

Workers' Compensation History

Name _____ Age _____ Date of Birth _____ M / F
Address _____ City _____ State _____ Zip _____
SS# _____ Driver's Lic. # _____
Employer's Name _____ Tel. # _____
Address _____ City _____ State _____ Zip _____
Carrier's Name _____ Tel # _____
Address _____ City _____ State _____ Zip _____
Have you retained legal counsel for this injury? Y / N If yes: give name and address _____

Injury Description

Date present injury was received _____ Time of Injury _____ AM/PM Overtime? Y / N
Who saw the accident? Name _____ Title _____
Who reported the accident? Name _____ Title _____
What medical attention was rendered? _____
By whom? __ Nurse __ MD __ DO __ DC __ Other employee __ Other
How did the injury occur? _____
Chief complaint _____
Symptoms _____
Since the injury, are your symptoms __ Improving __ The same __ Getting worse
If working on a machine, give description _____
Do you use foot or hand levelers? Y / N Do you work overhead? Y / N
Do you have to reach? Y / N Where? _____
Movements on the job:
Do you move to your __ Right __ Left __ Up __ Down __ Under __ Over
Do you pick up or lift? Y / N If yes, how much? _____ How often? _____
From where to where? _____ Do you lift from __ Ground __ Bench
__ Platform __ Box __ Pallet __ Other (Please describe) _____
Do you lift in or out of a machine? Y / N
If working at a machine, do you __ Sit __ Stand __ Kneel
Is your work area cluttered Y / N If yes, with what? _____
Is your work area __ Oily __ Dirty __ Slippery __ Other _____
In your job, do you push or pull? Y / N If yes, give specifics _____
Total amount of weight being pushed or pulled on a daily basis _____

Office Work

If your injury has occurred from office work only, please fill out the following:
__ Sit at desk __ Walk __ Stand __ Stoop __ Hold __ Carry __ Other _____
Give percentage if applicable _____ Do you operate office machinery? Y / N
If yes, what type? _____
If your work is at a desk, give specifics of job, computer, typewriter, business machines,
phone, etc. _____
Do you carry anything or pick anything up? Y / N If yes, what? _____

Previous Work History

Was a pre-employment exam performed or required? Y / N
Date _____ Doctor _____ Place _____
Have you ever applied for Workers' Compensation benefits before? Y / N Date _____
Reason _____
Was there a time loss from work? Y / N From _____ To _____ Year _____
State the degree of recovery _____
Did you retain legal counsel for these injuries? Y / N If yes, give name and address _____

Present Work History

What is the job classification of your normal job? _____
Were you performing your normal job? Y / N What shift were you working? _____
How long have you been at your present job? _____ Has there been a
time loss or absenteeism caused from a job injury? Y / N If yes, explain _____
Average work week _____ Hours _____ Days _____

Job Conditions

Type of floor __ Rough __ Smooth __ Wood __ Concrete __ Steel __ Other _____
Type of lighting in building __ Fluorescent __ Overhead __ On Machine __ Other _____
Are you tired when you go home at night? Y / N
Do you have any outside jobs? Y / N If yes, what type? _____
Do you participate in any company-sponsored programs such as exercise, sports, etc?
Y / N If yes, describe _____
How many employees in the plant? _____ How many employees per shift? _____
How many employees do your job? _____ What is the current injury ratio for that job? _____
How many employees have been injured doing your job? _____ Do you like your job? Y / N
If off work, do you want to return to your job? Y / N
What changes would you make to in your job? _____

Patient Signature

Date

Patient Signature

Date

Patient Health Information Consent Form

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care treatment we must require you to read and sign this consent form, stating that you understand and agree with how your record will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information, we encourage you to read the HIPPA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understand and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, health care operations, and coordination of care. As an example, the patient agrees to allow this office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree with those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given to the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent, but would apply to any care given after the request has been presented.
5. For your security and rights privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used, and I agree to these policies and procedures.

Name

Date

PROFESSIONAL FEE SCHEDULE

INITIAL VISIT AND STANDARD VISITS

Consultation	No Charge
Examination	\$60 - \$140
X-rays (per view)	\$55
Office Visit, Adjustment	\$55 - \$70
Extremity Adjustment	\$55
Therapies	\$35

Our experience has shown that it is wise to have an understanding with our patients as to our office policies and fees. This form has been prepared for your convenience and information. We offer several methods of payment for your needs. This information will enable us to better serve you and help to avoid misunderstandings in the future. Our main concern is your health and well-being, and we will do our best to help you in any way we can.

PLAN 1: GROUP INSURANCE

If you have insurance which covers Chiropractic care, we will bill your insurance directly. Please present your card on your first visit. Until we have the completed necessary information to verify coverage, you will be required to pay for your care. This includes any deductible or co-pay at the time of your service. In the event the insurance check should come to you, you are expected to bring the check in to us. Remember, insurance companies do not guarantee payment, do not pay for maintenance care, and ordinarily are designed and intended to only take care of acute problems. Please understand that insurance companies have cost containment programs to reduce the amount of claims paid even when the patient's care is justified.

PLAN 2: CASH

Fees are to be paid at the time services are rendered, unless special arrangements have been made in advance.

PLAN 3: HEALTH CARE MADE AFFORDABLE (HCMA)

For those patients who qualify, we offer discounted cash agreements on a monthly and block basis. Please ask for details.

PLAN 4: WORKER'S COMPENSATION INJURY

You need to report your injury to your employer and bring in insurance information. Payment for services is required until insurance information is verified. We will bill the insurance company directly.

PLAN 5: AUTO/PERSONAL INJURY

You need to report the accident and present your auto insurance card to us on your first visit. Payment will be required until your coverage can be verified. We will bill the insurance company directly.

I have read and understand all of the options available to me.

SIGNATURE: _____ DATE: _____