WORKERS COMPENSATION QUESTIONNAIRE

Today's Date _____

Last Name _____ First Name _____ Initial _____

Street _____ City _____ State _____ Zip _____

Home Phone# _____ Work Phone# _____ Cell #

SS# _____ Date of Birth _____ Sex _____ Marital Status _____

Email Address _____ Employer _____

Street _____ City _____ State _____ Zip _____

INJURY INFORMATION

To ensure all billing is submitted properly, please provide us with the following information. During the course of your treatment, you may recieve important paperwork from other sources regarding your injury, please bring it into our office so we can make a copy for our records.

Date of Injury _____ Time of Injury _____

Place of Injury (City, Town, or Villiage) _____

When did your present symptoms appear? _____

Injury was reported to Employer? ☐No ☐ Yes To whom? _____

Please describe how injury occurred, Patient states, "While at work, I _____

_____

_____

Have you seen other doctors for this condition? ☐ No ☐ Yes If yes, please provide us with their name(s):

_____

Were X-rays taken? ☐ No ☐ Yes Other tests? ☐ No ☐ Yes If yes, please list test(s) and result(s):

_____

Have you lost time from work? ☐ No ☐ Yes How much? _____

Any previous Worker Compensation injuries? ☐ No ☐ Yes Please provide us with previous injuries and dates:

_____

I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment in the event that my claim for Workers Compensation benefits is denied.

Patient's Signature _____ **Date** _____

AGREEMENT TO PAY MEDICAL COSTS IN THE EVENT OF FAILURE TO PROSECUTE OR IF COMPENSATION CLAIM IS DISALLOWED

WCB CASE# (if known)	CARRIER CASE# (if known)	DATE OF INJURY	NATURE OF INJURY OR ILLNESS	INJURED PERSON'S SOCIAL SECURITY#

CLAIMANT	NAME	ADDRESS
EMPLOYER		
INSURANCE CARRIER		

IN THE EVENT I FAIL TO PROSECUTE THE CLAIM FOR WORKERS' COMPENSATION FOR THIS ILLNESS OR CONDITION OR IT IS DETERMINED BY THE WORKERS' COMPENSATION BOARD THAT THE ILLNESS OR CONDITION IS NOT A RESULT OF A COMPENSABLE WORKERS' COMPENSATION CASE, I _____, hereby agree to pay (name of doctor) _____(address of doctor) _____his/her usual and customary fees for services rendered to the above named claimant in the above identified case.

Date_____Signature_____

If signed by other than claimant, print below: name, address, and relationship of signer.

_____ _____
Name Relationship

_____
Address

Prescribed by Chairman
Workers' Compensation Board
State of New York

A-9 (10-84)
NY/WC

PATIENT HISTORY

NAME_____ DATE_____

DATE OF BIRTH_____ SS#_____

CHIEF COMPLAINT: NECK PAIN HEADACHES MID-BACK LOW BACK ARM SHOULDER LEG OTHER
EXPLAIN_____

PAIN RADIATES: YES NO IF YES FROM _____ TO _____

ONSET: DATE_____ ONSET WAS: GRADUAL SUDDEN PROGRESSIVE OVER TIME

HOW LONG HAVE YOU HAD THIS PROBLEM? _____

HAS THIS PROBLEM: IMPROVED REMAINED THE SAME WORSENED ON AND OFF

IS THE COMPLAINT INJURY RELATED? YES NO WORK AUTO
EXPLAIN_____

MODE OF ONSET: POSITIONAL TRIP/ FALL OTHER_____

SEVERITY OF PROBLEM: 1 2 3 4 5 6 7 8 9 10
(BEST) (WORST)

DURATION OF SYMPTOMS: INTERMITTENT (25% OF THE TIME) OCCASIONAL (25-50%)
FREQUENT (50-75%) CONSTANT (100%)

CHARACTER OF PAIN: DULL/ ACHE SHARP/ STABBING BURNING NUMBNESS/TINGLING
THROBBING OTHER(EXPLAIN)_____

HAS THIS PROBLEM AFFECTED: BOWEL OR BLADDER _____
OTHER BODY SYSTEMS (EXPLAIN)_____
NO APPERANT RELATIONSHIP

RELIEVING FACTORS: REST EXERCISE BRACING SITTING STANDING LYING DOWN HEAT COLD
OTHER:_____

AGGRAVATING FACTORS: COUGHING SNEEZING LIFTING BENDING PUSHING PULLING DRIVING
RIDING SITTING STANDING WALKING RUNNING OTHER_____

MEDICATIONS/SURGERIES_____

PREVIOUS INJURIES OR ACCIDENTS_____

HAVE YOU EVER BEEN TO A CHIROPRACTOR FOR THIS PROBLEM? YES NO

HAVE YOU EVER BEEN TO A CHIROPRACTOR FOR ANY OTHER PROBLEM? YES NO

DO YOU HAVE ANY OF THE FOLLOWING SYMPTOMS?

SYMPTOMS	YES	NO
HEADACHES		
IRRITABILITY		
NUMBNESS IN TOES		
FINGERS		
FACE FLUSHED		
NECK PAIN		
CHEST PAIN		
SHORTNESS OF BREATH		
BUZZING IN EARS		
HANDS COLD		
STIFF NECK		
DIZZINESS		
FATIGUE		
LOSS OF BALANCE		
UPSET STOMACH		
SLEEPING PROBLEMS		
HEAD SEEMS TO HEAVY		
DEPRESSION		
FAINTING SPELLS		
CONSTIPATION		
BACK PAIN		
PINS AND NEEDLES IN ARMS / LEG		
LIGHT BOTHER EYES		
LOSS OF SMELL		
TASTE		
COLD SWEATS		
NERVOUSNESS		
LOSS OF MEMORY		
FEVER		
TENSION		
COLD FEET		
EARS RING		
DIARRHEA		

OTHER_____

HAVE YOU LOST ANY TIME FROM WORK OR OTHER ACTIVITIES AS A RESULT OF THIS CONDITION?

YES_____ FROM_____TO_____ NO_____

SIGNATURE_____

PAIN DIAGRAM

PATIENT NAME:_____ TODAY'S DATE:_____

PLEASE COMPLETE THE FOLLOWING "*PAIN DIAGRAM*" BY USING LETTERS AT THE LEFT TO INDICATE ON THE DIAGRAM YOUR AREAS OF PAIN:

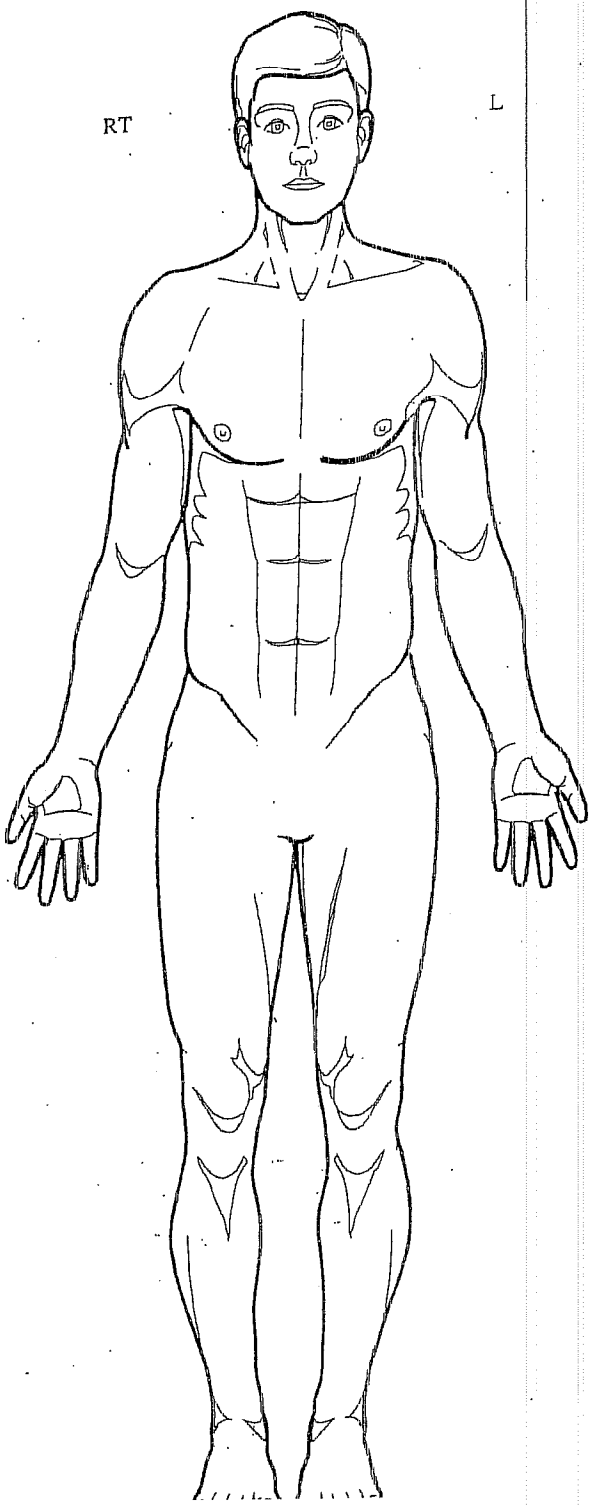
PATIENT'S SIGNATURE:_____

PAIN (P)
TINGLING (T)
NUMBNESS (N)
BURNING (B)
STIFFNESS (S)

FRONT

RT

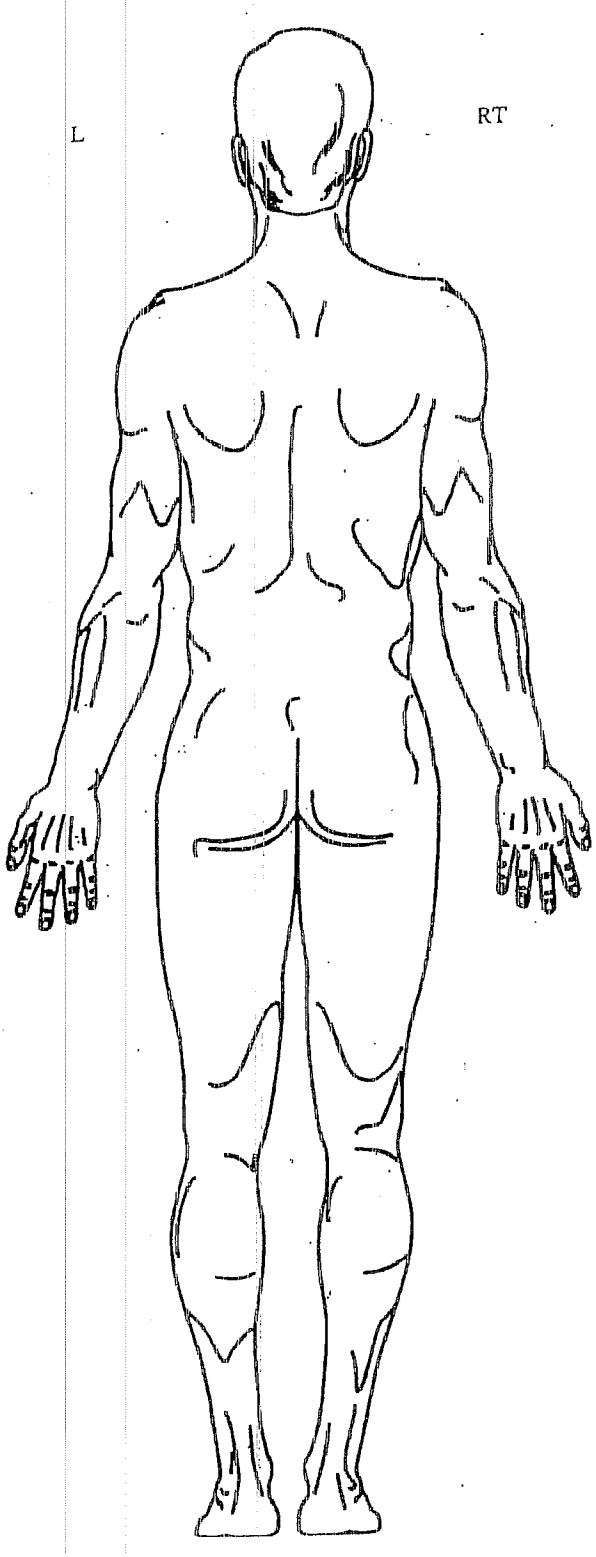
L



BACK

L

RT



Morgante Family Chiropractic

Terms of Acceptance

The practice of chiropractic in this office consists of:

1. Analysis of the spine for the purpose of locating vertebral subluxations (spinal misalignments causing nerve interference).

2. Adjustment of the spine for the purpose of correcting vertebral subluxations.

3. Education and encouragement of our patients/practice members to become aware of and responsible to their well being.

4. Empowerment of our patient/practice members as to the inherent healing capabilities of the human body.

Our intention is to provide you with the best care we can offer as outlined above. We do not offer care with the intent of treating or curing diseases or conditions.

I understand and wish to receive care at Morgante Family Chiropractic for myself/my family, as outlined in this "Terms of Acceptance."

Signed:_____

Name (Please Print):_____

Witness:_____

Date:_____

FINANCIAL POLICY
Morgante Family Chiropractic

SCHEDULING

All appointments during regular hours must be scheduled so as to reduce waiting time for you and others.

You are free to stop in at any time; however you will have to wait until all scheduled appointments are seen. You will be fit in as soon as possible.

Cancellations require 24 hour notice.

PAYMENT

Payment is expected in full at the time services are rendered. This includes all co-payments.

For your convenience we accept cash, checks, and most major credit cards.

Patients with deductibles will pay the full visit amount until the deductible is met.

Should you discontinue care for any reason other than discharge by the doctor, any outstanding balances will become immediately due and payable in full by you.

INSURANCE

Our office will verify your insurance coverage in an effort to help you determine exactly what chiropractic coverage is available under your policy.

It is your responsibility to provide us with all the appropriate insurance forms, insurance cards, addresses, and information so that proper filing can be submitted.

We are not obligated to accept your insurance payment on assignment although for your convenience we may, based on our experience with your insurance carrier.

You are always responsible for the portion of your bill the insurance company may not cover and for your annual deductible.

ACCEPTED INSURANCES

Univera, GHI, Aetna, Medicare, Veterans Administration (with referral), Workers Compensation, and No-Fault.

We can submit claims for Blue Cross and Blue shield as an Out-of-Network provider, however we must take the payment from you up front.

Remember that your insurance coverage is a contract between you, your employer, and your insurance company. We do not bill any secondary insurance carriers.

FEES

Our fees generally fall within what is considered reasonable and customary for this area.

Many insurers pay a percentage of this reasonable and customary rate.

LASTLY

You are responsible for all charges incurred as a patient in this office.

We will do all we can with your insurance claims, however, you are ultimately responsible for payment.

Past due statements for unpaid balances will be mailed. Statements unpaid for more than 30 days may be subject to and interest charge.

It is the goal of this office to provide you with the finest quality chiropractic care available. If you have any questions with regard to your health of any of our policies, please let us know. **WE WELCOME YOUR REFERRALS** and look forward to a doctor-patient relationship that works for our mutual benefit.

I, the undersigned, have read and agree to the guidelines of the above stated financial, insurance and office policies.

Patient's Signature_____ Date_____

Informed Consent to Chiropractic Treatment

Doctors of chiropractic who use manual therapy techniques are required to advise patients that there are or may be some risks associated with such treatment. In particular you should note:

a) While rare, some patients may experience short term aggravation of symptoms, rib fractures or muscle and ligament strains or sprains as a result of manual therapy techniques;

b) There are reported cases of stroke associated with many common neck movements including adjustment of the upper cervical spine. Present medical and scientific evidence does not establish a definite cause and effect relationship between upper cervical spine adjustment and the occurrence of stroke. Furthermore, the apparent association is noted very infrequently. However, you are being warned of this possible association because stroke sometimes causes 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 extremely remote;

c) There are rare reported cases of disc injuries following cervical and lumbar spinal adjustment although no scientific study has ever demonstrated such injuries are caused, or may be caused, by 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. Chiropractic care contributes to your overall well being. The risk of injuries or complications from chiropractic treatment is substantially lower than that associated with many medical or other treatments, medications, and procedures given for the same 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.

Dated this _____ **day of** _____, **20**____.

_____ _____

Patient Signature (or Legal Guardian) **Signature of Witness**

Patient Name: _____ **Witness Name:** _____

(please print) **(please print)**

Prior Chiropractic Treatment Information

Name of Chiropractor:_____ Location (city):_____

When was your last treatment?_____ Have you had x-rays? _____

AUTHORIZATION FOR RELEASE OF RECORDS

To: _____ **From:**

_____

_____

_____

This authorization will permit you to furnish a copy of the health records, notes, and medical information in your possession regarding my condition while under your observation or treatment including the history obtained, x-ray, and physical findings, diagnosis or prognosis.

I hereby take full responsibility for these records received by your office.

_____

Patient's Name (please print)

_____ _____

Patient's signature Date

_____ _____

Social Security Number of Patient Date of Birth

_____ _____

Witness Date

CONSENT TO TREATMENT AND EXAMINATION OF A MINOR CHILD

I hereby authorize Dr. Theresa Morgante and/or Dr. Anthony Morgante and/or her/his staff to examine and treat my child in this office.

Full Name of Child_____

Address_____

Parent or Guardian Signature_____Date_____

Staff Witness_____Date_____