WELCOME TO ADVANCED HEALTH CHIROPRACTIC

WORKER'S COMPENSATION AUTHORIZATION

Date of Injury:

_____

Employer:

_____

_____

Supervisor:

_____

Supervisor Phone Number:

_____

Employee:

_____

Insurance Carrier:

_____

Adjuster/Agent:

_____

Adjuster/Agent Phone Number:

_____

Authorization Number:

_____

The above named patient has reported to our office for examination ad treatment due to injuries sustained while on the job. Please sign and return this authorization for treatment in our office AND submit a copy of the completed EMPLOYER'S INJURY REPORT.

SIGNATURE: _____ TITLE: _____

WORKER'S COMPENSATION HISTORY

PATIENT REGISTRATION

Name: _____ Today's Date: _____
Date of Birth: _____ Age: _____ Sex: ☐ M ☐ F S.S. Number: _____-_____-_____
Address: _____ /_____ /_____ /_____
Street City State Zip Code
Phone: (Home)_____ (Cell)_____ (Work)_____ Ext._____
Email: _____
Occupation: _____ Employer: _____
Emergency Contact: (Name) _____ (Phone Number) _____
Who may we thank for referring you to our office? _____

COMPENSATION CARRIER

Name of Compensation Carrier:_____
Address: _____ /_____ /_____ /_____
Street City State Zip Code
Employer's Name: _____
Address: _____ /_____ /_____ /_____
Street City State Zip Code
Type of Business:_____
Your Occupation: _____

NATURE OF ACCIDENT/INJURY

Date of Injury: _____

Time of Day: _____

Last Day Worked: _____

Are You Off Work? ☐ Yes ☐ No

Previous Worker's Compensation Injury: ☐ Yes ☐ No

Accident Reported to Employer? ☐ Yes ☐ No If yes, name of person reported accident to: _____

Injured At: _____
Address: _____ /_____ /_____ /_____
Street City State Zip Code
Length of Time Worked There Prior to Accident: _____

Type of Work Being Done at Time of Injury: _____

In your own words, describe the accident: _____
_____
_____
_____
_____
_____

If You Have Returned To Work Since Your Accident, Please Fill Out The Information Below:

DATE	EMPLOYER	OCCUPATION	LIGHT DUTY/ REGULAR DUTY	FULL TIME/ PART TIME

TREATMENT

Have You Been Treated By Another Doctor For This Accident? ☐ Yes ☐ No

If yes, please list doctor's name and address: _____

_____

Type of Treatment Received: _____

How Long Were You Treated By This Doctor? _____

Are You: ☐ Improved ☐ Unchanged ☐ Getting Worse

What Medications Are You Taking? _____

_____

_____

Do These Medications Help? ☐ Yes ☐ No ☐ I Don't Know

Have You Had Physical Therapy? ☐ Yes ☐ No If yes, how often?

☐ Daily ☐ Every Other Day ☐ Several Times a Week ☐ Weekly ☐ Every Other Week ☐ Monthly

☐ Other: _____

Does The Physical Therapy Help? ☐ Yes ☐ No ☐ I Don't Know

MEDICAL HISTORY

Prior to This Accident, Have You Ever Had Any of The Physical Complaints Similar to What You Have Now?

☐ Yes ☐ No ☐ I Don't Know

If yes, please describe: _____

_____

_____

_____

Were These Similar Complaints The Result of a Previous Accident(s)? ☐ Yes ☐ No

Please Provide Details of Accident(s): _____

_____

_____

_____

Have You Had Any Other Serious Accidents Which Required Medical Care? ☐ Yes ☐ No

If yes, please describe: _____

_____

_____

_____

Have You Had Any Serious Illnesses That Required Hospitalization? ☐ Yes ☐ No

If yes, please describe: _____

_____

_____

_____

Have You Had Any Surgeries? ☐ Yes ☐ No

If yes, list type of surgery and date: _____

_____

_____

_____

Have You Had Any Mental Illness? ☐ Yes ☐ No

Have You Had Psychiatric Care? ☐ Yes ☐ No

Have You Received A Medical Discharge From The Armed Forces? ☐ Yes ☐ No

CURRENT MEDICAL COMPLAINTS

BACK PAIN

Currently I Have Pain In My:	☐ Low Back	☐ Middle Back	☐ Upper Back
My Pain Began:	☐ Gradually	☐ Suddenly	
I Have Pain:	☐ Sometimes	☐ All of the Time	
My Pain Goes Into My:	☐ Right Leg	☐ Left Leg	☐ Both
I Have Tingling/Numbness in My:	☐ Right Leg	☐ Left Leg	☐ Both
My Pain Is Worse When I….	☐ Cough	☐ Sneeze	☐ Sit
	☐ Bend	☐ Walk	☐ Lift
	☐ Push	☐ Pull	☐ Sexual Activity

My Back Pain Wakes Me Up During The Night: ☐ Yes ☐ No

NECK PAIN

My Neck Pain Began:	☐ Gradually	☐ Suddenly	
I Have Pain:	☐ Sometimes	☐ All of the Time	
My Pain Goes Into My:	☐ Right Arm	☐ Left Arm	☐ Both
I Have Tingling/Numbness In My:	☐ Right Arm	☐ Left Arm	☐ Both
My Pain Is Worse When I….	☐ Cough	☐ Sneeze	☐ Bend Forward
	☐ Lift	☐ Push	☐ Pull
	☐ Turn My Head	☐ Other: _____	

My Neck Pain Wakes Me Up During The Night: ☐ Yes ☐ No
Changes In The Weather Affect My Pain: ☐ Yes ☐ No
I Have Neck Stiffness: ☐ Yes ☐ No
I Have Headaches: ☐ Yes ☐ No
If I Do Get Headaches, They Occur: ☐ Sometimes ☐ All Of The Time

OTHER PAIN

Please describe any current medical complaints which you are experiencing and were not previously covered on this questionnaire, or list comments you wish to make regarding your condition.

_____
_____
_____
_____
_____

JOB DESCRIPTION

(In terms of an 8-hour workday, "Occasionally" means 1-33%, "Frequently" means 34-66%, and "Continuously" means 67-100% of the day.)

In A Typical 8 Hour Workday I Sit _____ Hours Per Day.
In A Typical 8 Hour Workday I Stand _____ Hours Per Day.
In A Typical 8 Hour Workday I Walk _____ Hours Per Day.

On The Job, I Perform The Following Activities:

	NOT AT ALL	OCCASIONALLY	FREQUENTLY	CONTINUOUSLY
Bend/Stoop	☐	☐	☐	☐
Squat	☐	☐	☐	☐
Crawl	☐	☐	☐	☐
Climb	☐	☐	☐	☐
Reaching Above Shoulder Level	☐	☐	☐	☐
Crouch	☐	☐	☐	☐
Kneel	☐	☐	☐	☐
Balancing	☐	☐	☐	☐

On The Job, I Lift:

	NOT AT ALL	OCCASIONALLY	FREQUENTLY	CONTINUOUSLY
Up To 10 Pounds	☐	☐	☐	☐
11-24 Pounds	☐	☐	☐	☐
25-34 Pounds	☐	☐	☐	☐
35-50 Pounds	☐	☐	☐	☐
51-74 Pounds	☐	☐	☐	☐
75-100 Pounds	☐	☐	☐	☐
100+ Pounds	☐	☐	☐	☐

Do You Have To Bend Over While Doing Any Lifting: ☐ Yes ☐ No
Are Your Feet Used For Repetitive Movements, Such As Operating Foot Controls? ☐ Yes ☐ No

Do You Use Your Hands For Repetitive Actions, Such As:

	Simple Grasping		Firm Grasping		Fine Manipulating	
Right Hand	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
Left Hand	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No

Are You Required To Work On Unprotected Heights? ☐ Yes ☐ No
If yes, please describe: _____
_____
_____
_____

Are You Required To Be Around Moving Machinery? ☐ Yes ☐ No
If yes, please describe: _____
_____
_____
_____

Are You Exposed To Marked Changes In Temperature And Humidity? ☐ Yes ☐ No
If yes, please describe: _____
_____
_____
_____

Are You Required To Drive Automotive Equipment? ☐ Yes ☐ No
If yes, please describe: _____
_____
_____
_____

Are You Exposed To Dust, Fumes, And/Or Gasses? ☐ Yes ☐ No
If yes, please describe: _____
_____
_____
_____

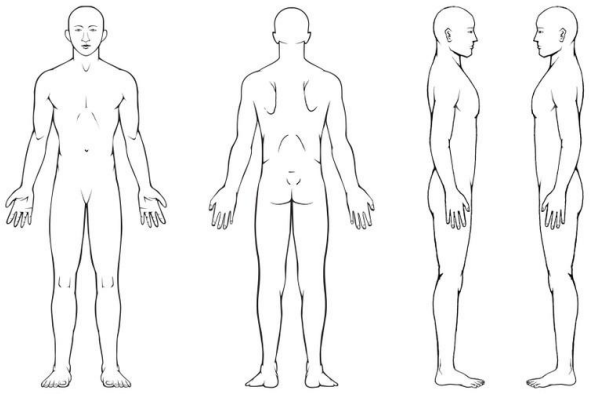
Please List Any Additional Comments:
_____
_____
_____
_____
_____
_____
_____

Signature: _____ Date: _____

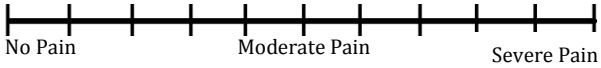
CONDITION

1. Area of Complaint: _____
   When did your symptoms start? _____
   How did your symptoms begin? _____

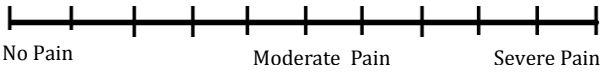
   Mark or shade in where you have pain or other symptoms on the drawings to the right:



2. How often do you experience your symptoms?
   - ☐ Constantly (76-100% of the day)
   - ☐ Frequently (51-75% of the day)
   - ☐ Occasionally (26-50% of the day)
   - ☐ Intermittently (0-25% of the day)
3. What describes the nature of your symptoms? (Check all that apply)
   - ☐ Sharp ☐ Shooting
   - ☐ Dull Ache ☐ Burning
   - ☐ Numb ☐ Tingling
   - ☐ Other: _____
4. How are your symptoms changing?
   ☐ Getting Better ☐ Not Changing ☐ Getting Worse
5. Circle the average intensity of your symptoms:



6. Circle in your symptoms at their worst:



7. Who have you seen for your symptoms?
   ☐ No One ☐ Medical Doctor ☐ Physical Therapist ☐ Other Chiropractor
   ☐ Other: _____
8. Have you had similar symptoms in the past? ☐ Yes ☐ No If so, when? _____
9. What makes your symptoms feel better? _____
10. What makes your symptoms feel worse? _____
11. What activity/activities does this problem prevent you from doing, either partially of totally, that you would really like to be doing again? _____
    _____
12. Does it interfere with your: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation
13. Do you suffer from any conditions other than that which you are now consulting us? _____
14. Have you had any fevers lately? _____ If so, when? _____
15. Have you had any unusual shortness of breath? _____If so, when? _____

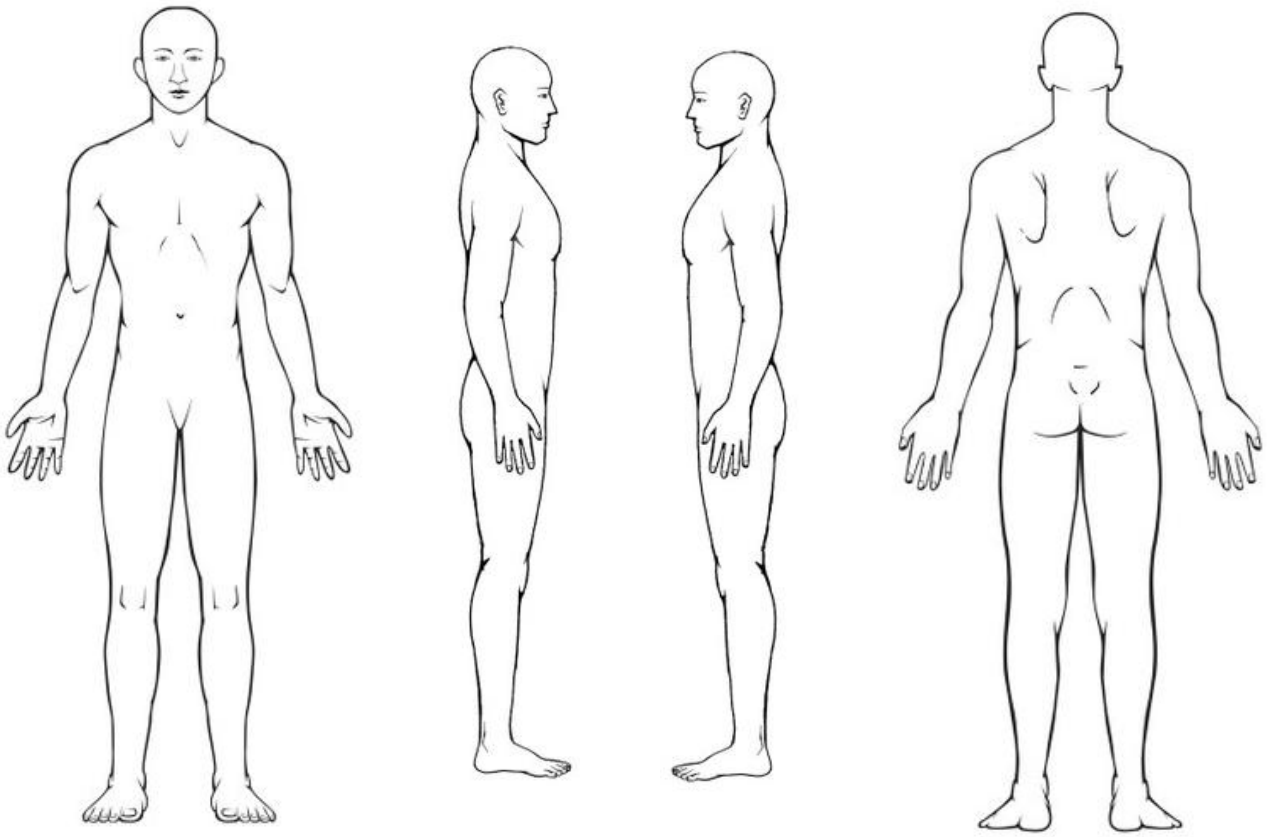
Most patients that come to our office have one of two objectives in mind concerning their healthcare. Some patients come for symptomatic relief of pain or discomfort (relief care). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (corrective care). Dr. George will weigh your needs and desires when recommending your treatment program.

☐ Relief Care ☐ Corrective Care ☐ Check here if you want Dr. George to select the type of care appropriate for your condition

_____ DO NOT WRITE BELOW THIS LINE _____
_____
_____
_____
_____
_____
_____

Please draw the location of your pain or discomfort on the images below. Use the symbols shown to represent type(s) of pain.

D – Dull	S – Stabbing/Cutting
B – Burning	T – Tingling (Pins & Needles)
N – Numb	C – Cramping



On the scales below, please draw a vertical line representing your pain or discomfort:

Rate the pain you have right **now**:

No Pain Moderate Pain Severe Pain

Rate your pain at its **best** in the past week:

No Pain Moderate Pain Severe Pain

Rate your **average** pain in the past week:

No Pain Moderate Pain Severe Pain

Rate your **worst** pain in the past week:

No Pain Moderate Pain Severe Pain

AUTHORIZATION, ASSIGNMENT AND RELEASE

AUTHORIZATION AND ASSIGNMENT

In consideration of your undertaking care of me, I agree to the following:

1. You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred.
2. I authorize 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/or by any insurance company obligated to make any payment to me or you based in whole or in part upon the charges made for your services.
3. In the event of any insurance company obligated by any contractual agreement to make payment to me or to you for the charges made for your services refuses to make such payment upon demand to you, I hereby assign and transfer to you the cause of action that exists in my favor against any such company (the name(s) of which is believed to be correctly set forth under pertinent data) and authorize you to prosecute said action in my name as you see fit and further authorize you to compromise, settle or otherwise resolve said claim as you see fit. However, it is understood that until a reasonable effort has been made to collect the sums due from the insurance company or companies contractually obligated, you will refrain from collecting the amounts owes, directly from me. I understand that whatever amounts you do not collect from insurance companies proceeds, whether it be part of what is due, I personally owe and agree to pay to you.
4. In addition to the above, I hereby waive the statute of limitations on collection and/or recovery in this State of Massachusetts.
5. I further agree that this authorization and assignment is irrevocable and ongoing until all monies owed are paid in full.
6. This authorization and assignment will be in continual effect until revoked by both parties.

Signature: _____ Date: _____

RECORDS RELEASE

To _____ I hereby authorize you to release to _____
Any information, including the diagnosis and records of treatment or examination, rendered to me for all care during the period from _____ to _____.

Patient Signature: _____ Date: _____

Staff Signature: _____ Date: _____

RELEASE FROM CARE

I, _____, hereby understand that Dr. George Palaiologos is releasing me from care for my accident dated _____ and that I have reached:
☐ A pre-accident status or ☐ maximum medical improvement.
I further understand that all expenses incurred from this accident are my responsibility or the insurance company's and that all expenses incurred after the date below will be my personal responsibility. I will make financial arrangements for payment directly.

Patient Signature: _____ Date: _____

Staff Signature: _____ Date: _____

PRIVACY NOTICE ACKNOWLEDGEMENT

We are very concerned with protecting your privacy, especially in matters that concern your personal health information. In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPPA), we are required to supply you with a copy of our privacy policies and procedures. We encourage you to read this document carefully, for it outlines the use and limitation of the disclosure of your health information and your right as a patient. It is located on the last page of this packet. If you have any questions or concerns regarding the use or dissemination of your personal health information, we will be happy to address them.

I acknowledge that I have received a copy of Advanced Health Chiropractic's Notice of Privacy Practices for Protected Health Information.

Signature: _____ Date: _____

APPOINTMENT REMINDER AND HEALTH CONCERN

Your chiropractor and members of the practice staff may need to use your name, address, phone number, and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other related information that may be of interest to you. If this contact is made by phone and you are not available, a message will be left on your answering machine.

You may restrict individuals or organizations to which your health care information is released or you may revoke your authorization to us at any time; however, your revocation must be in writing and mailed to us at our office address. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke authorization. In addition, if we are required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims. Information that we use or disclose based on the authorization you are giving us may be subject to re-disclosure by anyone who has access to the reminder or other information and may no longer be protected by the federal privacy rules.

You have the right to refuse to give us this authorization. If you do not give us this authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives, or other health related information at any time (164.524).

This notice is effective as of today's date. This authorization will expire seven years after the date on which you last received services from us.

Do you wish to provide us authorization to use or disclose my health information in the manner described above?

☐ Yes ☐ No

Signature: _____ Date: _____

NON-COVERED SERVICES WAIVER

I, _____, understand that the services and/or supplies rendered to me may not be eligible for benefits (e.g. service may be determined to not be medically necessary, non-covered or investigated) by _____. I understand that my health insurance has certain restrictions and limitations, such as non-covered services and/or limits to number of visits per year. Since I have chosen to receive the services, I agree to be financially responsible for any and all related charges, if not covered by my insurance.

Signature: _____ Date: _____

I, Dr. George Palaiologos D.C., certify that I have informed my patient, _____, that _____ may not cover certain services under the member's plan as they are considered non-covered services or there may be a limited number of visits per year.

Signature: _____ Date: _____

DOCTOR-PATIENT RELATIONSHIP IN CHIROPRACTIC
INFORMED CONSENT

CHIROPRACTIC

It is important to acknowledge the difference between the health care specialties of chiropractic, osteopathy and medicine. Chiropractic health care seeks to restore health through natural means without the use of medicine and surgery. This gives the body maximum opportunity to utilize its inherent recuperative powers. The success of the chiropractic doctor's procedures often depends on environment, underlying causes, and physical and spinal conditions. It is important to understand what to expect from chiropractic health care.

ANALYSIS

A doctor of chiropractic conducts a clinical analysis for the express purpose of determining whether there is evidence of Vertebral Subluxation Syndrome (VSS) or Vertebral Subluxation Complex (VSC). When such VSS and VSC complexes are found, chiropractic adjustments and ancillary procedures may be given in an attempt to restore spinal integrity. It is the chiropractic premise that spinal alignment allows nerve transmission throughout the body and gives the body an opportunity to use its inherent recuperative powers. Due to the complexities of nature, no doctor can promise you specific results. This depends upon the inherent recuperative powers of the body.

DIAGNOSIS

Although doctors of chiropractic are experts in chiropractic diagnosis, the VSS and VSC, they are not internal medical specialists. Every chiropractic patient should be mindful of his/her own symptoms and should secure opinions if he/she has any concern as to the nature of his/her total condition. Your doctor of chiropractic may express and opinion as to whether or not you should take this step, but you are responsible for the final decision.

INFORMED CONSENT FOR CHIROPRACTIC CARE

A patient, in coming to the doctor of chiropractic, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, defects, deformities, or pathologies may render the patient susceptible to injury. The doctor, of course, will not give a chiropractic adjustment, or health care, if he is aware that such care may be contraindicated. Again, it is the responsibility of the patient to make it known or to learn through health care procedures whatever he/she is suffering from: latent pathological defects, illness, or deformities which would otherwise not come to the attention of the doctor of chiropractic. The patient should look to the correct specialist for the proper diagnosis and clinical procedures. The doctor of chiropractic provides a specialized, non-duplicating health service. The doctor of chiropractic is licensed in a special practice and is available to word with other types of providers in your health care regime.

RESULTS

The purpose of chiropractic services is to promote natural health through the reduction of the VSS or VSC. Since there are so many variables, it is difficult to predict the time schedule of efficacy of the chiropractic procedures. Sometimes the response is phenomenal. In most cases there is a more gradual, but quite satisfactory response. Occasionally, the results are less than expected. Two or more similar conditions may respond differently to the same chiropractic care. Many medical failures find quick relief through chiropractic. In turn, we must admit that conditions which do not respond to chiropractic care may come under the control or be helped through medical science. The fact is that the science of chiropractic and medicine may never be so exact as to provide definite answers to all problems. Both have made great strides in alleviating pain and controlling disease.

TO THE PATIENT

Please discuss any questions or problems with the doctor before signing this statement of policy.

I have read, and understand the foregoing. Signature: _____

Date: _____

EXCLUSIVE AND IRREVOCABLE ASSIGNMENT OF BENEFIT
AUTHORIZATION FOR RELEASE OF CHIROPRACTIC REPORTS
DOCTOR'S EQUITABLE LIEN
ATTORNEY'S ACCEPTANCE

Re: Name of Patient: _____

Name of Facility: Advanced Health Chiropractic

Name of Doctor: Dr. George Palaiologos D.C.

Name of Attorney: _____

In consideration of the agreement of the doctor described above that provides me with chiropractic services, I hereby irrevocably assign to said doctor, all my right and interest in and to all insurance or indemnification benefits of any and all types. This includes, but is not limited to, automobile, Health Insurance, Personal Injury Protection (PIP) Coverage, and automobile medical payment coverage to which I may be entitled to the extent of the amount of the bill for services rendered to me on and after the above date in connection with my injury or illness, and I hereby grant to said doctor an equitable lien on any of the above-mentioned insurance benefits that may be due me, and furthermore, I authorize my doctor to provide the insurance company responsible for payment of services and my attorney with a full report concerning my condition and treatment, including, but not limited to, dates of visits and charges incurred. I further grant to said after the above date in connection with my injury or illness.

I hereby authorize and direct the immediate payment of said benefits directly to the doctor and request and direct that the above-named insurance company pay the said doctor such sums as may be due to him or her upon receipt of an itemized statement for services rendered to me by the doctor.

It is further understood and agreed that payment of said itemized statement by the above-mentioned insurance company as herein directed by me shall be considered the same as if paid directly by me. I am aware that I am personally responsible to the doctor for full amount of my bill and direct my attorney to pay the outstanding balance on my bills from the proceeds of any settlement of disposition of my case. I understand I am fully responsible for all legal fees including all attorney fees incurred in the cost of collections and I am also responsible for interest at the rate of 0.5% per month on outstanding amounts more than 60 days old.

Patient Signature: _____ Date: _____

AGREEMENT OF ATTORNEY

As an inducement for the doctor to render services to my client, I hereby do honor the above assignment and pay immediately to the doctor all sums received by me attribute to the doctor's bill and also agree to pay from the proceeds of any settlement or recovery any balance due to the doctor.

Attorney Signature: _____ Date: _____

Name of Attorney (Please Print): _____