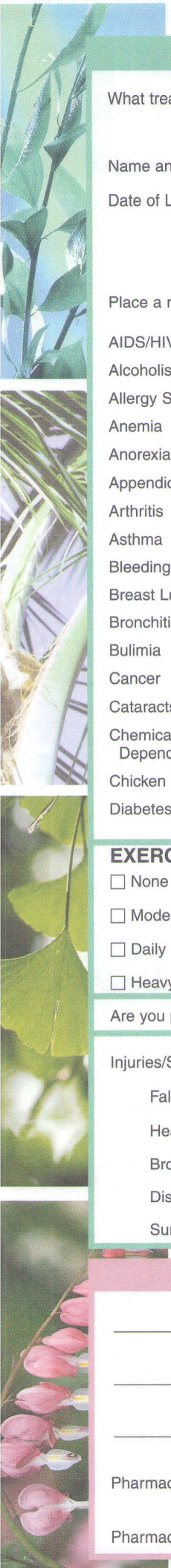
Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting
☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities or movements that are painful to perform ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down



HEALTH HISTORY

What treatment have you already received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therapy

☐ Chiropractic Services ☐ None ☐ Other _____

Name and address of other doctor(s) who have treated you for your condition _____

Date of Last: Physical Exam _____ Spinal X-Ray _____ Blood Test _____

Spinal Exam _____ Chest X-Ray _____ Urine Test _____

Dental X-Ray _____ MRI, CT-Scan, Bone Scan _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes ☐ No	Emphysema	☐ Yes ☐ No	Migraine Headaches	☐ Yes ☐ No	Sexually Transmitted Disease	☐ Yes ☐ No
Alcoholism	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No	Miscarriage	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Allergy Shots	☐ Yes ☐ No	Fractures	☐ Yes ☐ No	Mononucleosis	☐ Yes ☐ No	Suicide Attempt	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Multiple Sclerosis	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No
Anorexia	☐ Yes ☐ No	Goiter	☐ Yes ☐ No	Mumps	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Appendicitis	☐ Yes ☐ No	Gonorrhea	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	Gout	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No	Tumors, Growths	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Heart Disease	☐ Yes ☐ No	Parkinson's Disease	☐ Yes ☐ No	Typhoid Fever	☐ Yes ☐ No
Bleeding Disorders	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No	Pinched Nerve	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No
Breast Lump	☐ Yes ☐ No	Hernia	☐ Yes ☐ No	Pneumonia	☐ Yes ☐ No	Vaginal Infections	☐ Yes ☐ No
Bronchitis	☐ Yes ☐ No	Herniated Disk	☐ Yes ☐ No	Polio	☐ Yes ☐ No	Whooping Cough	☐ Yes ☐ No
Bulimia	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	Prostate Problem	☐ Yes ☐ No	Other _____
Cancer	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Prosthesis	☐ Yes ☐ No	
Cataracts	☐ Yes ☐ No	High Cholesterol	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No	
Chemical Dependency	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Rheumatoid Arthritis	☐ Yes ☐ No	
Chicken Pox	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No	
Diabetes	☐ Yes ☐ No	Measles	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No	

EXERCISE

☐ None
☐ Moderate
☐ Daily
☐ Heavy

WORK ACTIVITY

☐ Sitting
☐ Standing
☐ Light Labor
☐ Heavy Labor

HABITS

☐ Smoking Packs/Day _____
☐ Alcohol Drinks/Week _____
☐ Coffee/Caffeine Drinks Cups/Day _____
☐ High Stress Level Reason _____

Are you pregnant? ☐ Yes ☐ No Due Date _____

Injuries/Surgeries you have had	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

MEDICATIONS

_____
_____
_____

Pharmacy Name _____

Pharmacy Phone (____) _____

ALLERGIES

_____
_____
_____
_____
_____

VITAMINS/HERBS/MINERALS

_____
_____
_____
_____
_____

Advanced Health Center

46 South Glebe Road, Suite 100
Arlington, VA 22204
Tel: 703-521-0644

Treatment Consent and Financial Policy Agreement

Thank you for choosing our physicians for your health care needs. We are committed to providing the very best medical care and successful treatment. The following is a statement of our Treatment Authorization and Financial Policy which you must read, agree, and sign prior to treatment. Our Treatment Authorization and Financial Policy apply to all services by our physicians. In order to provide medical treatments and bill for your services, we must have you complete this form at least once a year.

Patient Responsibilities and Financial Policies:

Provide Accurate Information: You have a responsibility to provide accurate and complete information about your health history, mailing address, health insurance and other billing information. If any information changes – name, address, phone, insurance coverage, etc. – you must inform our practice immediately. Insurance denials or billing errors due to patient supplied information will result in the transfer of the account balance to the patient's immediate financial responsibility.

Know Your Insurance Coverage, Benefits and Referral Requirements: Your health insurance is a contract between and you and your health insurance plan(s). Patients are responsible for understanding their health insurance coverage(s), benefits, referrals and pre-authorization requirements.

Patient with Private Insurance: Our office will file claim(s) to the insurance companies we contract with, provided that you authorize the 'assignment of benefits' for payment directly to our practice. For participating insurance plans, the practice will accept payment based on contractual agreements. Any coverage or payment dispute is a matter between the insurance policyholder and the insurance company.

Self-Pay Patients: Patients without insurance coverage are expected to pay in full for services received at the time of service.

Consent for Treatment: I authorize medical treatments for myself or my minor child by physicians and medical assistants at Advanced Health Center.

Patient Payment Agreement: I understand that I am financially responsible to **Internal Medicine of Arlington / Advanced Back and Neck P.C.** for all charges regardless of third-party involvement. I agree to pay any deductible, co-insurance, co-payments, or services deemed as "non-covered" by my insurance carrier at the time of service. If my insurance has not paid on my account in 75 days, the outstanding services will become my responsibility for immediate payment. Should any balances arise due to insurance co-payments, co-insurance, deductibles, termination of coverage, or non-payment at time of service and/or any other reason; I agree to pay all charges within 30 days from the date that the amount due is billed. I understand that failure to pay outstanding balances or make payment arrangements within 90 days will result in the amount due being considered delinquent and subject to legal action or assignment to a collection agency.

In consideration for medical services rendered, I acknowledge receiving notice of the financial policy and agree to pay for said medical services according to the above terms. My signature below indicates that I have read and agree to the treatment consent and financial policy stated above.

_____

Please Print Name of the Patient

_____ _____

Signature of Patient or Legal Guardian **Date**

Advanced Health Center

An Advanced approach to great health care

IRREVOCABLE ASSIGNMENT OF BENEFITS, AUTHORIZATION AND LIEN

To Whom It May Concern:

This Irrevocable Assignment of Benefits, Authorization and Lien (this "Assignment") is made by and between _____ ("Patient") and Advanced Back & Neck Pain Center, P.C. . With this Assignment, and in consideration of treatment without having to render concurrent payment, Patient, hereby irrevocably transfers sets over and assigns to Advanced Back & Neck Pain Center, P.C. all insurance and/or litigation proceeds to which Patient is now or may hereafter become entitled, including those listed below, up to the total amount due and owing Advanced Back & Neck Pain Center, P.C. for services rendered to the Patient by reason of accident or illness, including interest thereon, as well as any other charges that are due or may become due Advanced Back & Neck Pain Center, P.C. , including, without limitation, requested reports, collection costs and expenses and attorney's fees, and Patient further hereby irrevocably authorizes and directs any insurance company and/or attorney to whom an original or copy of this Assignment is provided to withhold from Patient and pay directly to such Advanced Back & Neck Pain Center, P.C. such amount(s) from (1) any insurance benefits payable to Patient or on Patients behalf, including, but not limited to, medical payments benefits, No Fault benefits, health and accident benefits, personal injury protection benefits, third-party liability coverage, foundation grants, governmental or agency benefits, worker's compensation benefits or any other insurance proceeds or benefits of any kind which are payable to or on behalf of the Patient, and (2) any litigation proceeds (which may include insurance proceeds) from any settlement, judgment or verdict in Patients favor as may be necessary to fully pay any and all financial obligations owed to Advanced Back & Neck Pain Center, P.C. by the Patient. This Assignment is to be a complete and current transfer of Patients right, title, and interest, separate from any statutory or contractual lien or claim to which the Health care Provider may also be entitled. Patient acknowledges that Advanced Back & Neck Pain Center, P.C. has a substantial pecuniary interest in the enforcement of this Assignment.

The Patient further agrees that, in the event the insurance company and/or attorney obligated hereunder to make payments to Advanced Back & Neck Pain Center, P.C. fails or refuses to make payment for the full amount due as set forth above, this Assignment is a full, immediate and complete assignment of all the Patient's rights, title, interest, remedies and benefits in and to the assigned property to the extent of Advanced Back & Neck Pain Center, P.C. s total claim amount; therefore, Patient hereby irrevocably and fully assigns and transfers to Advanced Back & Neck Pain Center, P.C. any and all causes of action that Patient might have or that might exist in Patients favor against such insurance company and/or attorney with respect to the assigned property. In addition to the foregoing assignment, Patient hereby authorizes, nominates and appoints as Patients attorney-in-fact any officer of Advanced Back & Neck Pain Center, P.C. , to prosecute said causes(s) of action either in Patients name or in Advanced Back & Neck Pain Center, P.C. s name and Patient further authorizes Advanced Back & Neck Pain Center, P.C. to compromise, settle or otherwise resolve said claim(s) or cause(s) of action as it sees fit.

In further consideration of the services provided by Advanced Back & Neck Pain Center, P.C. , Patient hereby grants a lien to said Advanced Back & Neck Pain Center, P.C. against any and all insurance benefits and litigation proceeds outlined in the first paragraph above which may be payable to or on behalf of the Patient as a result of the injuries or illness for which Patient has been treated by said Advanced Back & Neck Pain Center, P.C. . The Patient further agrees that the statute of limitations applicable to Advanced Back & Neck Pain Center, P.C. s right to demand payment from the patient shall be tolled for all reasonable times that negotiations or litigation between third parties and the Patient are ongoing. Patient hereby acknowledges that Virginia law imposes a lien in the amount of $750.00 upon Patients claim against the individual or entity whose negligence is alleged to have caused Patients injuries.

Notwithstanding the foregoing, the Patient agrees that until Advanced Back & Neck Pain Center, P.C. is paid in full, the Patient shall remain personally and fully responsible for and promises to pay the total amount due Advanced Back & Neck Pain Center, P.C. (including principal, interest, collection costs and attorney's fees of 35%) until fully paid. The Patient further understands and agrees that this Assignment does not constitute any agreement of or consideration for Advanced Back & Neck Pain Center, P.C. to await payments from any source, and in the event Advanced Back & Neck Pain Center, P.C. deems itself in its sole discretion insecure as to the prospect payment, it may demand payments from Patient immediately upon rendering services at its option and proceed to collect same through legal means if necessary.

Patient authorizes Advanced Back & Neck Pain Center, P.C. to release this Assignment and any information pertinent to Patients case to any insurance company, adjuster or attorney to facilitate collection under this Assignment. Patient hereby nominates and appoints any officer of Advanced Back & Neck Pain Center, P.C. as Patient's attorney-in-fact to endorse/sign Patient's name on any and all checks for payment of the services provided to Patient by said Advanced Back & Neck Pain Center, P.C. . In the event that any part or provision of this Assignment shall be determined to be invalid or unenforceable, the remaining parts and provisions of this Assignment which can be separated from the invalid, unenforceable provision shall continue in full force and effect.

Notice regarding the assignment of medical expense benefits is provided in a separate document. I have been presented with and had an opportunity to read the notice. Acknowledged:_____(patient initials)

Patients Signature_____

Printed Name_____

Date_____ SS#_____

Advanced Back & Neck Pain Center, P.C.

Witness_____

Date_____

46 S. Glebe Road
Suite 100
Arlington, VA 22204

Tel: (703) 521-0644
Fax: (703) 521-9413
www.advhealthctr.com

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An **advanced** approach to good health care

www.advhealthctr.com

ATTORNEY_____ **PATIENT**_____

_____ _____

_____ _____

Reference: **MEDICAL LIEN**

I do hereby authorize **ADVANCED BACK & NECK PAIN CENTER, P.C.** to furnish my attorney who is named above with reports, copies of both my medical records and charges incurred related to injuries sustained from the accident in which I was involved.

My signature below irrevocably assigns authorizes and directs my attorney who may represent me to pay direct and prompt all outstanding balances, to the facility referenced above from any proceeds recovered resulting from compromise, judgment, or monies received from insurance benefits. I, the patient direct that my attorney shall not withhold any portion of the amount due to the named facility above and shall not disburse any monies for attorney expenses to include fees until all outstanding amounts at **ADVANCED BACK & NECK PAIN CENTER, P.C.** are satisfied.

I fully understand that I am directly liable to the named facility for any charges incurred from treatment relating to my accident. I understand that should the said facility request periodical case status information from the attorney and or myself they must receive a response from the party/parties within **five (5) days if no response is received within this time the lien will become null and void,** payment for the balance will be due within **five (5) business days.** This lien serves as an additional means of protection and consideration for a waiting period of **6 months.** I fully understand that such payment is not contingent on any settlement, judgment or verdict that I may eventually recover.

I hereby agree to waive my defense of the **Statue of Limitations** as it pertains to any claims filed against me beyond any all statutory period after services were rendered. I also understand that any balance remaining after one (1) year will be subject to interest charges. If my account has to be transfer to an outside source for assistant in recovering payment my account will be subject to interest and or other applicable charges that will be determined by that agency.

A photocopy of this agreement and authorization shall be as binding as the original. By signing this medical lien, you are acknowledging that you have read and agree to all terms.

Patient Signature: _____ Date: _____

The undersigned attorney agrees to fully comply with the terms referenced above.

Attorney's Signature: _____ Date: _____

Advanced Health Center
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NOTICE: AUTOMOBILE ACCIDENT PATIENTS
(Addendum to Assignment of Benefits Form)

If you have been in an automobile accident, you may be entitled to payment from your automobile insurance if you have medical expense benefits coverage. By signing this assignment of benefits form, you are giving to your health care provider the right to receive some or all of the payment directly from your automobile insurance company.

If you have health insurance and your healthcare provider is in-network: As long as you provide information necessary to verify your health insurance coverage, the healthcare provider may only bill the amount you owe for any copayment, coinsurance, or deductibles to your automobile insurance and you may be entitled to any remainder of your automobile insurance benefit.

If you do not provide information necessary to verify your health insurance coverage, do not have health insurance, or your healthcare provider is not in your health insurer's provider network, your healthcare provider may bill its full charges to your automobile insurance.

You may want to consult your insurance agent or attorney before signing or initialing this form. **You are not required to sign/initial this form to receive care. However, if you do not sign this form, you will be required to (i) pay any applicable co-pays and deductibles at the time the services are provided and allow us to bill your health insurance company or (ii) pay for all care at the time of service.**

By signing below, I acknowledge that I have read or had the opportunity to read this notice.

Patient Signature:_____

Date:_____

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PERSONAL INJURY CONSULTATION FORM

PATIENT NAME: _____ **DATE:** _____

Date of injury: _____ **is condition due to accident? Yes/No What?** _____

Was the patient: (circle one) driver, passenger, pedestrian. If passenger were you sitting: (circle one) front, right rear, left rear. Were you restrained by the seat belted? Yes/No. Did airbags deployed? Yes/No. Did you strike with anything in the vehicle? Yes/No. What? _____**. Did police come to the scene? Yes/No**

Was the car: (circle one) motion or stop. Was your car hit: (circle one) Left, Right, Front, or Rear.

What are your complaints? _____

Any radiating pain (Please explain) _____

Is your pain (circle those that apply) sharp, dull, constant, on and off. Those your pain aggravates by: (circle those that apply) sitting, walking, standing, bending, lifting, laying, turning other_____

Did you go to the Hospital? Yes/No Name of hospital? _____

Was patient transported by ambulanced? Yes/No. Were you place in a :(circle one) collar, splints or brace.

Were x-rays taken? Yes/No. What part of the body? (Circle those that apply) neck, mid back, lower back, other___.

Was medication prescribed? Yes/No. what? _____

Are you allergic to any medication? Yes/No what? _____

Have any prior treatment been received for this condition? _____ **Where?** _____

DESCRIBE WHAT MAY HAVE CAUSED THIS CONDISION:

_____

_____

_____

_____

_____

_____

_____

_____

DIAGNOSIS:

PRIMARY: _____

SECONDARY: _____

TRICIARY: _____