GREATER ROCHESTER CHIROPRACTIC

LISTEN KNOW HEAL PROTECT

BRIGHTON Leslie W. Lange, DC
Samuel W. Ascioti, DC
E. Daniel Quatro, DC
Jason T. Swinton, DC
Megan A. Tuzzo, DC
WEBSTER Amy E. Kochersberger, DC
Samuel W. Ascioti, DC

WORKERS' COMPENSATION: WORK-RELATED INJURY INFORMATION

Patient's Name: _____ Today's Date: _____

Gender: ___M ___F Date of Birth: _____ /_____ /_____ Age: _____ Social Security #: _____

Address/City/State/Zip: _____

Cell Phone: _____ Home: _____ Work: _____

Employer Information:

Employer when injury occurred: _____

Employer Address:_____

Contact Person: _____ Phone#: _____

Workers' Compensation Billing Information:

Employer's insurance carrier: _____ Carrier Code# (if known): _____

Insurance carrier's address: _____

WCB Case # (if known): _____ Carrier Case # (if known): _____

Contact Person: _____ Phone#: _____

Injury History:

Date of injury/onset of illness: _____

Have you filed a Workers' Compensation accident report with your employer? ___ Yes ___ No

On the date of injury/illness what was the patient's job title or description: _____

On the date of injury/illness what were the patient's usual work activities: _____

_____

Briefly describe where and how the injury/illness happened: (Please also specify general area of injury i.e.: neck, mid-back, low back, other): _____

_____

Did another health provider treat this injury/illness including hospitalization and/or surgery? ___Yes ___No

If yes, give provider's names: _____

Have you missed work because of the illness/injury? ___ Yes ___No

If yes, date first missed work: _____

Have you returned to work? ___ Yes ___No

If yes, date returned to work: _____

Do you have an attorney who has advised you in this claim? ___ Yes ___ No

Attorney's Name: _____ Phone #: _____

Address: _____

Patient Signature:_____ **Date:**_____

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Patient Information

Patient's Name: _____ Today's Date: _____

Gender: ___M ___F Date of Birth: _____ /_____ /_____ Age: _____ Social Security #: _____

Address/City/State/Zip: _____

Cell Phone: _____ Home: _____ Work: _____

Email (for appointment reminders): _____

Emergency Contact: _____ Phone: _____ Relationship: _____

Marital Status: ___Single ___Living with partner ___Married ___Widowed ___Separated ___Divorced

Spouse's / Partner's Name: _____ # of Children: _____

Primary Care Physician: _____

Whom may we thank for referring you to our practice? _____

Health History

Main condition/symptom: _____

Other condition/symptoms: _____

How long have you had these symptoms? _____

Height: _____feet _____inches Weight: _____ lbs. Last known Blood Pressure: _____ / _____

Hypertension: ___Yes ___No Diabetes: ___Yes* ___No *If Yes: ___Type I ___Type II

Surgeries: _____ Approx. dates: _____

Hospitalizations: _____ Approx. dates: _____

Major Illnesses: _____ Approx. dates: _____

Allergies: ___Cortisone ___ Latex Other: _____

Food Allergies: _____

Medication Allergies: _____

Medication List *(Include regularly used over-the-counter medications.)*

Medication Name	Dosage and Frequency (i.e. 5 mg 1x per day, etc.)

Family Medical History

Family Member	Diagnosis / Details

Please complete and sign the next page →

Social History

Smoking	Caffeine	Recreational Drug Use	Alcohol
___never	___never	___none	___never
___former	___less than 3 per day	___recreational	___1-3 per week
___every day	___3-6 per day	___addiction	___4-6 per week
___occasionally	___more than 3-6 per day	___in recovery	___more than 6 per week

Occupation: _____ or ___full-time parent ___unemployed ___in school ___retired

Employer: _____

Have you been bothered by any of the following problems?

1) During the past month, have you felt down, depressed or hopeless? ___Yes ___No

2) During the past month, have you felt little interest or pleasure in doing things? ___Yes ___No

Current Complaints

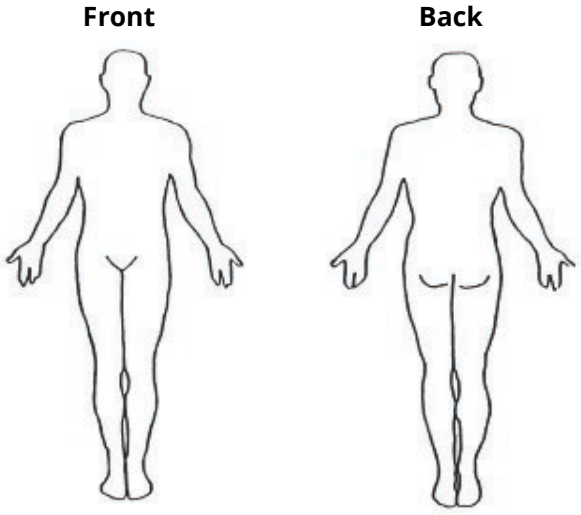
Using the symbols below, please indicate the location of your discomfort on the body diagram.

SHARP/STABBING † † † †

DULL/ACHEY V V V V

PINS/NEEDLES 0 0 0 0

NUMBNESS \ \ \ \



Please circle your pain level: (no pain) **0 1 2 3 4 5 6 7 8 9 10** (severe pain)

Do you have pain every day? ___Yes ___No Does your pain wake you at night? ___Yes ___No

What increases your pain? _____

What decreases your pain? _____

Are your symptoms: ___Worsening ___Unchanged ___Improving

Have you had previous chiropractic care? ___Yes ___No

Have you seen other doctors for this condition? If so, who? _____

Do you perform neck/back exercises? ___Yes ___No Date of last physical exam: _____

Date of last spinal X-RAYs/MRIs: _____ Date of last bloodwork: _____

Patient Signature:_____ **Date:**_____

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Functional Rating Index

Patient's Name: _____ Today's Date: _____

Please indicate the area of discomfort:

____Neck ____Mid-back ____Low back ____Other:_____

For each item below, **please circle the number which most closely describes your condition right now.**

1. Pain Intensity

0	1	2	3	4
No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

2. Sleeping

0	1	2	3	4
Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

3. Personal Care (washing, dressing, etc.)

0	1	2	3	4
No pain; no restrictions	Mild pain; no restrictions	Moderate pain; need to go slowly	Moderate pain; need some assistance	Severe pain; need 100% assistance

4. Travel (driving, etc.)

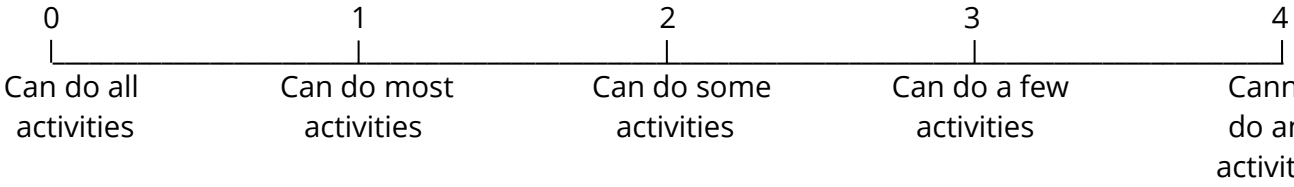
0	1	2	3	4
No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips

5. Work

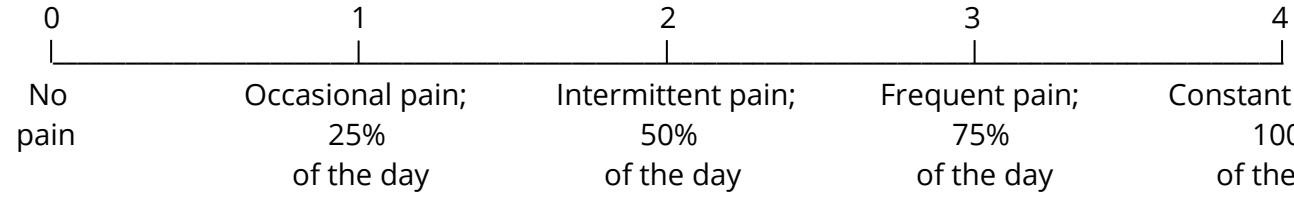
0	1	2	3	4
Can do usual work plus unlimited extra work	Can do usual work; no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work

Please complete and sign the next page ⟶

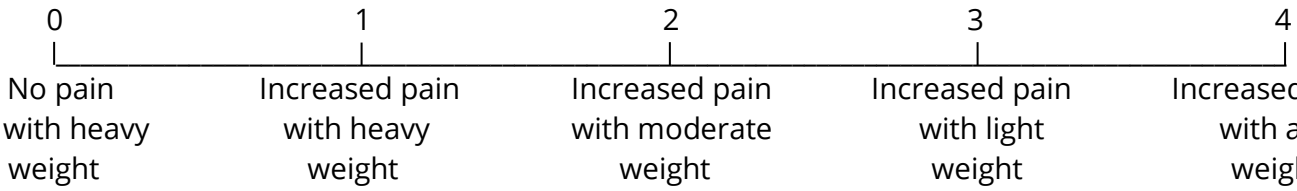
6. Recreation



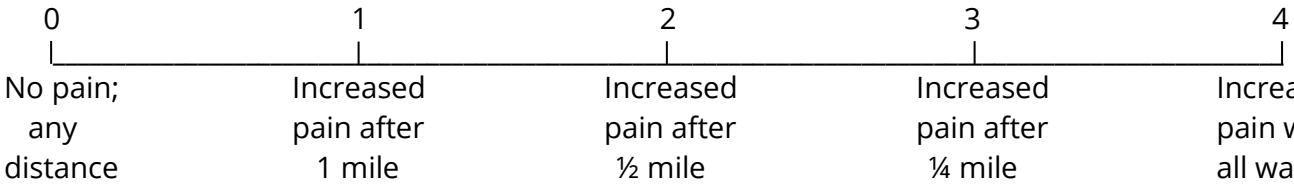
7. Frequency of pain



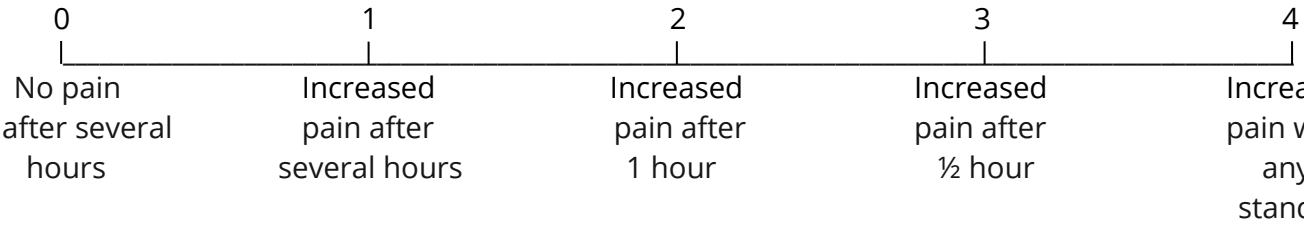
8. Lifting



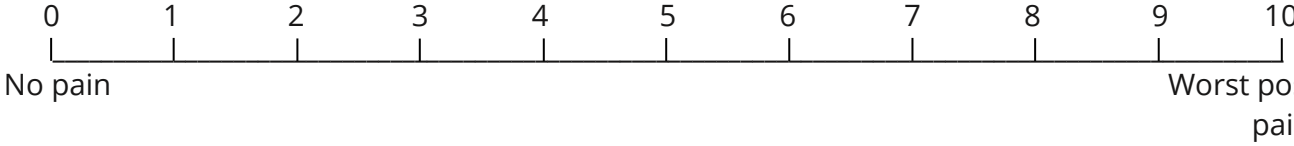
9. Walking



10. Standing



Please circle the number that best describes your pain intensity today.



Patient Signature:_____ **Date:**_____

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Office Guidelines and Fee Policy

Patient's Name: _____ Today's Date: _____

Please initial <u>EACH</u> line in this section.

<u>I UNDERSTAND AND AGREE TO THE FOLLOWING:</u>

____ **As per my health insurance contract and the Office Fee Policy, <u>my payment is due at the time of service</u> for any Self-pay, Co-Pay, Co-Insurance, and/or Deductible amounts (except for No Fault cases).**

***** *If full payment is not an option, please speak to the Office Manager* ***prior*** *to your treatment to request a payment plan or discount due to a financial hardship. You will be required to provide documentation such as income statements or proof of Medicaid insurance in order for a discount to be considered.* ***If a payment plan is not arranged <u>prior to receiving your treatment</u>, you may be ineligible for a payment plan for that treatment.***

____ **If my account becomes 90 days delinquent,** the office has the right to deem it a collection item and it will be turned over to a collection agency.

____ **A $20.00 fee will be added to my account for any check that is returned by the bank for "Insufficient Funds."**

____ **I may be charged a $50.00 Missed Appointment Fee,** if I fail to give 24 hours' notice when canceling an appointment, or if I fail to show up for a scheduled appointment.

____ **If I do not follow this agreement, Greater Rochester Chiropractic reserves the right to cancel or not schedule future appointments.**

Continued on next page ⟶

Please initial <u>ONE</u> line in this section.

<u>I UNDERSTAND AND AGREE TO THE FOLLOWING:</u>

____ **I have health insurance:** I am ultimately responsible for determining my health insurance policy's chiropractic coverage, including but not limited to the following: co-payments, co-insurances, deductible amounts, limits on number of visits, referral requirements, maximum reimbursements available for chiropractic services, and verifying that my doctor participates with my insurance plan. I am responsible for paying any charges that are NOT covered or are DENIED by my health insurance plan.

- ***** *Please contact your insurance company at the Customer Service phone number printed on your insurance card if you have questions pertaining to your coverage and benefits and/or questions about how your insurance company processed your claim.*
- ***** *Please be aware that health insurance companies provide quotes, but **<u>will not guarantee</u>** your coverage and benefits based on a quote. **<u>Your insurance company will process the claims we submit and make a final determination of your coverage.</u>***

____ **I have Medicaid:** Medicaid does not provide any coverage for chiropractic treatment. I will provide proof of continued Medicaid coverage each month and I will Self-pay.

____ **My doctor does not participate with my insurance company or specific insurance plan:** I will Self-pay for my treatment.

- ***** *We submit claims to the insurance companies and plans that our doctors participate with. If your doctor does not participate with your insurance company or your insurance plan, we will provide a detailed receipt for you to submit for possible reimbursement. As previously stated, your payment to our office will be due at the time of service.*

____ **My insurance does not cover chiropractic treatment:** I will Self-pay for my treatment.

____ **I do not have health insurance:** I will Self-pay for my treatment.

____ **My injury occurred at work (Workers' Compensation):** **<u>Choose ONE of the following options.</u>**

_____I am being treated by Samuel W. Ascioti, DC, who participates with the NYS Workers' Compensation Board. I am responsible for filing an injury report with my employer and will provide this office with all necessary information related to the case. Claims will be billed to my employer's Workers' Compensation insurance carrier and payment will be made directly to the doctor.

_____I am being treated by a doctor who does not participate with the NYS Workers' Compensation Board and I will Self-pay. My personal health insurance company is not responsible for and cannot be billed for any treatment of injuries that occurred at work, regardless of whether I file a Workers' Compensation claim through my employer or not.

____ **I was involved in a Motor Vehicle Accident/No-Fault (NF):**

I am responsible for filing an accident report with the automobile insurance carrier and providing this office with all necessary information related to the case. Claims will be billed to the insurance carrier and payment will be made directly to the doctor. If my NF or PI carrier deny payment for my case, I will owe payment for the services rendered.

- ***** *Please be aware that <u>some auto policies have a Medical Deductible</u> that must be paid by you before payments will be made by the insurance company. You must complete any paperwork your insurance carrier requests and attend any examinations they require. If you do not follow the insurance company's guidelines they could deny payment, making you fully responsible for payment.*

_____ _____

Printed Name of Patient or that of Legal Representative *Patient's Signature or that of Legal Representative*

_____ _____

Today's Date *If Legal Representative, indicate relationship*

Witness: _____ *(office staff)*

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Acknowledgement of Receipt of Notice of Privacy Practices

This form will be retained in your medical record.

NOTICE TO PATIENT

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice.

Patient Name:_____ **Date of Birth:**_____

I acknowledge that I have **received and had the opportunity to review** the Notice of Privacy Practices on the date below on behalf of Greater Rochester Chiropractic.

I understand that the Notice describes the uses and disclosures of my protected health information by Greater Rochester Chiropractic and informs me of my rights with respect to my protected health information.

_____ _____

Printed Name of Patient or that of Legal Representative *Patient's Signature or that of Legal Representative*

_____ _____

Today's Date *If Legal Representative, indicate relationship*

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

☐ The patient refused to sign.

☐ Due to an emergency situation it was not possible to obtain an acknowledgement.

☐ Communications barriers prohibited obtaining the acknowledgement.

☐ Other (please specify):_____

_____ _____

Employee Name *Today's Date*