Patient Registration Form

ORLANDO SPINE STUDIO
Dr. James M Bowles
Board Certified Chiropractic Physician

Patient Demographics

Patient's First Name		Middle Name	Last Name
Date of Birth	Age	Social Security Number	Martial Status
Home Address		City/Town	State / Zip
Home Phone		Mobile Phone	Email Address
Have you seen a Chiropractor before? Circle: Yes No		Preferred method of contact: Circle: Text Email Phone	How did you hear about us?

Employer Information

Employer Name		Your Occupation	Employer/School Phone
Employer/School Address		City	State / Zip

Emergency Contact Information

Emergency Contact Name	Emergency Contact Phone	Relation to Patient

Billing and Insurance

Primary Health Insurance

Insurance Company		Plan	
Plan or ID Number	Group Number	Claims Address and Phone Number	
Policy Holder's Full Name (as it appears on insurance card)		Relation to Patient	Policy Holder's Phone Number
Policy Holder's SSN(last 4 Digits)	Policy Holder Date of Birth	**Please submit your insurance card(s) and ID to our receptionist**	

Secondary Health Insurance

Insurance Company		Plan	
Plan or ID Number	Group Number	Claims Address and Phone Number	
Policy Holder's Name (as it appears on insurance card)		Policy Holder's Last 4 SSN	Relation to Patient

Responsible Party

Billing Name (if other than patient)		Phone	Relation to Patient
Address		City	State / Zip

I give consent for treatment(s), physical examination(s), and consultation(s) by Dr. James Bowles and/or any other physicians practicing with the Orlando Spine Studio group. I fully understand that payment/co-payment are required at the time of service. Should my insurance be filed, any unpaid balance is my personal responsibility. I further authorize the release of any medical information to my insurance company when necessary. In the event that insurance is filed by the doctors' office, I authorize benefits to be paid directly to Orlando Spine Studio. During the course of my treatment at Orlando Spine Studio, I understand that there may be occasions for charges of non face-to-face consultations, treatment recommendations, and/or review of records. I give my permission for Orlando Spine Studio to bill my insurance company for these services and any amount deemed patient responsibility by the insurance company will be billed accordingly. Any outstanding balances of 90 or more days will be forwarded to a collection agency.

Signature of Patient or Authorized Guardian _____ **Date** _____

Patient Full Name: _____

Date of Appointment: _____

ORLANDO SPINE STUDIO

Reason for Visit *What brings you to our office today? List all symptoms, if any, that you are experiencing.*

Severity (0-10): How long: Frequency: Getting better or worse:

Current Medications *List all medication **names, dose, and frequency.***

Past Medical History *Which conditions have you been diagnosed with? **Please list both current and past diagnosis.***

Imaging (X-ray, MRI, CT, etc.):

Hospitalizations & Surgeries

Reason	Date
Reason	Date
Reason	Date

Allergies *List any drug and non-drug allergies*

Allergy	Reaction
Allergy	Reaction
Allergy	Reaction

Social History

Have you ever smoked?

☐ Yes ☐ No # of years _____ # packs/day _____

Do you smoke now?

☐ Yes ☐ No # packs/day _____

Do you use recreational drugs?

☐ Yes ☐ No Types? _____ # times/week _____

How much alcohol do you drink per week?

drinks per week _____

How much caffeine do you drink per day?

drinks per day _____

How often do you exercise?

times per week _____

Sexual History

Are you sexually active?

☐ Yes ☐ No # of partners in past year _____

Are you concerned of sexually transmitted diseases?

☐ Yes ☐ No

Women Only

of Pregnancies: _____ # of Miscarriages: _____

Last Mammogram: _____ Last Pap Smear: _____

Birth Control Method: _____

Family History

Which conditions do your parents and/or grandparents have?

Mother:

Father:

Grandmother(s):

Grandfather(s):

Additional Information

Last Annual Physical: _____ Last Colonoscopy: _____

If there is additional information regarding your medical history that we should be aware of(such as specialist information,medications, allergies, symptoms), please detail it here:

FINANCIAL POLICY

Insurance

We participate in most major commercial health insurance plans and Medicare. ***Knowing your health insurance benefits is your responsibility. Please be aware we only verify that you have active insurance and we can file a claim on your behalf. Our office does not verify what your specific plan covers.*** Please contact your insurance company with any questions you may have regarding your coverage.

All patients must complete our demographic form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance card at the time of your appointment, you can be self-pay for your appointment.

Payments

It is your responsibility to pay any deductible, co-pay, co-insurance or any portion of the charge as specified by your plan. This is your contract with your insurance company. If you do not pay your co-pay upon checking out from your visit, you will have a $25.00 additional fee added to your account. Bounced checks will also have an added $25 dollar fee which must be paid before an office visit.

Please be aware that some (and perhaps all of the services, depending on your plan) you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You agree to pay any portion of the charges that is not covered by insurance.

Claims Submission

Please be sure to follow up with your insurance company regarding claim status. You are responsible for any balance on your account. If claims are unpaid after 90 days, they will be referred to a collection agency. We will file to both your primary and secondary insurance policy. We do not file to tertiary plans. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. If your insurance company does not respond within 60 days, you are responsible for the remaining balance. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

Balances

Unless other arrangements are approved by us in writing, you are responsible to pay your balances within 30 days of services being rendered. Once we send you a statement, the balance on your statement is due and payable upon receipt. Please be aware that if a balance remains unpaid, we will refer your account to a collection agency and you may be discharged from the practice. If this occurs, you will be notified by regular or certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physicians will only be able to treat you on an emergency basis.

Motor Vehicle Accident Claims

We do not file motor vehicle claims. All patients being seen regarding a motor vehicle accident will be self-pay and must file their own paperwork with any 3rd party company.

Workers Compensation Claims

If you are being seen in our office due to a work related injury, you must bring the first report of incident form, which should include the original injury date, your claim number and the claims address that we are to file these claims for you.

I have read and understand this office financial policy and agree to comply and accept the responsibility for any payment that becomes due as outlined previously.

Signature of Patient/Guardian: _____ Date: _____

Dr. James M Bowles
Board Certified Chiropractic Physician
11500 University Blvd, Ste 103, Orlando FL, 32817
Phone: 407 658 6500
Fax: 407 277 2690

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION MAY BE USED AND DISCLOSED PURSUANT TO THE HEALTH INSURANCE PROBABILITY AND ACCOUNTABILITY ACT (HIPAA)

Our practice is dedicated to maintaining the privacy of your Individually Identifiable Health Information (IIHI). In conducting our business, we utilize paper and electronic medical records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your IIHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time. We realize that these laws are complicated, and we want to provide you with the following important information.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices. Additionally, this policy is available on our website, www.orlandospinestudio.com.

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office who are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of your physician's practice. We may use or disclose your protected health information in the following situations without your authorization or providing you the opportunity to agree or object: required by law, public health reasons, communicable diseases, required by the FDA, abuse or neglect of a patient, workers' compensation, national security, inmates under treatment.

You have the right to inspect and copy your protected health information. You must submit your request in writing to your physician in order to inspect or obtain a copy of your IIHI. As permitted by federal or state law, we charge you a reasonable copy fee for a copy of your records. You have the right to request a restriction of your protected health information and ask us not to disclose your information to certain individuals. You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. You may have the right to have your physician amend your protected health information if you believe it is incomplete or inaccurate. You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. All requests must be made in writing.

I authorize the following individuals to have full access to my health information:

_____

Print Name Relationship Date

_____

Print Name Relationship Date

I, _____ give my permission for Orlando Spine Studio and its staff to leave any medical/lab information for me at the following phone numbers and email. You acknowledge that you have been advised of the risk of transmission of this information, understand that this is not a secure format, acknowledge that this information may be seen by a third unauthorized party and take full responsibility of the possible security breach.

MOBILE: _____
HOME: _____
EMAIL: _____

Receipt of Notice of Privacy Practices Acknowledgment

Signature of Patient or Guardian: _____ **Date**:_____/_____/_____

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Informed Consent to Procedures

I hereby request and consent to the performance of chiropractic manipulation or adjustments and other chiropractic procedures, including various modes of physical therapy or physical medicine procedures, and diagnostic x-rays, on me (or on the patient named below for whom I am legally responsible) by the chiropractic physician named below and/or other licensed chiropractors who now or in the future treat me while employed by, working or associated with or serving as backup for the chiropractic physician named below.

I have had an opportunity to discuss with the doctor named below and/or with other office or clinic personnel the nature and purpose of chiropractic manipulations or adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including, but not limited to, fractures, disc injuries, strokes, dislocations, and sprains. I understand all procedures being performed at this facility are deemed safe and supported by clinical research and evidence but, the risk must be disclosed even if an extremely small percentage of patients report adverse effects. I do not expect the doctor to be able to anticipate and explain all possible risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure, which the doctor feels at the time, based upon the facts then known, is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present condition.

Patient Signature: _____

Date: _____

To be completed by the patient's representative, if necessary, e.g., if patient is a minor or physically or otherwise legally incapacitated.

Signature of Patient's Representative: _____

Date: _____

Orlando Spine Studio
11500 University Blvd, Ste 103
Orlando FL, 32817

Dr. James M Bowles
Chiropractic Physician

Missed Appointment Policy

We want to thank you for choosing us as your chiropractic health provider. In order to provide you and our other patients with the best optimal care, we request that you follow our guidelines regarding missed and/or cancelled appointments. Please remember that we have reserved appointment times especially for you. Therefore, we request at least 24 hours' notice to reschedule your appointment. This will also enable us to offer your cancelled time to other patients that desire to get their treatment completed. When you cancel your appointment at the last minute everyone loses out; you, the doctor and the other patients that would like to have utilized your appointment time.

Our office does charge a $25 fee for broken or canceled appointments with less than 24-hour notice or a no show without notice. We do realize last-minute emergencies arise, so this fee will be assessed on a case-by-case basis. Please realize how important it is to keep your reserved time.

You may notify us via phone call, text, or email before the 24-hour deadline to be considered in good standing with our policy. Thank you for your consideration of our policies and for the opportunity to serve you.

Please sign acknowledging that you have read our above statement and you understand our right to enforce the cancellation fee if the policy is broken.

Name (print): _____

Signature: _____

Date: _____

ORLANDO
SPINE STUDIO

NECK Pain and Disability Questionnaire

ORLANDO SPINE STUDIO

Rate the severity of your pain by circling one number: (No Pain) 0…1…2…3…4…5…6…7…8…9…10 (Excruciating Pain)

This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage everyday life. Read through each section and check only ONE line that applies to you. You may find that two of the statements in a section relate to you, but please just check ONE line that best describes your current predicament.

Section 1– Pain Intensity
___ I have no pain at the moment.
___ The pain is very mild at the moment.
___ The pain is moderate at the moment.
___ The pain is fairly severe at the moment.
___ The pain is very severe at the moment.
___ The pain is the worst imaginable at the moment.

Section 2– Personal Care (washing, dressing, etc.)
___ I can look after myself normally without causing extra pain.
___ I can look after myself normally but it causes extra pain.
___ I am slow and careful because it is painful for me to look after myself.
___ I need some help but manage most of my personal care.
___ I need help every day in most aspects of care.
___ I do not get dressed, I wash with difficulty and stay in bed.

Section 3– Lifting
___ I can lift heavy weight without extra pain.
___ I can lift heavy weight but it causes extra pain.
___ I cannot lift heavy weight off the floor, but I can manage if they are conveniently positioned like on a table.
___ I cannot lift heavy weight, but I can manage light to medium weights if they are conveniently positioned.
___ I cannot lift any weight due to neck pain.

Section 4– Reading
___ I can read as much as I want to with no pain in my neck.
___ I can read as much as I want to with slight neck pain.
___ I can read as much as I want to with moderate neck pain.
___ I cannot read as much as I want to due to moderate neck pain.
___ I can hardly read at all because of severe neck pain.

Section 5– Headaches
___ I have no headaches at all.
___ I have slight headaches that occur infrequently.
___ I have moderate headaches that occur infrequently.
___ I have frequent moderate headaches.
___ I have frequent severe headaches.
___ I have severe headaches all the time.

Section 6- Concentration
___ I can concentrate fully when I want to with no difficulty.
___ I can concentrate fully when I want to with slight difficulty.
___ I have a fair degree of difficulty in concentrating when I want to.
___ I have a great deal of difficulty in concentrating when I want to.
___ I cannot concentrate at all.

Section 7- Work
___ I can do as much work as I want to.
___ I can only do my usual work, but no more.
___ I can do most of my usual work, but no more.
___ I cannot do my usual work.
___ I can barely do any work at all.
___ I cannot do any work at all.

Section 8- Driving
___ I can drive my car without any neck pain.
___ I can drive my car as long as I want with slight neck pain.
___ I can drive my car as long as I want with moderate neck pain.
___ I cannot drive my car as long as I want.
___ I can hardly drive at all because of severe neck pain.
___ I cannot drive my car at all.

Section 9- Sleeping
___ I have no trouble sleeping.
___ My sleep is slightly disturbed (less than 1 hour sleepless)
___ My sleep is mildly disturbed (1 hour sleepless)
___ My sleep is moderately disturbed (2 to 3 hours sleepless)
___ My sleep is greatly disturbed (4 to 5 hours sleepless)
___ My sleep is completely disturbed (6 to 7 hours sleepless)

Section 10- Recreation
___ I am able to engage in all my recreation activities with no neck pain.
___ I am able to engage in all my recreation activities with some neck pain.
___ I am able to engage in most, but not all of my usual recreation activities.
___ I am able to engage in a few of my usual recreation activities.
___ I can hardly do any recreation activities.
___ I cannot do any recreation activities due to neck pain.

_____ _____ _____
Patient Name (Print) Patient Signature Date

FOR OFFICE USE ONLY:
_____ x 2 = _____ _____
Total Points Disability Percentage Rating Scale

11500 University Blvd, Ste 103, Orlando FL, 32817 P 407-658-6500 | F 407-277-2690

Patient's Name_____ Number_____ Date_____

LOW BACK DISABILITY QUESTIONNAIRE (REVISED OSWESTRY)

This questionnaire has been designed to give the doctor information as to how your back pain has affected your ability to manage in everyday life. **Please answer every section and mark in each section only ONE box** which applies to you. We realize you may consider that two of the statements in any one section relate to you, but **please just mark the box which MOST CLOSELY describes your problem.**

Section 1 - Pain Intensity

☐ I can tolerate the pain without having to use painkillers.
☐ The pain is bad but I can manage without taking painkillers.
☐ Painkillers give complete relief from pain.
☐ Painkillers give moderate relief from pain.
☐ Painkillers give very little relief from pain.
☐ Painkillers have no effect on the pain and I do not use them.

Section 2 -- Personal Care (Washing, Dressing, etc.)

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

Section 3 – Lifting

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

Section 4 – Walking

☐ Pain does not prevent me from walking any distance.
☐ Pain prevents me from walking more than one mile.
☐ Pain prevents me from walking more than one-half mile.
☐ Pain prevents me from walking more than one-quarter mile
☐ I can only walk using a stick or crutches.
☐ I am in bed most of the time and have to crawl to the toilet.

Section 5 -- Sitting

☐ I can sit in any chair as long as I like
☐ I can only sit in my favorite chair as long as I like
☐ Pain prevents me from sitting more than one hour.
☐ Pain prevents me from sitting more than 30 minutes.
☐ Pain prevents me from sitting more than 10 minutes.
☐ Pain prevents me from sitting almost all the time.

Scoring: Questions are scored on a vertical scale of 0-5. Total scores and multiply by 2. Divide by number of sections answered multiplied by 10. A score of 22% or more is considered significant activities of daily living disability.
(Score___ x 2) / (____Sections x 10) = _____ %ADL

Section 6 – Standing

☐ I can stand as long as I want without extra pain.
☐ I can stand as long as I want but it gives extra pain.
☐ Pain prevents me from standing more than 1 hour.
☐ Pain prevents me from standing more than 30 minutes.
☐ Pain prevents me from standing more than 10 minutes.
☐ Pain prevents me from standing at all.

Section 7 -- Sleeping

☐ Pain does not prevent me from sleeping well.
☐ I can sleep well only by using tablets.
☐ Even when I take tablets I have less than 6 hours sleep.
☐ Even when I take tablets I have less than 4 hours sleep.
☐ Even when I take tablets I have less than 2 hours sleep.
☐ Pain prevents me from sleeping at all.

Section 8 – Social Life

☐ My social life is normal and gives me no extra pain.
☐ My social life is normal but increases the degree of pain.
☐ Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. dancing.
☐ Pain has restricted my social life and I do not go out as often.
☐ Pain has restricted my social life to my home.
☐ I have no social life because of pain.

Section 9 – Traveling

☐ I can travel anywhere without extra pain.
☐ I can travel anywhere but it gives me extra pain.
☐ Pain is bad but I manage journeys over 2 hours.
☐ Pain is bad but I manage journeys less than 1 hour.
☐ Pain restricts me to short necessary journeys under 30 minutes.
☐ Pain prevents me from traveling except to the doctor or hospital.

Section 10 – Changing Degree of Pain

☐ My pain is rapidly getting better.
☐ My pain fluctuates but overall is definitely getting better.
☐ My pain seems to be getting better but improvement is slow at the present.
☐ My pain is neither getting better nor worse.
☐ My pain is gradually worsening.
☐ My pain is rapidly worsening.

Comments_____

Reference: Fairbank, Physiotherapy 1981; 66(8): 271-3, Hudson-Cook. In Roland, Jenner (eds.), Back Pain New Approaches To Rehabilitation & Education. Manchester Univ Press, Manchester 1989: 187-204

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