

REINJURY WORKERS COMPENSATION/PATIENT HISTORY

NAME _____ DATE _____
DATE OF BIRTH _____ SS# _____

HOW DID FLARE-UP 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 WORSENERD 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 _____

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

AUTHORIZATION AND CONSENT

TO: _____

FROM: MORGANTE FAMILY CHIROPRACTIC
1660 KENSINGTON AVENUE, SUITE 4
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

PATIENT REGISTRATION
MORGANTE FAMILY CHIROPRACTIC

Today's Date: _____

Personal Information:

Last Name _____ First Name _____ Middle Initial _____

Street _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Work phone _____

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

Email Address _____

Who to contact in case of emergency _____

Who referred you to our office _____

Employment Information:

Occupation: _____ Employer _____

Street _____ City _____ State _____ Zip _____

Insurance Information:

Insurance Company _____ Phone _____

Name of Insured _____ SS # _____ Date of Birth _____

Policy # _____ Group # _____ Contract # _____

Employer of Insured _____ Relationship _____

Signature _____ Date _____

Primary Doctor _____ Phone _____

Primary Doctor Address _____

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 WORSENER 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 _____

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

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 _____

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:

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.

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 or 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 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 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 (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 ____

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 _____

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

**Workers Compensation/No Fault
Insurance Verification**

Patient's Name _____ Date _____
Patient Diagnosis 1) _____ 2) _____ 3) _____ 4) _____
First Visit Date _____ Is Patient Working? No Yes Disability Type Total Partial None
Disability 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 _____

AUTOMOBILE ACCIDENT VERIFICATION

Verified with Insurance Co. by _____ Phone # _____ Spoke To _____

Did the patient report the accident? Yes ___ No ___ Date of Accident _____

Did patient submit "Application of No-Fault Benefits"? Yes No Does patient belong to PPO? Yes No

Will the Insurance Co. be sending out NF-3 Form to the doctor? Yes No

Will the Insurance Co. be sending the check for services to the Patient Doctor

Does the Insurance Co. need an "Assignment of Benefits" sent in? Yes No

Name of Insurance Co. (Where to send the bills) _____

Street _____ City _____ State _____ Zip _____

Policy Holder _____ Relationship (patient/policyholder) _____

Claim # _____ File# _____ Policy # _____

Does patient have a deductible? Yes No If "YES" amount of deductible _____ Met? Yes No

Does the Insurance Company want office notes sent in with every claim? Yes No

Comments _____

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 me and that I am personally responsible for payment in the event that my claim for Workers Compensation benefits are denied.

Patient's Signature _____ Date _____