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WORKERS COMPENSATION/PATIENT HISTORY

NAME ______________________ DATE ______________

DATE OF BIRTH ______________________ SS# ______________

HOW DID INJURY OCCUR, PLEASE BE SPECIFIC ______________________

____

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% F THE TIME) OCCASSIONAL (25-50%)
FREQUENT (50-75%) CONSTANT (100%)

CHARACTER OF PAIN: DULL/ACHE SHARP/STABBING BURNING THROBBING
NUMBNESS/TINGLING OTHER ______________

HAS THE PROBLEM AFFECTED: BOWEL OR BLADDER
OTHER BODY SYSTEMS (EXPLAIN) ______________
NO APPARENT 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 ______________________

____

ALLERGIES ______________ ADVERSE REACTION ______________

____

PREVIOUS INJURIES OR ACCIDENTS ______________________

____

____

____

____

HAVE YOU EVER BEENT O A CHIROPRACTOR FOR THIS PROBLEM? YES NO

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

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AUTHORIZATION AND CONSENT

TO: ______________________________
____
____
____

FROM: MORGANTE FAMILY CHIROPRACTIC
1660 KENSINGTON AVENUE, SUITE 1
CHEEKTOWAGA, NY 14225
716-833-2960

This authorization will permit you to furnish a copy of 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, and prognosis.

I hereby take full responsibility for these records received by your office. I hereby state that I have the right to review MFC's privacy policy. I also have the right to request any restrictions I deem appropriate on information released and the right to revoke consent of authorization at my request.

______________________________ ______________
Patient's Name (please print) Date of Birth

______________________________ ______________
Patient's Signature Date

______________________________ ______________
Witness Date

______________________________ ______________
Revocation of Authorization Date

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DO YOU HAVE ANY OF THE FOLLOWING SYMPTOMS?

SYMPTOMS	YES	NO
HEADACHES		
IRRITABILITY		
NUMBNESS IN TOES		
NUMBNESS IN 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 TOO HEAVY		
DEPRESSION		
FAINTING SPELLS		
CONSTIPATION		
BACK PAIN		
PINS AND NEEDLES IN ARMS/LEGS		
LIGHT BOTHERS 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____

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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.

Signature: ______________________________

Name (please print): ______________________________

Witness: ______________________________

Date: ______________________________

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

For your convenience we accept cash, checks, Master Card, and Visa.

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, No-Fault, Blue Cross and Blue Shield, and Independent Health.

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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 an 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______________

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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 to 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 bee 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 (please print) Witness Name (please Print)

PRIOR CHIROPRACTIC TREATMENT INFORMATION

Name of Chiropractor___________________________________Location (city)___________________________

When was your last treatment?____________________Have you had x-rays? Yes _____ No _____

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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______________

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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 COMEPENSATION 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

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Workers Compensation/No Fault
Insurance Verification

Patient's Name ________________________________ Date ____________

Patient Diagnosis 1) __________ 2) __________ 3) __________ 4) ____________

First Visit Date ______________ Is Patient Working? No Yes Dissability Type Total Partial None

Disabilty Date ___________________ Estimated Return To Work Date _________________

WORKERS COMPENSATION VERIFICATION

Verified With Employer By _______ Phone # ___________________Spoke To ____________________________

Date Of Injury ____________________ What Did The Employer Report __________________________________

Did the employer report the injury to the Insurance Carrier (file a C-2) Yes No

Name of Insurance Carrier ________________________________ Phone # ____________

Street____City______________________State_______Zip_________

Comments ____

Private Insurance Information

Insurance Company _______________________________________Phone Number ____________________

Name of Insured ___________________________________SS# ________________Date of Birth _________

Policy # ____________________________________Group #________________Contract #_________________

Employer of Insured _____________________________________Relationship _________________________

Signature ____ Date______________________

Primary Doctor ____Phone ____________________

Primary Doctor Address____

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WORKERS COMPENSATION QUESTIONNAIRE

Today's Date _____________

Last Name ___________________________________First Name ______________________Middle Initial ____

Street____City_____________________State_______Zip________

Home Phone # ____________________Work Phone # _________________Cell Phone # __________________

SS # _______________________ Date of Birth ____________________ Sex ________ Marital Status ________

E-Mail Address __________________________________ Employer ___________________________________

Street____City_____________________State_______Zip________

INJURY INFORMATION

To insure all billing is submitted properly, please provide us with the following information. During the course of your treatment, you may receive 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 Village) ______________________________________

When did your present symptoms appear? ______________________________________

Injury was reported to employer? Yes No To Whom? _____________________________

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

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

Were X-rays taken? Yes No Other Tests? Yes No If Yes please list test(s) and result(s)

Have you lost time from work? Yes No If yes, how much? _____________________________

Any previous Workers Compensation injuries? Yes No Please provide us with previous injuries and dates

Primary Doctor name ____Phone # __________________________

Street____City_____________________State_______Zip________

Have you retained an attorney Yes No If "yes" attorney's name _________________________________

Street____City_____________________State_______Zip________

Phone # ____________________

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

Patient's Signature ____Date _______________

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Who May we we with regarding medical informaton?

Spouse Name ____
Parent Name ____
Child(children) Name ________________________________

Signature ____

Who can we contact in case of emergency?

Spouse_____ Parent_____Children_____

Who referred you to our office?
____