Authorization & Assignment

I authorize Ramon A. Gonzalez, D.C., P.A. to release any information deemed appropriate concerning my physical condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred by me.

I authorize the direct payment to you of any sum I now or hereafter owe you by my attorney out of the proceeds of any settlement of my case, and by any insurance company obligated to make payment to me or you based in whole or in part upon the charges made for your services.

I understand that whatever amounts you do not collect from insurance proceeds (whether it be all or part of what is due) I personally owe you.

I, the undersigned do hereby appoint Ramon A. Gonzalez, D.C., P.A. the authority necessary to endorse and cash any checks, drafts or money orders which are made payable to the undersigned or as co-payee with this clinic when said payments are due to services rendered on behalf of the undersigned by the clinic. Claims not paid within 45 days by your insurance company, will become your responsibility.

I understand and agree that health and accident insurance policies are an agreement between me and my insurance carrier. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. I will be responsible for any costs of collection, attorney's fee or court costs required to collect my balance.

Patient's Signature _____ Date _____

IF YOURS IS AN ACCIDENTAL INJURY, PLEASE COMPLETE THE FOLLOWING QUESTIONS

Auto Collision_____ On-the-job injury_____ Other_____
Date of Accident:_____ Location: _____
How did accident occur?_____ _____
_____
Please describe the accident or injury _____
_____
If work related, did you report the injury to your foreman or employer? ____Yes ____No
If work related, name and phone number of foreman or authorized person
_____
If auto accident were you ____ Driver ____ Passenger ____ Pedestrian
If auto collision, were you struck from ____Behind ____Right Side ____Left Side ____Front
If auto accident, did your car strike the other(s) involved? ____Yes ____No
Or did the other car strike yours? ____Yes ____No ____Undetermined
Did your vehicles airbag deploy? ____Yes ____No
Were you wearing a seat belt? ____Yes ____No
Did your body strike any objects in the car? ____Yes ____No
List Object(s) struck:_____
Lost work time ____Yes ____No Date you missed work _____

Name:_____ ID #_____ Date: _____

THE SPINE FIX

Welcome to our office.
We provide our patients with the most advanced treatment protocols available for the resolution of spinal conditions.
Our team of professionals will explain and guide you through every step of your diagnosis and treatment.

Our proven **SpineFix Recovery Technique** is designed to provide patients with a speedy recovery from pain and symptoms, but most importantly long lasting pain relief.

3 R's for Patient Recovery from Spine Pain

RELIEVE, RESTORE AND RECLAIM

Relieve Symptoms

- We continuously strive to effectively relieve acute and chronic pain through a comprehensive management of patient's condition with advanced approaches to care.

Restore Spinal Function and Movement

- We promote and utilize nonsurgical techniques, state-of-the-art technology, and breakthrough therapies. We seek to restore each patient to their individual maximum level of function.

Reclaim Spine Health

- By upholding the highest standards of care; integrated effective treatments; and encouraging self-reliant techniques, we work with each patient to reclaim their quality of life; return to active, enjoyable lifestyles; and prevent or minimize recurrence. We value our patients and their referrals and we are committed to be the best in everything we do to deliver the best care possible.

Keep a positive attitude and know that we will do everything we can so that you **HEAL STRONG!**

Dr. Ramon Gonzalez

HEALTH QUESTIONNAIRE

Dear Patient:
Please complete this questionnaire. Your answers will help us determine your course of treatment.

Patient Name: _____ Date of birth _____
Sex: ❑ Male ❑ Female
Social Security #: _____ Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed

Home Address: _____ City: _____ State: _____ Zip: _____

Current Occupation: _____ Referred by: _____

I wish to be contacted at ❑ Home: _____ ❑ Work: _____ ❑ Cell: _____

Email address: _____

PAIN HISTORY

What is your major complaint? _____

How long have you had this pain? ___**Weeks** ___**Months** ___**Years**

Which best describes the quality of your current pain?
❑ Sharp ❑ Burning ❑ Throbbing ❑ Dull ❑ Aching
❑ Stabbing ❑ Shooting ❑ Other _____

What is your pain severity? Please circle the **one** number that best describes your pain at its worst. (10 being worst)
0 1 2 3 4 5 6 7 8 9 10

How often do you have pain?
❑ Constant ❑ Occasional (several times /week)
❑ Intermittent (several times /day) ❑ Rarely (several times/ mo.)

What was the cause of your pain/problem?
❑ Lifting ❑ Fall ❑ Sport ❑ Auto Injury
❑ No particular event ❑ Don't know

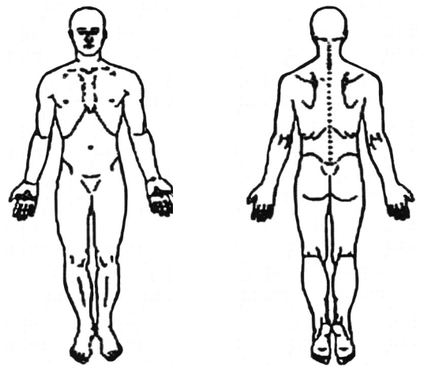
Additional Complaints: _____

Have you been diagnosed by a physician with any of the following:
❑ Herniated Disc ❑ Bulging/Protruded Disc
❑ Annular Disc Tears ❑ Stenosis ❑ Sciatica

Do you have any metal hardware from spinal surgeries?
❑ Yes ❑ No **Where?** ❑ Neck ❑ Back

List past therapies/procedures you have received.
❑ Facet Blocks ❑ Pain Meds ❑ Physical Therapy
❑ Epidurals ❑ Massage ❑ Chiropractic
❑ Other: _____

Please circle areas where you are having pain.



PAIN INDEX

Circle the **one** number that describes how, during the past month, pain has interfered with you:

A. General Activity
(none) 0 1 2 3 4 5 6 7 8 9 10 (completely)

B. Mood
(none) 0 1 2 3 4 5 6 7 8 9 10 (completely)

C. Walking Ability
(none) 0 1 2 3 4 5 6 7 8 9 10 (completely)

D. Normal Work
(none) 0 1 2 3 4 5 6 7 8 9 10 (completely)

E. Relations with Other People
(none) 0 1 2 3 4 5 6 7 8 9 10 (completely)

F. Sleep
(none) 0 1 2 3 4 5 6 7 8 9 10 (completely)

G. Enjoyment of Life
(none) 0 1 2 3 4 5 6 7 8 9 10 (completely)

TOTAL _____ (add the circled numbers)

What makes your pain worse?
❑ Coughing ❑ Lifting ❑ Sneezing ❑ Bending ❑ Sitting ❑ Standing ❑ Walking
❑ Reaching ❑ Exercise ❑ Twisting ❑ Lying Down ❑ Stress ❑ Heat ❑ Cold
❑ Neck Movement ❑ Straining at Stool ❑ Weather Change ❑ Other _____

What makes your pain better?
❑ Nothing ❑ Rest ❑ Heat ❑ Cold ❑ Medications ❑ Exercise/Activity ❑ Other _____

FEMALE ONLY

Are you currently pregnant or believe that you may be pregnant? ❑ Yes ❑ No

PAST MEDICAL HISTORY

Which of the following illnesses have you had?

❑ Arthritis	❑ Low Blood Pressure	❑ Bone Fracture _____
❑ Asthma	❑ Heart Trouble	❑ Dislocated Joints
❑ Sinus Trouble	❑ HIV/ARC	❑ Spinal Disc Disease
❑ Hay Fever	❑ AIDS	❑ Multiple Sclerosis
❑ Allergies	❑ Sexually Transmitted Disease	❑ Scoliosis
❑ Tuberculosis	❑ Ulcer	❑ Mental/Emotional Difficulty
❑ Diabetes	❑ Cancer _____	❑ Prostate Trouble
❑ Epilepsy	❑ Polio	❑ Kidney Trouble
❑ Thyroid Trouble	❑ Rheumatic Fever	❑ Other: _____
❑ High Blood Pressure	❑ Serious Injury	❑ No Previous Conditions

Have you had any prior surgeries? ❑ Yes ❑ No, If so please list below
Date: _____
Date: _____
Date: _____
Date: _____

What are your reasons for consulting our office today?
❑ I want to avoid surgery ❑ Pain is preventing me from being active ❑ My pain keeps coming back
❑ Pain interrupts my sleep ❑ I want to avoid long term medication use ❑ Other therapies didn't work

Is there anything you wish to discuss with the doctor today?