THE BACK ALLEY
CHIROPRACTIC & MASSAGE

# WORKER'S COMPENSATION INTAKE & QUESTIONAIRRE

*Please take the time to complete these forms to the best of your ability. If you have any questions we will be glad to help you.*

Patient Full Name _____ Gender: ☐ Male ☐ Female

Date of Birth _____ / _____ / _____ Social Security Number _____ - _____ - _____

**Home** Address _____

City _____ State _____ Zip Code _____

**Billing** Address _____

City _____ State _____ Zip Code _____

Email Address _____

By providing an email address, you are giving explicit consent and agree to receive communication and marketing emails (see our HIPAA notice for more details)

Cell Phone _____ Home Phone _____

Spouse's Name _____ Phone # _____

Emergency Contact _____ Phone # _____

Primary Care Physician _____ Phone # _____

Name of person, place, or physician who referred you so that we may thank them _____

Employer's Name _____ Phone # _____

Address _____

City _____ State _____ Zip Code _____

***Employer's*** Insurance Carrier _____

Mailing Address _____

Policy # _____ Claim # _____

Adjustor Name _____ Phone # _____

*To the best of my ability, the information I have supplied is complete and truthful. At any time, I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and may be released. I grant permission to be called or emailed to confirm or reschedule an appointment and to be sent occasional cards, letters or emails as an extension of my care in this office.*

Patient or Guardian Signature _____ Date _____

INJURED WORKER'S RIGHT TO CHOOSE DOCTOR:

When an injury occurs an employer has the right to have an injured worker seen by a doctor of the employer's choice *ONE* time. After *ONE* visit, you may report to a doctor of your choice. *Remember:* if you make a *SECOND* visit to the employer's doctor, you have established that doctor as your treating doctor. ***EXCEPTION***: if your employer is self-insured you must follow the self-insured employer's directed care program. To determine if your employer is self-insured, you may contact the industrial commission of Arizona claims division at (602) 542-4661. If you wish to change physicians after your initial selection, please contact the industrial commission of Arizona at (602) 542-4661.

## HEALTH INSURANCE

***Primary*** Health Insurance Company _____

Member ID # _____ Group # _____

Policy Holder Name _____ Date of Birth _____

***Secondary*** Health Insurance Company _____

Member ID # _____ Group # _____

Policy Holder Name _____ Date of Birth _____

***Attorney*** Name _____

Firm Name _____ Phone # _____

- *I authorize the release of any medical or other information necessary to process my claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.*
- *I authorize payment of medical benefits to The Back Alley Chiropractic and its physicians or supplier for services received.*

Print Patient Name _____

Patient or Guardian Signature _____ Date _____

## INFORMED CONSENT FOR CHIROPRACTIC TREATMENT

I hereby request and consent to the performance of chiropractic treatment (also known as CMT, chiropractic adjustments or chiropractic manipulative treatment) and any other associated procedures; physical examination, tests, diagnostic x-rays, physiotherapy, physical medicine, physical therapy procedures, etc. on me by the doctor of chiropractic named and/or other assistants and/or licensed practitioners.

I understand, as with any health care procedure, that there are certain complications that may arise during CMT. Those complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, Horner's Syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to complications including stroke.

I do not expect the doctor to be able to anticipate all risks and complications and I wish to rely upon the doctor to exercise judgment during the course of the procedure(s) which the doctor feels at the time, based upon facts known, are in my best interest. I have had the opportunity to discuss nature, purpose and risks of chiropractic treatment and other recommended procedures with the doctor and/or with office staff and/or clinic personnel.

I have read, or have had read to me, the above explanation of the CMT. I state that I have been informed and weighed the risks involved in CMT. I have decided that it is in my best interest to receive CMT. I hereby give my consent to that treatment. I intend for this consent to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

Patient or Guardian Signature _____ Date _____

## ACKNOWLEDGEMENT OF HIPAA PRIVACY NOTICE

I, _____, have received a copy of this office's Notice of Privacy Practices. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among health care providers who may be directly and indirectly involved in providing my treatment
- Obtain payment from third party payers
- Conduct normal health care operations such as quality assessments and accreditation

Patient or Guardian Signature _____ Date _____

## CONSENT TO TREATMENT OF A MINOR

I, _____, hereby authorize The Back Alley Chiropractic clinic/doctor/assistants to administer chiropractic treatment as deemed necessary to my son/daughter/legal dependent _____.

This authorization shall remain effective until _____ / _____ / _____, unless sooner revoked in writing.

Patient or Guardian Signature _____ Date _____

## INJURY INFORMATION

Date of Injury _____ Time _____ AM / PM (circle one)

Location of Injury _____

Describe ***where*** and ***how*** the injury occurred _____

_____

_____

Did you report the injury to a supervisor? ☐ Yes ☐ No Did you complete a report of injury? ☐ Yes ☐ No

Did you go to the hospital? ☐ Yes ☐ No -If yes, name of hospital _____

Have you lost time from work? ☐ Yes ☐ No -If yes, dates missed _____

Did your employer send you to a doctor? ☐ Yes ☐ No -If yes, name of doctor _____

Have you been treated anywhere else? ☐ Yes ☐ No -If yes, name of facility _____

Have you had x-rays for this injury? ☐ Yes ☐ No -If yes, name of facility _____

Please check any symptoms you have noticed since the injury:

| | | | | |
|---|---|---|---|---|
| ☐ Anxiety | ☐ Back pain | ☐ Blurred vision | ☐ Chest pain | ☐ Cold sweats |
| ☐ Depression | ☐ Dizziness | ☐ Fainting | ☐ Fatigue | ☐ Fever |
| ☐ Headache | ☐ Hearing loss | ☐ Irritability | ☐ Loss of balance | ☐ Loss of memory |
| ☐ Loss of smell | ☐ Loss of taste | ☐ Neck Pain | ☐ Neck stiff | ☐ Nervousness |
| ☐ Numbness | ☐ Painful joints | ☐ Pins and needles | ☐ Ringing in ears | ☐ Short of breathe |
| ☐ Sleeping problems | ☐ Tension | ☐ Upset stomach | | |

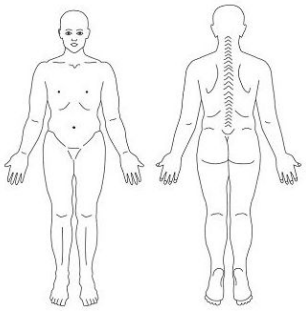
Symptoms other than above _____

_____

_____

Use the following abbreviations to indicate your symptoms on the illustration to the right:

**SS** = Spasms
**DP** = Dull Pain
**SH** = Shooting Pain
**NU** = Numbness
**ST** = Stiffness
**SP** = Sharp Pain
**TI** = Tingling
**O** = Other



When did you first notice your symptoms? _____

How extreme are your symptoms? (circle one) 0 1 2 3 4 5 6 7 8 9 10
Absent Uncomfortable Agonizing

How often are your symptoms present? ☐ 0-25% ☐ 26-50% ☐ 51-75% ☐ 76-100%

Print Patient Name _____

Patient or Guardian Signature _____ Date _____

# HEALTH HISTORY

Height _____ Weight _____ Are you pregnant? ☐ Yes ☐ No

**Illnesses** *Please check any illnesses that you've **had** OR currently **have***

| | | | | |
|---|---|---|---|---|
| ☐ Alcoholism | ☐ Allergies | ☐ Cancer | ☐ Chicken pox/shingles | ☐ Diabetes |
| ☐ Epilepsy | ☐ Gout | ☐ Heart disease | ☐ Hepatitis | ☐ HIV positive |
| ☐ Multiple sclerosis | ☐ Stroke | ☐ Tuberculosis | ☐ Typhoid fever | |

**Review of Systems** *Please check any condition that you've **had** OR currently **have***

| | | | | |
|---|---|---|---|---|
| ☐ Angina | ☐ Anorexia | ☐ Anxiety | ☐ Arthritis | ☐ Asthma |
| ☐ Back problems | ☐ Blurred vision | ☐ Chronic ear infection | ☐ Constipation | ☐ Depression |
| ☐ Diarrhea | ☐ Dizziness | ☐ Elbow/wrist pain | ☐ Emphysema | ☐ Excessive bruising |
| ☐ Fainting | ☐ Fatigue | ☐ Food sensitivities | ☐ Foot/ankle pain | ☐ Frequent infection |
| ☐ Hair loss | ☐ Hay fever | ☐ Headache | ☐ Hearing loss | ☐ Heartburn |
| ☐ High blood pressure | ☐ High cholesterol | ☐ Hip disorders | ☐ Immune disorders | ☐ Kidney stones |
| ☐ Knee injury | ☐ Loss of smell | ☐ Loss of taste | ☐ Low blood pressure | ☐ Low energy |
| ☐ Neck pain | ☐ Numbness | ☐ Osteoporosis | ☐ Pins and needles | ☐ Pneumonia |
| ☐ Poor appetite | ☐ Poor circulation | ☐ Poor posture | ☐ Prostate issues | ☐ Ringing in ears |
| ☐ Scoliosis | ☐ Shoulder problems | ☐ Skin cancer | ☐ Swollen glands | |
| ☐ Thyroid issues | ☐ TMJ issues | | | |

**Operations** *Please check any operations that you've ever **had***

| | | | | |
|---|---|---|---|---|
| ☐ Appendix removal | ☐ Bypass surgery | ☐ Cosmetic surgery | ☐ Elective surgery | ☐ Eye surgery |
| ☐ Hysterectomy | ☐ Pacemaker | ☐ Spine | ☐ Tonsillectomy | |

**Treatments** *Please check the treatments you've received in the **past** OR are **currently** receiving*

| | | | | |
|---|---|---|---|---|
| ☐ Acupuncture | ☐ Antibiotics | ☐ Birth control pills | ☐ Blood transfusion | ☐ Chemotherapy |
| ☐ Chiropractic care | ☐ Dialysis | ☐ Dietary supplements | ☐ Herbs | ☐ Homeopathy |
| ☐ Hormone replacement | ☐ Inhaler | ☐ Massage therapy | ☐ Physical therapy | ☐ Other _____ |

**Social History** *Please tell the doctor about your health habits*

| | | | |
|---|---|---|---|
| Alcohol use | ☐ Daily ☐ Weekly | How much? | _____ |
| Coffee use | ☐ Daily ☐ Weekly | How much? | _____ |
| Exercise | ☐ Daily ☐ Weekly | How much? | _____ |
| Pain relievers | ☐ Daily ☐ Weekly | How much? | _____ |
| Soft drinks | ☐ Daily ☐ Weekly | How much? | _____ |
| Tobacco use | ☐ Daily ☐ Weekly | How much? | _____ |
| Water intake | ☐ Daily ☐ Weekly | How much? | _____ |

Please list all prescription and over-the-counter medications you are **currently** using:

Prescription _____

Over-the-counter _____

Supplements/vitamins _____

*To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern. Inaccurate information could be dangerous to my health. If there is any change in my medical status I will notify the chiropractor immediately. I authorize the chiropractor and staff to perform any necessary services needed during diagnosis and treatment.*

Print Patient Name _____

Patient or Guardian Signature _____ Date _____

# OFFICE POLICY

**Appointments**
We value the time we have set aside to see you. The Back Alley Chiropractic is a multiple provider office and we must often schedule overlapping appointments according to the service requested and depending on the treatment required.

Walk-ins are ***always*** welcome, however, appointments will be seen first.

If you are late for your appointment, we will do our best to accommodate you.

We strive to minimize wait time, however, emergencies do occur and will take priority over a scheduled visit. We appreciate your understanding.

**If you have not been seen in our office in 18 months or longer, or if you have a new or different injury, a re-exam will be carried out and charged to you or your insurance carrier.** If you have not been seen in our office in 3 years or longer, you are considered a new patient.

**Self-Pay Patients**
We welcome patients whose insurance companies are out-of-network, do not provide chiropractic benefits, or are uninsured.

We recommend you keep a copy of our updated fee schedule for your records. All payments are to be paid in full at the time services are rendered.

Insurance ***cannot*** be used when opting for a Prompt Pay Fee service discount.

# FINANCIAL POLICY

**Payment** We accept cash, check, and debit, Visa, MasterCard and Discover. There is a minimum fee of $25 charged for returned checks.

**Insured** By request, as a courtesy to our patients, we will submit your medical claim to your insurance carrier. Patient balances are billed immediately upon receipt of your carriers EOB. Your remittance is due immediately upon receipt of our bill.

**Self-Pay** We offer a Prompt Pay fee discount for all patients by request. If you fail to provide payment at the time services are rendered, you will be responsible for and billed for 100% of the professional fee. You can request a copy of our updated fee schedule at any time.

**Delinquent Accounts** Unpaid balances are past due at 30 days. Balances left unpaid may receive a second and third notice prior to final notice, mailed at 30-day intervals. The Back Alley utilizes an outside collection agency. Balances over 120 days past due may be submitted to our collection agency.

**Medicare** We accept Medicare assignment. As a Medicare patient you are responsible for your deductible and co-insurance. If you have secondary or supplemental insurance we will bill it for you. Medicare non-covered services are due at the time of service.

**Workers Compensation** If you are here as a result of a work related injury; we will require information regarding your health insurance and your employers Workers Compensation insurance.

**Personal Injury Claims** We bill third party insurance carriers ***only*** on a lien basis. Please notify our staff of your personal injury immediately. You will be asked to complete forms specific to personal injury as well as a consent and notice for medical lien.

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I do not expect the doctor to be able to anticipate all risks and complications and I wish to rely upon the doctor to exercise judgment during the course of the procedure(s) which the doctor feels at the time, based upon facts known, are in my best interest. I have had the opportunity to discuss nature, purpose and risks of chiropractic treatment and other recommended procedures with the doctor and/or with office staff and/or clinic personnel.

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*I have read and understand the above policies and agree to accept responsibility for any and all payment(s) due as outlined.*

Print Patient Name _____

Patient or Parent/Guardian Signature _____ Date _____