



CAROLINA REHABILITATION & SURGICAL ASSOCIATES, P.A.

Chart # \_\_\_\_\_

**Cary Office**  
400 Keisler Drive, Cary, NC 27518  
Phone (919) 781-9950 Fax (919) 719-0213

**North Raleigh Office**  
10880 Durant Road, Suite 324, Raleigh, NC 27614  
Phone (919) 847-8200 Fax (919) 847-8249

# Registration Form

Patient Name: \_\_\_\_\_  
LAST FIRST MI

Home Phone: ( ) \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_

Cell Phone: ( ) \_\_\_\_\_ Email: \_\_\_\_\_

### PATIENT INFORMATION

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex:  M  F SS#: \_\_\_\_\_

Language: \_\_\_\_\_ Ethnicity (circle one): Non-Hispanic, Hispanic

Race (circle one): Caucasian, African American, American Indian, Alaska Native, Asian/Pacific Islander, Other

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

City: \_\_\_\_\_ State: \_\_\_\_\_ County: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Employer: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

Occupation: \_\_\_\_\_ Years Employed: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_  
LAST FIRST

Referring Physician: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_  
LAST FIRST

Family Contact: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

How did you hear about us?

Radio \_\_\_\_\_  
SPECIFY CHANNEL

Yellow Pages

TV \_\_\_\_\_  
SPECIFY CHANNEL

Case Manager \_\_\_\_\_  
SPECIFY NAME

Webpage

Physician \_\_\_\_\_  
SPECIFY NAME

Other \_\_\_\_\_

In your own words, describe when and how your injury occurred:

Is your visit related to:  Work Injury  Auto Accident  Other

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

To the best of my knowledge all the above information is correct.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian must sign if patient is under 18 years of age

## Medical History

DATE: \_\_\_\_\_ AGE: \_\_\_\_\_  
 NAME: \_\_\_\_\_  
 Male / Female      Right Handed / Left Handed  
 Please describe your injury/illness:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Currently Working       Not Working       Retired  
 Working w/restrictions: List: \_\_\_\_\_

Smoking:  Yes     No      \_\_\_\_\_ Packs Per Day x \_\_\_\_\_ Years  
 Stopped Smoking \_\_\_\_\_ Years Ago

Alcohol:  Yes     No      Daily / Socially

History of Drug Abuse:  Yes     No      Drug: \_\_\_\_\_

**FAMILY HISTORY:**  
 Family Member      Medical History Of  
 \_\_\_\_\_  
 \_\_\_\_\_

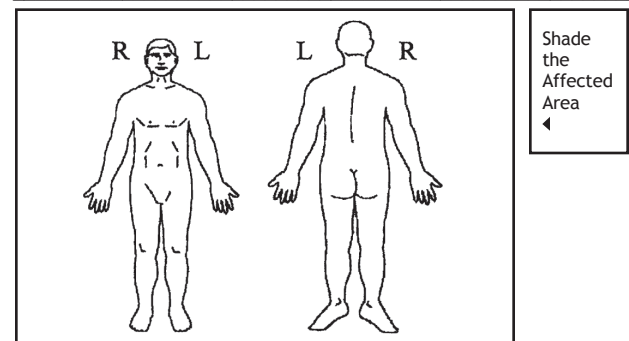
**MEDICATIONS:**  
 (List all medications, including over the counter.)  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Equipment Used for Walking: Cane    Wheelchair    Walker

**REVIEW OF SYMPTOMS:** (Please circle all that apply.)  
 Cons: Fever Chills Weakness Insomnia Fatigue  
 Eyes: Glasses Blurred Vision Double Vision  
 ENT: Hearing Aide Tinnitus  
 CVS: Chest Pain Palpitations DOE  
 Resp: SOB Cough  
 GI: Nausea Vomiting Diarrhea Constipation Incontinence  
 GU: Burning Retention Incontinence  
 Musc: Pain Weakness Decreased ROM  
 Neuro: Numbness Tingling Burning "Pins & Needles"  
 Psych: Depression Anxiety  
 Skin: Rash Ulceration Surgical Wound  
 Lymph/Heme: Swollen Glands Increased Bruising or Bleeding  
 Other: \_\_\_\_\_

**PRIMARY CARE DR.:** \_\_\_\_\_

**OTHER DOCTORS YOU SEE:**  
 \_\_\_\_\_  
 \_\_\_\_\_



Severity/Pain Scale: 0 1 2 3 4 5 6 7 8 9 10  
 Least Severe      Most Severe

Please circle all that you have been treated for:

**HEART:** Chest Pain Palpitations Heart Failure Pacemaker  
 Irregular Heart Rate Valve Replacement Hypertension  
 Hypercholesterol Phlebitis Cellulitis Lymphedema  
 Coronary Artery Disease Bypass Surgery Catherization  
 Angioplasty Stent Placement \_\_\_\_\_

**LUNGS:** Shortness of Breath Emphysema Pneumonia Asthma  
 Pulmonary Embolism \_\_\_\_\_

**GASTROINTESTINAL:** Reflux Disease Hiatal Hernia  
 Hemorrhoids Abdominal Aortic Aneurysm Gallstones  
 Gallbladder Removal Appendectomy Colon Resection Hepatitis  
 Bowel Incontinence \_\_\_\_\_

**GENITOURINARY:** Frequent Urinary Tract Infections Kidney Stones  
 Enlarged Prostate Indwelling Catheter Bladder Incontinence  
 Prostate Surgery Hysterectomy \_\_\_\_\_

**NEUROLOGICAL:** Stroke Traumatic Brain Injury Closed Head Injury  
 Intracranial Hemorrhage Herniated Disc Carpal Tunnel Syndrome  
 Sciatica Limb Numbness/Tingling \_\_\_\_\_

**MUSCULOSKELETAL:** Fractures Osteoarthritis Neck Pain  
 Rheumatoid Arthritis Osteoporosis Low Back Pain Scoliosis  
 Disc Disease \_\_\_\_\_

**ENDOCRINE:** Diabetes Hypothyroid \_\_\_\_\_

**MENTAL HEALTH:** Depression Anxiety Bipolar Disorder  
 Panic Attacks Schizophrenia \_\_\_\_\_

**DIFFICULTY SLEEPING**

**CANCER:** Location: \_\_\_\_\_

Sugery: \_\_\_\_\_

Chemo:  Yes     No      Radiation:  Yes     No

**LIST ALL PAST SURGERIES:**  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**MEDICINE ALLERGIES:** None

**SOCIAL HISTORY:**

Patient Lives with: Spouse / Parents / Son / Daughter / Alone

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



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## Acknowledgement of Receipt of Notice

I acknowledge that I have been given a copy of Carolina Back Institute Notice of Privacy Practices, dated April 14, 2003.

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

Name of Patient or Patient Representative: \_\_\_\_\_

Signature of Patient or Patient's Representative: \_\_\_\_\_

Relationship of Patient's Representative to Patient: \_\_\_\_\_

Evidence of authority of the Patient's representative: \_\_\_\_\_  
(Attach evidence to this page to be filed in chart)



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## Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This notice is effective on April 14, 2003. This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted by law. It also describes your rights to access your protected health information. "Protected Health Information" is information about you, including demographic information, which may identify you and relates to your past, present or future physical or mental health or condition and related health care services.

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 at the time of your next appointment.

### I. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that 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 the physician's practice. The following are examples of the types of uses and disclosures of your protected health care information that the physician's office is permitted to make.

**Treatment.** We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party, such as a home health agency, that has already obtained your permission to have access to your protected health information. We will also disclose protected health information to other physicians, specialists or laboratories who may be treating you or to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

**Payment.** Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may require before it approves or pays for the health care services we recommend for you such as making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and medical record review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

**Healthcare Operations.** We may use or disclose, as needed, your protected health information in order to support the business activities of **Carolina Back Institute**. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk and we may call you by name in the waiting room when your physician is ready to see you. We may also use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. For example, we may leave a message on your answering machine at home or work to confirm your appointment unless you specify otherwise. We also have a web site where you may contact us via e-mail us with any medical questions you may have.

We will share your PHI with third party “business associates” that perform various activities for the practice such as billing and transcription services. Whenever an arrangement between our office and a business associate involves the use or disclosure of your PHI, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your PHI as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also use and disclose your PHI or other marketing activities. For example, your name and address may be used to send you information about products or services that we believe may be beneficial to you or to send you a newsletter about our practice and the services we offer. You may contact our privacy officer to request that these materials not be sent to you.

**Others Involved in Your Healthcare.** Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your PHI that directly relates to that person’s involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose PHI to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your PHI to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

**Emergencies.** We may use or disclose your PHI in an emergency treatment situation.

**Required by Law.** We may use or disclose your protected health information to the extent that is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified of any such uses or disclosures.

**Public Health.** As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury or disability. We may also disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

**Health Oversight.** We may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

**Abuse or Neglect.** We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

**Food and Drug Administration.** We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, and tracking of products to enable product recalls, make repairs or replacements, or to conduct post marketing surveillance as required.

**Legal Proceedings.** We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court, subpoena, discovery request or other lawful process.

**Law Enforcement.** We may also disclose protected health information, as long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include legal processes required by law, limited information requests for identification and location purposes, pertaining to victims of a crime, suspicion that a death has occurred as a result of criminal conduct, in the event that a crime occurs on the premises of the practice and medical emergency (not on the practice's premises) and it is likely that a crime has occurred.

**Coroners, Funeral Directors, and Organ Donation.** We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaver organ, eye or tissue donation purposes.

**Research.** We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

**Criminal Activity.** Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

**Military activity and National Security.** When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel for activities deemed necessary by appropriate military command authorities, for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits or to foreign military authority if you are a member of that foreign military services. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

**Workers' Compensation.** Your protected health information may be disclosed as authorized to comply with workers' compensation laws and other similar legally established programs.

**Inmates.** Should you be an inmate of a correctional institution, we may disclose to the institution or agents thereof health information necessary for your health and the health and safety of other individuals.

**Required Uses and Disclosures.** Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Federal Law.

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law. You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physicians practice has already taken an action relying on the use of your previously signed authorization.

## II. YOUR RIGHTS

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

**You have the right to obtain a copy of your protected health information.** This means you may obtain a copy by providing our staff with a written request for your designated record set. A “designated record set” contains medical and billing records and any other records that your physician and the practice use for making decisions about you.

Under federal law, however, you may not inspect or copy the following records: psychotherapy notes, information being compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and any other records that are subject to Federal or State law. Depending on the circumstances, your request may be denied. You may have the right to have this decision reviewed. Please contact our Privacy Officer if you have questions about access to your medical record.

**You have the right to request a restriction of your protected health information.** This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If your physician believes it is in your best interest to permit use and disclosure of your protected health information, your information will not be restricted. If your physician does agree to the request, we may not violate that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you may wish to request with your physician. You may request a restriction by providing a written request to our Privacy Officer.

You may have the right to have your physician amend your protected health information. This means you may request an amendment of protected health information about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you a copy of any such rebuttal. Please contact our Privacy Officer, **Clara D. Lee at 919- 781-9950 Extension 262** if you have questions about amending your medical record.

**You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.** This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you, to family members or friends involved in your care or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003. The right to receive this information is subject to certain exceptions, restrictions and limitations.

### III. COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated. You may file a complaint with us by notifying our Privacy Officer of your complaint. You may contact our Privacy Officer, **Clara D. Lee at 919-781-9950 Extension 262** for further information about the complaint process.



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## Patient Consent for Use or Disclosure of Protected Health Information for Treatment, Payment or Healthcare Operations

I hereby consent to the use or disclosure of his/her individually identifiable health information (“protected health information”) by CAROLINA BACK INSTITUTE. (“Facility”) in order to carry out treatment, payment, or health care operations. I have the right to review the Facility’s Notice of Privacy Practices for Protected Health Information for a more complete description of the potential uses and disclosures of such information, and also have the right to review such Notice prior to signing this consent form.

Facility reserves for itself the right to change the terms of its Notice of Privacy Practices for Protected Health Information at any time. If the Facility does change the terms of its Notice of Privacy Practices, I may obtain a copy of the revised Notice by written request to the practice.

I retain the right to request that the Facility further restrict how his/her protected health information is used or disclosed to carry out treatment, payment, or health care operations. The Facility is not required to agree to such requested restrictions; however, if the Facility does agree to my requested restriction(s), such restrictions are then binding on the Facility.

At all times, I retain the right to revoke this Consent. Such revocation must be submitted to the Facility in writing. The revocation shall be effective *except* to the extent that the Facility has already taken action in reliance on the Consent.

The Facility may refuse to treat me if he/she (or an authorized representative) does not sign this Consent Form (except to the extent that the Facility is required by law to treat individuals). If I (or authorized representative) sign this Consent Form and then revokes Consent, the Facility has the right to refuse to provide further treatment to Patient as of the time of revocation (except to the extent that the Facility is required by law to treat individuals).

I HAVE READ AND UNDERSTAND THIS INFORMATION. I HAVE RECEIVED A COPY OF THIS FORM AND I AM THE PATIENT OR AM AUTHORIZED TO ACT ON BEHALF OF THE PATIENT TO SIGN THIS DOCUMENT VERIFYING CONSENT TO THE ABOVE STATED TERMS.

\_\_\_\_\_  
Signature of Patient or Legal Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Print Name of Patient or Legal Guardian\*

\*Please explain Representative’s Relationship to Patient and include a description of Representative’s Authority to act on behalf of the Patient:

If we are unable to reach you, are there any relatives or friends with whom you authorize our office to discuss your health information?

\_\_\_\_\_Yes      \_\_\_\_\_No      If so, please list their names below:  
\_\_\_\_\_  
Relationship: \_\_\_\_\_  
\_\_\_\_\_  
Relationship: \_\_\_\_\_  
\_\_\_\_\_  
Relationship: \_\_\_\_\_

By my signature, I authorize you to discuss my health information with those individuals indicated above. This authorization will be in effect until revoked in writing.

\_\_\_\_\_  
Patient/Guarantor Signature

\_\_\_\_\_  
Date

## Financial Policy

We are dedicated to providing you the best possible care and service and realize the cost of healthcare is a concern. To reduce confusion and misunderstanding, we have adopted the following financial policy. This policy is an essential element of your treatment.

In order to minimize your out-of-pocket expense, it is very important that we have your current insurance information on file. Please remember to provide this information to our staff when it changes. This will assist us with resolving your account balance in a timely manner.

### Health Insurance Policies (including Medicare or Medicaid)

- As a courtesy, we accept and file claims to numerous insurance plans. Charges not paid by your insurance company within 60 days will become due and payable to you, unless you have Medicare, Medicaid, or an insurance plan in which we participate. It is your responsibility to verify that we are a participating provider with your insurance plan. Please let us know if you have questions about our participation status.

### Co-payment, Coinsurance, and Deductibles

- All co-payment, coinsurance, and deductible amounts are due at the time services are rendered. We accept all major credit cards as well as Care Credit, an interest free program to assist patients with medical expenses. If you are unable to pay at the time of service, please let us know and we will gladly discuss payment options with you. Failure to take care of your account may result in your appointment being canceled.

**IMPORTANT:** Because we can only estimate patient responsibility, the amount you pay during your visit may not be all that is owed by you. Once your insurance has processed your claim, we will notify you if there is additional patient responsibility.

### Self-Pay or No Insurance

- We expect payment when services are rendered. If you need to make payment arrangements, please let us know and someone will gladly discuss payment options with you.

### Workers Compensation

- With a valid authorization from your adjustor, we will gladly bill your workers comp carrier for your treatment. If there is a problem obtaining an authorization, we will notify your case manager. If your workers comp case is denied, we will file your claim to your health insurance if you provide us with the necessary health insurance information.

### Third Party and Auto/Liability

- You are expected to pay for services personally and will be considered a self-pay patient, unless prior arrangements are made. We do not wait until your claim is settled for payment. You must notify your health insurance if you plan to have claims filed to them.

### Non-Covered Services

- In the event your insurance plan determine a service to be "not covered", you will be responsible for payment. We try to inform patients when services may not be covered but it is the patient's responsibility to understand his/her policy limitations.

### Past Due Accounts

- We want to work with you to keep your account from becoming delinquent. Please let us know if you need assistance so we can discuss payment options with you. If your account balance goes unpaid, it may be turned over to a collection agency and you may no longer be able to receive treatment.

### Missed Appointments

- If you are unable to keep your appointment, please notify us immediately. Failure to provide us adequate notice will result in a \$50 missed appointment fee.

### Other Fees

- A \$25 service charge will be applied to your account for any returned check. We charge \$25 for completion of each disability/medical form.

By signature below, I authorize Carolina Rehabilitation & Surgical Associates (CRSA) to bill my insurance company on my behalf and to collect any insurance payments directly. I further authorize the release of any information to my insurance company or any other party as needed to obtain payment for services rendered. I understand and agree to the financial policy stated above and I accept responsibility for any balance not covered by my insurance company.

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

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

(if patient is under 18 years of age, person responsible for payment must sign)