Spine & Sport Rehabilitation Woodbridge

Today's Date: _____

Patient Information

First Name: _____ **M.I.** _____ **Last Name:** _____

Date of Birth: _____ **SSN:** _____

Gender: ◯ M ◯ F ◯ U

Marital Status: ◯ Never Married ◯ Married ◯ Divorced ◯ Legally Separated ◯ Widowed ◯ Partner ◯ Other

Address: _____

City: _____ **State** _____ **Zip Code:** _____

Home Phone: _____ **Cell Phone*:** _____ **Work Phone:** _____

Email*: _____

***Opt-In for Reminders?** Choose one only ◯ Text/SMS ◯ Email ◯ Neither, I do not want to receive appointment reminders

Is Patient a Minor? (check one) ◯ No ◯ Yes (If Yes, please provide details of financially responsible parent/guardian below)

Relationship to Patient: _____

Parent/Guardian First Name: _____ **M.I.** _____ **Last Name:** _____

Parent/Guardian Date of Birth: _____ **SSN:** _____

Gender: ◯ M ◯ F ◯ U

Address: _____

City: _____ **State** _____ **Zip Code:** _____

Home Phone: _____ **Cell Phone*:** _____ **Work Phone:** _____

Email*: _____

Employment Status: ◯ Employed Full Time ◯ Employed Part Time ◯ Not Employed ◯ Self-Employed ◯ Full Time Student ◯ Part Time Student ◯ Retired ◯ Active Military

Occupation: _____

Employer Name: _____

Emergency Contact

First Name: _____ **M.I.** _____ **Last Name:** _____

Relationship to Patient: _____

Phone Number: _____

**We only use your phone numbers and email address for appointment reminders and strictly care-related communications. We do not sell your information to third parties.*

Today's Date: _____

☐ I am self paying for my treatment.

☐ I am using my health insurance for my treatment.

Insurance Information

IMPORTANT: *Patients with multiple health insurance policies must list policies in the correct order. Failure to do so or the lack of proper coordination of benefits (COB) with each insurance policy will result in claim denials. Patients are responsible for any balance that is not covered by their insurance(s).*

Patient's Name: _____ **Date of Birth:** _____

Primary Insurance: _____

Policy Holder: _____ **Policy Holder DOB:** _____

Member ID #: _____ **Group #:** _____

Secondary Insurance: _____

Policy Holder: _____ **Policy Holder DOB:** _____

Member ID #: _____ **Group #:** _____

How did you hear about our office? (please check all that apply)

☐ Google search/our website ☐ Insurance website (provider search) ☐ Referred by _____

☐ Other: _____

Notice of Privacy Practices Acknowledgment

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of your Notice of Privacy Practices. I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

_____ _____

Patient Name or Legal Guardian (Print) Date

_____

Signature

Spine & Sport Rehabilitation Woodbridge

Dr. Steven Han, DC PC

Patient's Name: _____ **DOB:** _____ **Today's Date:** _____

REASON FOR VISIT: _____

Date of injury or symptoms: _____ **How did it start?** _____

What makes it better? _____ **Worsened by:** _____

The pain is: ☐ Constant ☐ Frequent ☐ Occasional **If female, are you pregnant?** ☐ **No** ☐ **Yes,** _____ **weeks**

Are there any activities that you are having difficulty performing due to your condition? _____

_____

Medical History (medical conditions, illness, significant injuries, surgeries, previous treatments)? _____

_____

Personal History (type of work, social activities, physical activities): _____

_____

Medications:

Name: _____ **Date Prescribed:** _____ **Name:** _____ **Date Prescribed:** _____

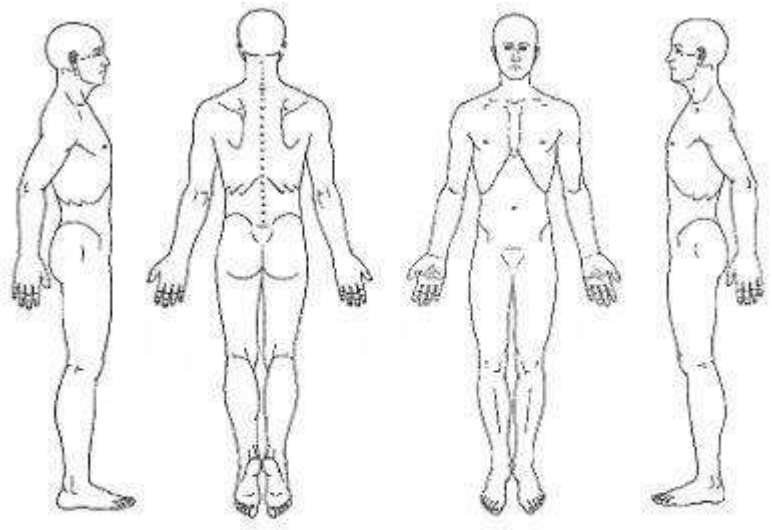
Name: _____ **Date Prescribed:** _____ **Name:** _____ **Date Prescribed:** _____

By using the key below, indicate on the body diagram where you are experiencing the following symptoms:

N *= Numbness* ***B*** *= Burning* ***A*** *= Dull Ache*

T *= Pins & Needles / Tingling* ***S*** *= Sharp Pain*

Please mark next to each symptom area the intensity using numbers from 1 to 10 (1 is minimal and 10 is unbearable).



Is there anything else that you would like to share with the doctor?

_____

_____

Woodbridge Spine & Sports Rehabilitation
Steven Han, DC PC
14130 Noblewood Plaza, Suite #204 · Woodbridge, VA 22193
Tel: 703-878-3434 Fax: 703-878-3833

Consent to Evaluation and Treatment

I hereby request and consent to the performance of chiropractic adjustments, various modes of physical therapy and diagnostic X-rays, on me (or the patient named below, for whom I am legally responsible) by Dr. Steven Han and/or other licensed Doctors of Chiropractic or Physical Therapists or those working at the clinic or office who now or in the future treat me while employed by, working or associated with, or serving as a backdrop for Dr. Steven Han. I understand and I am informed that, in the practice of chiropractic and physical therapy that there are some risks to examination and treatment including, but not limited to, bruising, soreness, fractures, disc injuries, strokes, dislocations, sprains and increased symptoms and pain or no improvement of symptoms or pain. I do not expect the doctor to be able to anticipate and explain all 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 on the facts then known, is in my best interest. I further acknowledge that no guarantees or assurances have been made to me concerning the results intended from the treatments. I intend this consent form to cover the entire course of treatment of my present condition and for any future condition(s) for which I seek treatment. I understand that I may refuse treatment at any time and that I am responsible for my healthcare choices.

Our Privacy Policy

The office of Dr. Steven Han is committed to upholding the security and confidentiality of personal information that you provide to us. We take our responsibility of safeguarding your information very seriously. We do not share or sell patient information with anyone outside our office without your written consent. This policy covers information including personal, financial, or health information about a consumer or customer relationship. I hereby authorize that my records of evaluation and treatment with the office of Dr. Steven Han, DC may be forwarded to referring physicians, specialists, or therapists who are also involved in my healthcare.

By signing below, I have read, or have had read to me, the above consent to evaluation and treatment statement, that I am aware of the privacy policy, and that I certify that my medical information above is correct to the best of my knowledge.

Patient Signature: _____ Date: _____

Consent to Treatment of Minor Child

I hereby authorize Dr. Steven Han and his staff to administer chiropractic and/or physical therapy treatments as deemed necessary to my _____ (indicate relationship of child),

_____.
(Name of child)

Patient or Guardian Signature: _____

Spine & Sport Rehabilitation
Woodbridge
drstevenhan.com • 703-878-3434

Patient Billing Acknowledgement Form

Non-Covered Services

Fee schedule effective July 1, 2019, subject to change

Health insurance patients only

As a courtesy to our patients, we will do a basic verification of health insurance benefits, but this does not constitute a guarantee of coverage and payment. It is the patient's responsibility to know their insurance benefits and contact their carrier for any questions regarding their plan limits and coverage.

Under your health plan, you are financially responsible for co-payments, co-insurance and deductibles for covered services, as well as those services that exceed benefit limits. You are also financially responsible for all non-covered services as defined by your health plan contract. For example, this may include items such as certain treatments/modalities, supplies, and durable medical equipment. The services listed below may not be covered according to your health plan as exclusions or if you exceed your benefit limits. Your acknowledgement below indicates that you have been advised of this information and that you agree to pay for the listed services as necessary. Please note that any non-covered treatment will not count towards your health plan's deductible (if applicable) or your out-of-pocket maximum.

- **Exam** — New patients $120.00, Re-exam $90.00
- **Spinal Adjustment** — $50.00-$60.00
- **X-rays** — $60.00 per region
- **Physical Therapy** — $75.00
- **Massage Therapy** — $45.00 for 25 minutes, $70.00 for 50 minutes
- **Myofascial Therapy** — $25.00
- **Electric Stim or Ultrasound** — $20.00
- **Traction** — $20.00
- **Dry Needling** — $25.00
- **Graston** — $25.00

Please ask the front desk for detailed pricing on supplies and durable medical equipment.

PATIENT:

I, _____, acknowledge that I have been told in advance by
Patient Name – Printed or Typed

my provider that the services/products listed above may not be covered by my health plan. I agree to pay for any non-covered service(s) as self-pay.

Patient/Guardian Signature _____

Date _____

Spine & Sport Rehabilitation
Woodbridge
drstevenhan.com • 703-878-3434

Patient Billing Acknowledgement Form

Maintenance/Elective Care

Health insurance patients only

Under your health plan, you are financially responsible for co-payments, co-insurance or deductibles for covered services. You are also financially responsible for all non-covered services, including care determined to be elective or maintenance. Maintenance/Elective care is treatment that does not significantly improve a clinical condition. While being treated for a chronic condition, you may elect to receive care beyond that which is determined to be medically necessary. You may also choose to receive maintenance care once maximum benefit from treatment has been reached. If your health plan denies coverage because they deem your treatment to be medically unnecessary, you will be soley responsible for your treatment. Please note that any non-covered treatment will not count towards your health plan's deductible (if applicable) or your out-of-pocket maximum.

If, during the course of Maintenance/Elective Care, you develop a new condition or a previous condition becomes significantly worse, care may no longer be considered Maintenance/Elective and may then be covered by your health plan. You should discuss these situations with your provider and they will submit a request for insurance coverage.

PATIENT:

I, _____, acknowledge that I have been told in advance by
Patient Name – Printed or Typed
my provider that I may be responsible for services rendered if my health plan deems my treatment medically unnecessary. I agree to pay for these non-covered services.

Patient/Guardian Signature _____

Date _____

Woodbridge Spine & Sports Rehabilitation
Steven Han, DC PC
14130 Noblewood Plaza, Suite #204 · Woodbridge, VA 22193
Tel: 703-878-3434 Fax: 703-878-3833

Assignment of Benefits

Health insurance patients only

Patient Name:_____ Date:_____

Claim/Group #: _____ SSN/ID#: _____

I authorize and assign to you, Steven Han DC PC D/B/A Woodbridge Spine & Sports Rehabilitation, the right to receive direct payment from my attorney, insurance company or any other party who may become obligated to pay us any sums. I further authorize the endorsement of my name to any drafts containing my name to which you are legally entitled.

I hereby instruct and direct my insurance company to pay electronically or by check made out and mailed directly to:

STEVEN HAN, DC PC
D/B/A Woodbridge Spine & Sports Rehabilitation
14130 Noblewood Plaza Suite #204 Woodbridge, VA 22193
EIN# 20-2637430

OR

If my current policy prohibits direct payment to the doctor, then I hereby instruct and direct you to make the check payable to me and mail it as follows:

C/O 14130 Noblewood Plaza Suite #204 Woodbridge, VA 22193.

For professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment towards the total charges for professional services rendered. This is a direct assignment of my rights and benefits under this policy. The payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional fees for non-covered services and/or fees over and above the insurance payment or as required by my insurance policy.

A photocopy of the Assignment shall be considered as effective and valid as the original.

I authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this claim.

Signature : _____ Date: _____

MEDICAL RECORDS RELEASE

OPTIONAL

Patient Name:_____ Date of Birth:_____

I hereby request and authorize:

Woodbridge Spine & Sports Rehabilitation
Steven Han, DC PC
14130 Noblewood Plaza, Suite #204 Woodbridge, VA 22193
Tel: 707-878-3434 Fax: 703-878-3833

☐ To provide copies of records to **self**.

☐ To **Disclose** information to: ☐ To **Receive** Information from:

Name of Doctor/Provider:

Address:_____
City/State/Zip_____
Phone: _____ Fax: _____ Email: _____

Information to be disclosed include copies of:

☐ Entire Record ☐ Progress Notes ☐ Daily Notes ☐ Lab results/tests

☐ MRI / Reports ☐ X-Rays / Reports

☐ Other, specify: _____

* X-ray films are originals (considered medical records) and must be returned to this office within 30 days. Digital x-rays on CD are copies and need not be returned.

This authorization will be effective for one year after the date signed, unless canceled in writing. I understand that the cancellation will have no effect on information released prior to receiving the cancellation. A copy of this authorization is as valid as the original. **I understand that I may be charged a fee for record copies.**

_____ Date:_____
Signature of Patient

_____ Date:_____
Signature of Legal Representative/Relationship

(If signing for a minor patient, I hereby state that my parental rights have not been revoked by a court of law.)

Notice to recipient of information: This information has been disclosed to you from confidential records, which are protected by law. Unless you have further authorization, laws may prohibit you from making any further disclosures of this information without the specific written consent of the patient or legal representative.