Patient Information and Intake Form

Thank you for choosing Connecticut Spine & Rehab, LLC as part of your health care team.

Today's Date________________________________

Patient Name____________________________________ Social Security#____

Date of Birth_____________________________________ Age_________ M_______F____________________________________

Marital Status: Single______________Married______________Divorced_____________Widowed_______________

Occupation____ Employed By____

Street Address____

City____________________________________State________________________Zip Code________________________________

Home Phone #_________________________Cell Phone #_________________________Work #___________________________

E-mail address____

If needed, I can also be contacted through:

Name ___________________________________ Phone #________________________Relationship_______________________

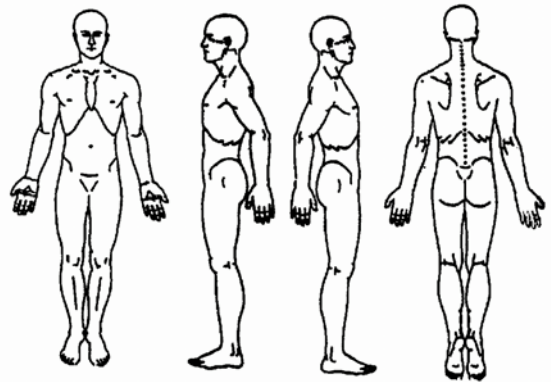
Connecticut Spine & Rehab

Injury Relief Centers

CONFIDENTIAL PATIENT INFORMATION

LIST PRESENT COMPLAINTS: **Please rate pain level (0-10)**

1. ______________________________ /10
2. ______________________________ /10
3. ______________________________ /10
4. ______________________________ /10
5. ______________________________ /10
6. ______________________________ /10



LIST ANY DISEASE OR ILLNESS WITH WHICH YOU HAVE BEEN DIAGNOSED:

(Examples: Diabetes, Heart Disease, High Blood Pressure, Stroke, Asthma, Ulcers, Cancer, Arthritis, Depression, Etc)

____

____

____

____

____

LIST MEDICATIONS AND/OR DIET SUPPLEMENTS YOU TAKE:

What/Frequency/Doctors/Side Effects/Remarks______________________________

____

____

____

____

WHAT SURGERIES HAVE YOU HAD?

Type/When/Doctor/Results______________________________

____

____

____

LIST FORMER SERIOUS ACCIDENTS AND FALLS: (AUTO, WORK, HOME, LEISURE, SPORTS, OTHER)

What/When/Symptoms/Treatment/Results______________________________

____

____

____

MOTOR VEHICLE INTAKE FORM

CARRIER INFORMATION

Insurance Carrier Name: ____ Carrier Phone No. _________________

Address: ____

Policy No. __________________________ Claim No. _______________________ Date of Accident: _________________

Was the accident reported to your carrier? ☐ yes ☐ no

Do you have medical coverage with your auto insurance policy? ☐ yes ☐ no

ATTORNEY INFORMATION

Attorney's Name: ____ Phone No. _________________

Address: ____

May we contact your attorney regarding your case? ☐ yes ☐ no

AUTHORIZATION

I, the undersigned, certify that the information given above is correct. I clearly understand and agree that all services rendered to me that are not covered, are charged directly to me, and that I am personally responsible for payment.

Patient's Signature: ____ Date: _____________________

Please note: In this instance, we will attempt to bill any back-up insurance you may have prior to billing you directly.

Automobile Accident Questionnaire

Today's Date ________________ Date of Injury ____________ Location of Injury ____________________________
(Connecticut, New York, Etc.)

Were you the driver or passenger?____

Where were you seated in the car?____

Were you wearing a seat belt? Y N

Mechanism of injury (rear impact, passenger side impact, driver side impact, front impact)?______________

Was there a secondary impact (another car, a curb or barrier, etc.)?_____________________________

Were you prepared for the impact? Y N

Did you strike any part of your body on the interior of the car? (What and Where) ____________________

____

Did you lose consciousness? Y N How long? _____________________________________

Were you attended to by an EMT? Y N

Were you taken to the hospital? Y N Which Hospital?___________________________

IF YES: By ambulance or other transportation?___________________________

Were x-rays performed? Y N What body areas?_____________________________

Were you admitted over night? Y N

Were you given orthopedic supports or braces? Y N What type? ____________________

Were you given medications or prescriptions? Y N What type? ____________________

____

What were your discharge instructions? (no work, rest, home care, follow-up, exercise, etc.)_____________

____

Have you had any other medical care since the injury? Y N

Doctor or clinic name ____

When consulted ____

Treatment:____

Have you had any diagnostic tests since the accident? (MRI, CT Scan, Bone Scan, X-Ray, etc.)

____

Have you had any previous accident or injuries? Y N When?______________________________________

Have you missed days from work? Y N How many? ______________________________________

PRIMARY PAYER FORM

Dear Attorney, subsequent attorneys, and insurance companies:

I have agreed to have Connecticut Spine & Rehab, LLC consider my litigation case as primary payer. I request that they bill its normal full fee schedule, and if it is presented for settlement in regard to liable insurance companies or other liable parties in regards to litigation case I will pay, and direct my attorney to pay out of proceeds.

Connecticut Spine & Rehab will bill any collateral insurance presented to us in accordance with their contract. We will accept payment for any covered services. This lien letter will protect all uncovered services.

I hereby direct you, my attorney, the insurance company paying my attorney, to pay directly to Connecticut Spine & Rehab, LLC such sums as may be due for professional services rendered to me by reason of this accident that are due their office and to withhold such sums from any settlement, judgment or verdict which may be paid to you, my attorney, or myself as the result of the injuries for which I have been treated.

This agreement is made solely for said doctor's additional protection and in consideration of his awaiting payment.

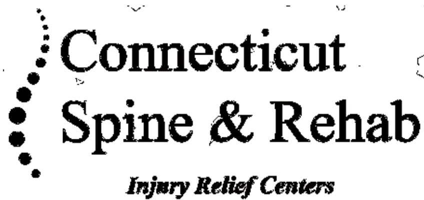
Patient Signature_________________________________ Date _______________________

We would appreciate you signing and returning this letter of protection below as soon as possible to our office:

I shall protect the outstanding bill for services rendered of Connecticut Spine & Rehab, LLC out of the proceeds of any judgment or settlement for above mentioned patient by this office for the above-mentioned accident.

By: ____Date: ______________________

Attorney's Signature



PRIVACY STATEMENT ACKNOWLEDGEMENT

At Connecticut Spine & Rehab, LLC maintaining our patients trust and confidence is very important to us. That is why we have made it our priority to keep the information you provide us safe and confidential. Our employees are educated on the importance of maintaining the confidentiality of your health information.

The Practice's Privacy Notice has been provided to me prior to my signing this form. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information (PHI) necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out health care operations. The Practice explained to me that the Privacy Notice is available to me now, or in the future at my request.

The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.

I understand that, and consent to, the following appointment reminders that may be used by the Practice: a postcard mailed to me at the address provided by me; telephoning my home and leaving a message on my answering machine or with the individual answering the phone.

The practice may use and/or disclose my PHI (which includes information about my health or condition and treatment provided to me) in order for the Practice to treat me and obtain payment for that treatment, and as necessary for the Practice to conduct its specific health care operations.

I understand that I have a right to request an accounting of the disclosure of my PHI other than for treatment, payment and/or health care operations. I understand I may restrict access or disclosure of my PHI. However, the Practice is not required to agree to any restrictions that I have requested. If the Practice agrees to be requested restriction, then the restriction is binding on the Practice.

I understand the Practice may share my PHI with the Connecticut Chiropractic Association in the event advocacy is needed for insurance claims or utilization disputes.

I acknowledge that I have received the Privacy Statement of Connecticut Spine & Rehab, LLC.

_______________________________________ _______________________________________

Name of Individual (Printed) Signature of Individual

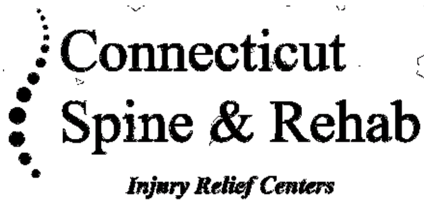
____ _______________________________________

Signature of Legal Representative Relationship

(Guardian, Parent if a minor)

Date Signed ______/______/_______ ____

Witness



PHYSICAL THERAPY RESPONSIBILITY

1. I hereby authorize Connecticut Spine & Rehab, LLC to obtain any information which may have been acquired by examination or other means regarding my physical condition, and thereby release them of any consequences thereof.

2. I acknowledge that I have received and or read the Privacy Statement acknowledgement of Connecticut Spine & Rehab, LLC.

3. I hereby authorize release of information necessary to file a claim with my insurance company.

4. I understand the Doctor may administer services uncovered by my insurance company, which I will be responsible for.

5. I understand that I am solely responsible for any outstanding balances due to Connecticut Spine & Rehab, LLC upon completion of my treatment.

6. I assign insurance benefits otherwise payable to me, to Connecticut Spine & Rehab, LLC.

Date:___/___/___ ______________________ ______________________

Patient Name Patient Signature

Informed Consent to Chiropractic Treatment

While rare, some patients may experience short term aggravation of symptoms, rib fractures, muscle and ligament strains/sprains, and dizziness as a result of manual therapy techniques. There are reported cases of stroke associated with many common neck movements including adjustment of the upper cervical spine. The apparent association is noted infrequently, however, you are being warned of this possible association because stroke can cause serious neurological impairment, and may on rare occasion result in injuries including paralysis. The possibility of such injuries resulting from upper cervical spinal adjustment is rare, however, possible. There are rare reported cases of disc injuries following cervical and lumbar spinal adjustments or chiropractic treatment. Chiropractic treatment, including spinal adjustment, has been the subject of government reports and multi-disciplinary studies conducted over many years and has been demonstrated to be effective treatment for many neck and back conditions involving pain, numbness, muscle spasm, loss of mobility, headaches and other similar symptoms. I acknowledge I have discussed, or have had the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic treatment in general and my treatment in particular (including spinal adjustment) as well as the contents of this Consent.

I consent to the chiropractic treatments offered or recommended to me by my chiropractor, including spinal adjustment. I intend this consent to apply to all my present, and future chiropractic care.

Patient Name: ______________________________**Date:**___________________

Witness Name: _____________________________**Date:**___________________