

## WELCOME

Date: \_\_\_/\_\_\_/\_\_\_

Social Security #: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_

Email: \_\_\_\_\_

Sex:  Male  Female

Birth date: \_\_\_\_\_

Married  Widowed  Single

Minor  Separated  Divorced

Partnered for \_\_\_\_\_ years

Occupation: \_\_\_\_\_

Patient Employer/ School: \_\_\_\_\_

\_\_\_\_\_

Employer/ School Address: \_\_\_\_\_

\_\_\_\_\_

Employer/School Phone#: \_\_\_\_\_

Spouses Name: \_\_\_\_\_

Birth date: \_\_\_\_\_

Social Security #: \_\_\_\_\_

Spouse's Employer: \_\_\_\_\_

Whom may we thank for referring you?

\_\_\_\_\_

## PHONE NUMBERS

Home #: \_\_\_\_\_

Cell #: \_\_\_\_\_

Best time and place to reach you:

\_\_\_\_\_

## IN CASE OF AN EMERGENCY, CONTACT

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Home #: \_\_\_\_\_

Work#: \_\_\_\_\_

Cell #: \_\_\_\_\_

## INSURANCE INFORMATION

Who is responsible for this account?

\_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Insurance Co: \_\_\_\_\_

ID#: \_\_\_\_\_

Group#: \_\_\_\_\_

Is patient covered by additional insurance?

Yes  No

Subscriber's Name: \_\_\_\_\_

Birth date: \_\_\_\_\_

Social Security #: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Insurance Co: \_\_\_\_\_

\_\_\_\_\_

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

\_\_\_\_\_

and assign directly to Dr. Patrick Borja 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 of the benefits payable for related services. The consent will end when my current treatment plan is completed or one year from the date signed below.

x \_\_\_\_\_

Signature of Patient/ Guardian

x \_\_\_\_\_

Please print Patient/ Guardian

# HEALTH HISTORY

Place a mark in the boxes below to indicate if you have/ had any of the following:

- AID/HIV
- Alcoholism
- Allergy Shots
- Anemia
- Anorexia
- Appendicitis
- Arthritis
- Asthma
- Bleeding Disorder(s)
- Bronchitis
- Bulimia
- Cancer
- Cataracts
- Chemical Dependency
- Chicken Pox
- Diabetes
- Emphysema
- Epilepsy
- Fractures
- Glaucoma
- Goiter
- Gonorrhea
- Gout
- Heart Disease
- Hepatitis
- Herpes
- High Blood Pressure
- High Cholesterol
- Kidney Disease
- Liver Disease
- Measles
- Migraine Headaches
- Miscarriage
- Mononucleosis
- Multiple Sclerosis
- Mumps
- Osteoporosis

- Pacemaker
- Parkinson's Disease
- Pinched Nerve
- Pneumonia
- Polio
- Prostate Problems
- Prosthesis
- Psychiatric Care
- Rheumatoid Arthritis
- Scarlet Fever
- Sexually Transmitted Disease
- Stroke
- Suicide Attempt
- Thyroid Problems
- Tuberculosis
- Tumors/ Growths
- Typhoid Fever
- Ulcers
- Vaginal Infections
- Whooping Cough
- Other: \_\_\_\_\_

What treatment have you already received for your condition?

- Medications
- Surgery
- Physical therapy
- Chiropractic services
- None
- Other: \_\_\_\_\_

Name and contact information of other doctors who have treated you for this condition: \_\_\_\_\_

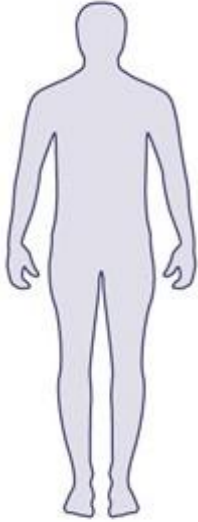
Date of Last: \_\_\_\_\_  
Physical Exam: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Spinal Exam: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Dental X-ray: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Spinal X-ray: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Blood Test/ Urine Test: \_\_\_\_/\_\_\_\_/\_\_\_\_  
MRI/ CT-Scan/ Bone Scan: \_\_\_\_/\_\_\_\_/\_\_\_\_

# ACCIDENT INFORMATION

Is this related to:

- Auto Accident: \_\_\_/\_\_\_/\_\_\_
- Work Accident: \_\_\_/\_\_\_/\_\_\_

Attorney Name (if applicable):  
\_\_\_\_\_



FRONT



BACK

Please mark an "x" on *all* areas of the body where you are experiencing pain.

# PATIENT CONDITION

Reason for visit today: \_\_\_\_\_

When did your symptoms appear?  
\_\_\_\_\_

Is this condition progressively worse?  
\_\_\_\_\_

Type of Pain:

- Sharp
- Stabbing
- Throbbing
- Numbness
- Aching
- Swelling
- Shooting
- Burning
- Tingling
- Dull
- Cramps
- Other

How often do you have this pain?  
\_\_\_\_\_

Does it interfere with your:

- Work
- School
- Sleep
- Daily Routine
- Recreation

Activities or movements which are painful:

- Sitting
- Standing
- Walking
- Bending
- Lying Down

Exercise

- None
- Moderate
- Daily
- Heavy

Work Activity

- Sitting
- Standing
- Light Labor
- Heavy Labor

Habits

- Smoking: \_\_\_\_\_ daily/weekly
- Alcohol: \_\_\_\_\_ daily/weekly
- Coffee/Caffeine: \_\_\_\_\_ daily
- High Stress Level: \_\_\_\_\_

Are you Pregnant and if so, due date:  
\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Medications: \_\_\_\_\_

Allergies: \_\_\_\_\_

Vitamins/ Herbs/ Minerals: \_\_\_\_\_

Injuries/ Surgeries and dates:

Falls: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Head Injuries: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Broken Bones: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Dislocations: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Surgeries: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

**The Spine and Wellness Center Dr. Patrick Borja  
WORKER COMPENSATION INFORMATION**

**PATIENT INFORMATION**

Patient Name: \_\_\_\_\_ Date \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Sex \_\_\_ Male \_\_\_ Female      Single \_\_\_ Married \_\_\_ Other \_\_\_  
Occupation \_\_\_\_\_ Number of years doing current job \_\_\_\_\_  
Have you retained an attorney? \_\_\_ Yes \_\_\_ No      Litigation? \_\_\_ Yes \_\_\_ No \_\_\_ Maybe  
If so, name and phone number \_\_\_\_\_

**INJURY INFORMATION**

Date of Injury \_\_\_\_\_ Time of Injury \_\_\_\_\_ Occupation when injured \_\_\_\_\_  
Activity being performed at the time of the injury \_\_\_\_\_  
Was the injury witnessed by anyone? \_\_\_ Yes \_\_\_ No If yes, whom? \_\_\_\_\_  
To whom was the injury Reported? \_\_\_\_\_  
Date and Time the injury was reported \_\_\_\_\_  
Have you lost time from work due to this injury? \_\_\_ Yes \_\_\_ No If yes, which Dates \_\_\_\_\_  
Describe where and how the accident or cause of disability occurred?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Did you consult any other doctor? \_\_\_ Yes \_\_\_ No  
If so, Name and phone number \_\_\_\_\_  
Doctor's diagnosis \_\_\_\_\_  
What treatments did you receive? \_\_\_\_\_  
Have you ever injured this area before? \_\_\_ Yes \_\_\_ No If so, when? \_\_\_\_\_  
If injured before, did you lose time from work? \_\_\_ Yes \_\_\_ No  
If you lost time from work with injuries prior to this injury, give name of doctor and doctors consulted \_\_\_\_\_  
\_\_\_\_\_

Do any other diseases or accidents affect your employment? \_\_\_ Yes \_\_\_ No If so, explain \_\_\_\_\_

In your work do you have to favor any part of your body? \_\_\_ Yes \_\_\_ No If so, explain \_\_\_\_\_

Do you have a history of absenteeism caused from accidents on the job? \_\_\_ Yes \_\_\_ No

Have you ever had a Workers Compensation claim before? \_\_\_ Yes \_\_\_ No

Before the injury were you capable of working on an equal basis with others your age? \_\_\_ Yes \_\_\_ No

Are your work activities restricted as a result of this accident? \_\_\_ Yes \_\_\_ No

Since this injury are your symptoms \_\_\_ improving? \_\_\_ getting worse? \_\_\_ the same?

### **EMPLOYER INFORMATION**

Employer's name \_\_\_\_\_ Phone \_\_\_\_\_

Employer's address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Whom should be contacted regarding the injury? \_\_\_\_\_ Phone \_\_\_\_\_

### **INSURANCE INFORMATION**

Worker's Compensation Insurance Carrier \_\_\_\_\_

Adjuster's Name \_\_\_\_\_ Phone \_\_\_\_\_ Ext \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Claim # \_\_\_\_\_

### **PAYMENT INFORMATION**

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I ever have a change in health.

Patient's Signature \_\_\_\_\_ Print Name \_\_\_\_\_

Date \_\_\_\_\_

The Spine and Wellness Center  
Dr. Patrick Borja  
3933 Perkiomen Avenue, Suite 101  
Reading, PA 19606-2718  
(610) 779-4588

Dear Patient:

Thank you for choosing us as your healthcare provider. The following is our financial policy. Our main concern is that you receive optimal care resulting in better health. Therefore, if you have any questions or concerns about our payment policies, please do not hesitate to ask our office manager.

We ask that you kindly read and sign our financial policy as well as complete our patient information form prior to seeing the doctor.

**Payment for services is due at the time services are rendered.** We accept cash, checks and for your convenience **VISA, MASTERCARD and DEBIT CARDS.** We will be happy to help process your insurance claims. **We accept assignment from most insurance companies; however you must understand that:**

1. Your insurance policy is a contract between you, your employer and the insurance company. We are NOT a party to that contract. Our relationship is with you, not your insurance company.
2. All charges are your responsibility, whether your insurance company pays or not. Not all services are covered benefits in all contracts. Some insurance companies arbitrarily select certain services they will not cover. Fees for these services, along with unpaid deductibles and co-payments are due at the time of treatment.
3. If the insurance company does not pay your balance **in full** within **45** days, we kindly ask that you contact your insurance carrier to help speed things along.
4. If the insurance company does not pay **at all** within **45** days, we require you to pay the balance due.
5. Returned checks and balances older than **60** days may be subject to an additional collection fee and interest charges of 1 ½ % per month.

If you are in our office due to a personal injury covered by your auto or workers compensation policy, we will make every attempt to process your claims quickly, and some of the above statement may not apply due to certain state laws. In special circumstances we will require a letter of protection from your attorney for payment.

We understand that temporary financial problems may affect timely payment of your balance. We encourage you to communicate any such problems so that we can assist you in the management of your account.

We appreciate your confidence in us and we appreciate the opportunity to serve you.

Thank you,

Patrick M. Borja, DC

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

**CONSENT FOR USE OR DISCLOSURE OF HEALTH INFORMATION**

**OUR PRIVACY PLEDGE**

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health care information.

1. We may have to disclose your health information to another health care provider or hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
2. We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
3. We may need to use your health information within our practice for quality control or other operational purposes.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before you sign this consent form (164.520). We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by mail. Please feel free to call us at any time for a copy of our privacy notices.

**Please check which of the following we may leave information with:**

- Cell phone
- Home phone (answering machine/voice mail)
- Spouse \_\_\_\_\_ (name)
- Significant Other \_\_\_\_\_ (name)
- Email
- Other \_\_\_\_\_

**YOUR RIGHT TO LIMIT USES OR DISCLOSURES**

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us.

**YOUR RIGHT TO REVOKE YOUR AUTHORIZATION**

**You may revoke your consent to us at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information. Before we receive your request to revoke your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.**

I have read your consent policy and agree to its terms. I am also acknowledging that I have received a copy of this notice

\_\_\_\_\_  
PRINTED NAME

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
AUTHORIZED PROVIDER REPRESENTATIVE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
DATE

**APPOINTMENT REMINDERS & HEALTH CARE INFORMATION AUTHORIZATION**

Your chiropractor and members of the practice staff may need to use your name, address, phone number and clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If this contact is made by phone you are giving us authorization to contact you with these reminders and information.

You may restrict the individuals or organizations to which your health care information is released or you may revoke your authorization to us at any time; however, your revocation must be in writing and mailed to us at our office address. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. In addition, if you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

Information that we use or disclose based on authorization you are giving us may be subject to re-disclosure by anyone who has access to the remainder of other information and may no longer be protected by the federal privacy rules.

You may have the right to refuse to give us this authorization. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternative, or other health related information at any time.

This notice is effective as of \_\_\_\_\_. This authorization will expire seven years after the date on which you last received services from us.

I authorize you to use or disclose my health information in the manner described above. I am also acknowledging that I have received a copy of this authorization.

**Please check which of the following we may leave information with:**

- Cell phone
- Home phone (answering machine/voice mail)
- Spouse \_\_\_\_\_ (name)
- Significant Other \_\_\_\_\_ (name)
- Email
- Other \_\_\_\_\_

\_\_\_\_\_  
Print Name (patient)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Authorized Provider Representative

\_\_\_\_\_  
Personal Representative Name Printed

\_\_\_\_\_  
Personal Representative Signature

\_\_\_\_\_  
Description of personal representative's authority to act for the patient