



## Application for Patient Care

### Patient Information

Name: \_\_\_\_\_  
Last First MI

Email address: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Phone Number: Home \_\_\_\_\_ Work \_\_\_\_\_ Other \_\_\_\_\_

Your preferred method of contact for appointment reminders? Email / Text by Cell Phone/ Phone Call

Date of Birth: \_\_\_\_\_ Sex:  Male  Female SS# \_\_\_\_\_

Marital Status:  Single  Married  Divorced  Widowed  Separated  Minor

Race:  Caucasian  African American  Asian  Native American  Latin American  Other \_\_\_\_\_

Ethnicity:  Hispanic  Latino  Non-Hispanic/Non- Latino

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Employer Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Emergency Contact: Name \_\_\_\_\_ Relation: \_\_\_\_\_ Phone # \_\_\_\_\_

### Accident Information

Is this visit due to an accident?  Yes  No If yes, what type?  Auto  Work  Other \_\_\_\_\_

Has it been reported?  Yes  No If yes, to whom? \_\_\_\_\_

Attorney Information: \_\_\_\_\_ Phone Number: \_\_\_\_\_

### Insurance Information

Name of Health Insurance Carrier: \_\_\_\_\_ Secondary Insurance? \_\_\_\_\_

Policy Holder Name: \_\_\_\_\_ DOB \_\_\_\_\_

Relationship to Patient (if other than self): \_\_\_\_\_ Phone # \_\_\_\_\_

PLEASE PROVIDE THIS OFFICE WITH A COPY OF YOUR ID & INSURANCE CARD(S)

SIGNATURE (X) \_\_\_\_\_ DATE \_\_\_\_\_

Patient Health History

Check off any of the following symptoms you have experienced in the past 6 months:

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Low Back Pain         | <input type="checkbox"/> Tension Across Top of Shoulders | <input type="checkbox"/> Tired/Fatigued      |
| <input type="checkbox"/> Pain between Shoulder | <input type="checkbox"/> Numbness/Tingling in Arms/Hands | <input type="checkbox"/> Difficulty Sleeping |
| <input type="checkbox"/> Neck Pain             | <input type="checkbox"/> Numbness/Tingling in Legs/Feet  | <input type="checkbox"/> Allergies           |
| <input type="checkbox"/> Tension/Headaches     | <input type="checkbox"/> Pain in the legs                | <input type="checkbox"/> Digestive           |
| <input type="checkbox"/> Fibromyalgia          | <input type="checkbox"/> Pain in the feet                | <input type="checkbox"/> Carpal Tunnel       |

Other (explain) \_\_\_\_\_

Which of the above is the worst? \_\_\_\_\_

How long have you had it? \_\_\_\_\_

How often does it occur? \_\_\_\_\_

What does it feel like?(describe) \_\_\_\_\_

What have you done that has helped this problem? \_\_\_\_\_

What activities would you like to do if this was not a problem? \_\_\_\_\_

**Does this cause you to be:**

- Moody
- Irritable
- Interrupt sleep
- Restricted in your daily

**Does this affect your work:**

- Decision making
- Poor attitude
- Decreased productivity
- Exhausted at the end of the day
- Unable to work long hours

**Does this affect your life:**

- Lose patience with spouse/children
- Restricted household duties
- Hinders ability to exercise or
- Interferes with ability to do hobbies or other activities

**What have you tried to help relieve/get rid of this problem and how much did it help? (circle appropriately)**

- |   |  |
|---|--|
| <input type="checkbox"/> Medications...Helped: Little Some Much     | <input type="checkbox"/> Exercise...Helped: Little Some Much   |
| <input type="checkbox"/> Physical Therapy...Helped: Little Some Muc | <input type="checkbox"/> Nutrition...Helped: Little Some Much  |
| <input type="checkbox"/> Chiropractic...Helped: Little Some Much    | <input type="checkbox"/> Stretching...Helped: Little Some Much |

Are you currently under drug and/or medical care?  Yes  No

Who is your primary care doctor? \_\_\_\_\_

Please all medications: **(Be sure to include dosage and frequency)** \_\_\_\_\_

Supplements (vitamins/herbs/minerals): \_\_\_\_\_

Allergies: \_\_\_\_\_

Approximate Date of last Flu vaccine: \_\_\_\_\_ **WOMEN ONLY:** Date of LMP: \_\_\_\_\_ **Any possibility of pregnancy: YES or NO**

**Surgical History:**

Surgeries and/or hospitalizations (**type & date**): \_\_\_\_\_

**Family History:** Is there a family history of any of the following conditions? (Indicate parents, grandparents, children, & siblings)

- |  |   |
|--|---|
| <input type="checkbox"/> Heart Disease _____ | <input type="checkbox"/> Diabetes _____                                       |
| <input type="checkbox"/> Cancer _____        | <input type="checkbox"/> Arthritis _____ <input type="checkbox"/> Other _____ |

**Social History:**

Intake of the following: Cigarettes \_\_\_ packs/day Alcohol \_\_\_ drinks/week Caffeine \_\_\_ cups/day

Exercise frequency:  Never  Daily  Weekly  Walks  Runs  Swims

## Past Medical History and Review of Systems

Y	N	
		<b>Neurological</b>
___	___	Migraines
___	___	Headaches: how often? Slurring of speech
		<b>Ear/Nose/Throat</b>
___	___	Altered taste/smell
___	___	Night Blindness
___	___	Sore Throat
___	___	Gingivitis
___	___	Nose bleeds
		<b>Endocrine</b>
___	___	Diabetes
___	___	Thyroid problems
		<b>Cardiovascular</b>
___	___	High blood pressure
___	___	High cholesterol
___	___	Chest pain
___	___	Palpitations-racing heart beat
___	___	Swelling in hands/feet
___	___	Anemia
		<b>Respiratory</b>
___	___	Recurrent Respiratory Infections
___	___	Asthma
___	___	Chest Congestion
___	___	Wheezing
		<b>GI</b>
___	___	Stomach Pains or Cramping
___	___	Constipation
___	___	Reflux or Heartburn
___	___	Bloating/Gas
___	___	Nausea or Vomiting
		<b>Musculoskeletal</b>
___	___	Joint Pain
___	___	Arthritis
___	___	Chronic pain
___	___	Muscle Aches

Y	N	
		<b>Skin</b>
___	___	Eczema
___	___	Dermatitis
___	___	Excessive Sweating
___	___	Rashes
___	___	Brittle Nails
___	___	Hair Loss
___	___	Easy Bruising
___	___	Increased Bleeding
___	___	Numbness/tingling
		<b>Genitourinary</b>
___	___	Uterine fibroids
___	___	Ovarian cysts
___	___	Cancer (breast, ovarian, prostate, uterine)
___	___	Prostate problems
		<b>Emotional/Mental</b>
___	___	Depression
___	___	Anxiety
___	___	Mood Swings
___	___	Irritability
___	___	Memory Loss
___	___	Confusion
		<b>Energy</b>
___	___	Fatigue
___	___	Hyperactivity
___	___	Restlessness
___	___	Insomnia
___	___	Decreased Libido
___	___	Stress
		<b>Weight</b>
___	___	Decreased Appetite
___	___	Weight Gain
___	___	Inability to Lose Weight
___	___	Food Cravings
___	___	Binge Eating
___	___	Water Retention

Medicines previously tried, dosage, duration and outcome.

Advil  Aleve  Tylenol  Steroids  Prescriptions for a period of  0-3mos,  3-6mos,  6-12 mos  12+mos

Please check ALL options you have previously tried to assist in above symptoms:

- |   |   |
|---|---|
| <input type="checkbox"/> Over the counter medications | <input type="checkbox"/> Consult with specialist                    |
| <input type="checkbox"/> Prescriptions                | <input type="checkbox"/> Supplements                                |
| <input type="checkbox"/> Dietary Changes              | <input type="checkbox"/> Alternative medication/treatment therapies |
| <input type="checkbox"/> Exercise                     |   |

## Duties Performed Under Duress at Work and Home

Patient \_\_\_\_\_ Date \_\_\_\_\_ Date of Injury \_\_\_\_\_

Initial  Update

Please check all that apply to your WORK because of the accident.

- |   |  |
|---|--|
| <input type="checkbox"/> I go to work but work in pain            | <input type="checkbox"/> I work in pain because I have bills to pay        |
| <input type="checkbox"/> I limit my work activities               | <input type="checkbox"/> I can't take time off because I would lose my job |
| <input type="checkbox"/> Bending at work hurts                    | <input type="checkbox"/> I keep working so I don't lose status at company  |
| <input type="checkbox"/> Stooping at work hurts                   | <input type="checkbox"/> My business would fail if I took time off         |
| <input type="checkbox"/> Sitting at work hurts                    | <input type="checkbox"/> I believe in working even when I'm in pain        |
| <input type="checkbox"/> Using the Computer at work hurts         | <input type="checkbox"/> I feel obligated to work even though I'm in pain  |
| <input type="checkbox"/> Pushing at work hurts                    | <input type="checkbox"/> My business would lose money if I took time off   |
| <input type="checkbox"/> Pulling at work hurts                    | <input type="checkbox"/> My work is not as good as it was before accident  |
| <input type="checkbox"/> Kneeling at work hurts                   | <input type="checkbox"/> My boss reprimanded me for poor performance       |
| <input type="checkbox"/> I have lost status in my company         | <input type="checkbox"/> I got a different job within the same company     |
| <input type="checkbox"/> I have lost job security                 | <input type="checkbox"/> I got a different job in another company          |
| <input type="checkbox"/> I didn't get a promotion                 | <input type="checkbox"/> I make less money than before the accident        |
| <input type="checkbox"/> I don't enjoy work as much as before     | <input type="checkbox"/> I cannot do the same work/job as before accident  |
| <input type="checkbox"/> I doze off at work                       | <input type="checkbox"/> I can't concentrate as well at work               |
| <input type="checkbox"/> I take unpaid time off work to go to Dr. | <input type="checkbox"/> I take paid time off to go to Dr.                 |
| <input type="checkbox"/> I daydream at work more than before      | <input type="checkbox"/> I make mistakes at work I didn't used to          |
| <input type="checkbox"/> I feel tired at work                     | <input type="checkbox"/> I hide my poor work performance from my boss      |
| <input type="checkbox"/> _____                                    | <input type="checkbox"/> _____   |
| <input type="checkbox"/> _____                                    | <input type="checkbox"/> _____   |

Please check all that apply to your HOME/DOMESTIC duties because of the accident.

- |   |  |
|---|--|
| <input type="checkbox"/> My house is not as clean now       | <input type="checkbox"/> I cannot take time off because I care for children  |
| <input type="checkbox"/> My yard is not as neat now         | <input type="checkbox"/> I have _____ children ages _____                    |
| <input type="checkbox"/> My garden is not as productive now | <input type="checkbox"/> I had to hire a paid housekeeper                    |
| <input type="checkbox"/> I do yard work, but do it in pain  | <input type="checkbox"/> I asked someone for unpaid housekeeping help        |
| <input type="checkbox"/> I cannot do my normal yard work    | <input type="checkbox"/> I had to hire a paid gardener                       |
| <input type="checkbox"/> I do house work, but do it in pain | <input type="checkbox"/> I asked someone for unpaid yard work help           |
| <input type="checkbox"/> I cannot do my normal house work   | <input type="checkbox"/> Mowing the lawn hurts me                            |
| <input type="checkbox"/> Doing laundry hurts me             | <input type="checkbox"/> I cannot mow the lawn                               |
| <input type="checkbox"/> I cannot do laundry now            | <input type="checkbox"/> Taking out the trash hurts me                       |
| <input type="checkbox"/> Washing dishes hurts me            | <input type="checkbox"/> I cannot take out the trash                         |
| <input type="checkbox"/> I cannot wash dishes now           | <input type="checkbox"/> I do not enjoy my gardening/yardwork like I used to |
| <input type="checkbox"/> Vacuuming hurts me                 | <input type="checkbox"/> I do not enjoy my housework like I used to          |
| <input type="checkbox"/> I cannot vacuum now                | <input type="checkbox"/> Gardening hurts me                                  |
| <input type="checkbox"/> Cooking hurts me                   | <input type="checkbox"/> I cannot do my gardening at all since the accident  |
| <input type="checkbox"/> I cannot cook now                  | <input type="checkbox"/> Others living with me do my share of the work now   |
| <input type="checkbox"/> Washing the car hurts me           | <input type="checkbox"/> Others living with me do my share of the yard work  |
| <input type="checkbox"/> I cannot wash my car               | <input type="checkbox"/> Others living with me do my share of the gardening  |
| <input type="checkbox"/> _____                              | <input type="checkbox"/> _____   |
| <input type="checkbox"/> _____                              | <input type="checkbox"/> _____   |

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

## Loss of Enjoyment of Sports, Hobbies, Travel, Daily activities, & School (1 of 2 pages)

Patient's name \_\_\_\_\_ Date of Injury \_\_\_\_\_ Today's date \_\_\_\_\_

Initial     Update

**Please check all that apply to your EXERCISE & SPORTS Activity because of the accident**

<input type="checkbox"/> My exercise was affected by this crash <input type="checkbox"/> I go to the gym & work out in pain <input type="checkbox"/> I no longer go to the gym to work out <input type="checkbox"/> I run but in pain <input type="checkbox"/> I no longer run <input type="checkbox"/> I take walks & have pain while walking <input type="checkbox"/> I no longer take walks <input type="checkbox"/> I used to make income at sports <input type="checkbox"/> I have lost sports income since crash <input type="checkbox"/> I am an amateur athlete <input type="checkbox"/> I am a professional athlete <input type="checkbox"/> _____ <input type="checkbox"/> _____	<input type="checkbox"/> I have gained _____ pounds since the accident <input type="checkbox"/> I had to quit my _____ team after the accident <input type="checkbox"/> I had to quit my _____ team after the accident <input type="checkbox"/> I had to quit my _____ team after the accident <input type="checkbox"/> I had to quit my _____ team after the accident <input type="checkbox"/> I don't enjoy the sport of _____ anymore <input type="checkbox"/> I didn't enjoy the sport of _____ for _____ weeks <input type="checkbox"/> I don't enjoy the sport of _____ anymore <input type="checkbox"/> I didn't enjoy the sport of _____ for _____ weeks <input type="checkbox"/> I don't enjoy the sport of _____ anymore <input type="checkbox"/> I didn't enjoy the sport of _____ for _____ weeks <input type="checkbox"/> I don't enjoy the sport of _____ anymore <input type="checkbox"/> I didn't enjoy the sport of _____ for _____ weeks
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**Please check all that apply to your HOBBY Activities because of the accident**

<input type="checkbox"/> My hobbies were affected by accident <input type="checkbox"/> Hobby #1 _____ <input type="checkbox"/> I can't do hobby #1 anymore <input type="checkbox"/> I do hobby #1 but in pain <input type="checkbox"/> I have lost money from not doing #1 <input type="checkbox"/> I didn't do hobby #1 for _____ weeks <input type="checkbox"/> Hobby #2 _____ <input type="checkbox"/> I can't do hobby #2 anymore <input type="checkbox"/> I do hobby #2 but in pain <input type="checkbox"/> I have lost money from not doing #2 <input type="checkbox"/> I didn't do hobby #2 for _____ weeks	<input type="checkbox"/> Hobby #3 _____ <input type="checkbox"/> I can't do hobby #3 anymore <input type="checkbox"/> I do hobby #3 but in pain <input type="checkbox"/> I have lost money from not doing #3 <input type="checkbox"/> I didn't do hobby #3 for _____ weeks <input type="checkbox"/> Hobby #4 _____ <input type="checkbox"/> I can't do hobby #4 anymore <input type="checkbox"/> I do hobby #4 but in pain <input type="checkbox"/> I have lost money from not doing #4 <input type="checkbox"/> I didn't do hobby #4 for _____ weeks <input type="checkbox"/> _____
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**Please check all that apply to your TRAVEL Activities because of the accident**

<input type="checkbox"/> Business travel was affected by crash <input type="checkbox"/> Pleasure travel was affected by crash <input type="checkbox"/> I hurt driving in my own car <input type="checkbox"/> I am in too much pain to drive <input type="checkbox"/> I hurt when a passenger in a car <input type="checkbox"/> I am in too much pain to sit in a car <input type="checkbox"/> I have anxiety when I'm in a car <input type="checkbox"/> I hurt when I'm on an airplane <input type="checkbox"/> I am in too much pain too much pain to travel by plane	<input type="checkbox"/> Travel Plan #1 <input type="checkbox"/> I did not go on travel plan #1 <input type="checkbox"/> I went, but did not enjoy #1 as much <input type="checkbox"/> I went and the accident had no effect on #1 <input type="checkbox"/> Travel Plan #2 <input type="checkbox"/> I did not go on travel plan #2 <input type="checkbox"/> I went, but did not enjoy #2 as much <input type="checkbox"/> I went and the accident had no effect on #2 <input type="checkbox"/> I missed time with my family/friends b/c can't travel
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# Loss of Enjoyment of Sports, Hobbies, Travel, Daily activities, & School (2 of 2 pages)

Patient's name \_\_\_\_\_ Date of Injury \_\_\_\_\_ Today's date \_\_\_\_\_

Initial  Update

**Please check all the DAILY LIVING activities that cause you pain because of the accident**

- |   |   |
|---|---|
| <input type="checkbox"/> Dressing                     | <input type="checkbox"/> Riding in a car                                  |
| <input type="checkbox"/> Putting on pants             | <input type="checkbox"/> Opening a jar                                    |
| <input type="checkbox"/> Putting on shoes             | <input type="checkbox"/> Lifting a pan when cooking                       |
| <input type="checkbox"/> Tying my shoes               | <input type="checkbox"/> Closing the trunk on my car                      |
| <input type="checkbox"/> Putting on shirt             | <input type="checkbox"/> Opening the garage door                          |
| <input type="checkbox"/> Drying my hair               | <input type="checkbox"/> Using my home computer                           |
| <input type="checkbox"/> Combing my hair              | <input type="checkbox"/> Climbing stairs                                  |
| <input type="checkbox"/> Washing my hair              | <input type="checkbox"/> Sexual activity                                  |
| <input type="checkbox"/> Taking a shower              | <input type="checkbox"/> Turning my head to left or right                 |
| <input type="checkbox"/> Taking a bath                | <input type="checkbox"/> Holding my head up all day                       |
| <input type="checkbox"/> Leaning forward              | <input type="checkbox"/> Watching TV                                      |
| <input type="checkbox"/> Laying in bed                | <input type="checkbox"/> I have pain sitting & doing nothing              |
| <input type="checkbox"/> Sitting in my favorite chair | <input type="checkbox"/> Talking on the phone                             |
| <input type="checkbox"/> Sleeping                     | <input type="checkbox"/> Reading  |
| <input type="checkbox"/> Going out with my friends    | <input type="checkbox"/> Writing  |
| <input type="checkbox"/> Sitting at a restaurant      | <input type="checkbox"/> Opening doors                                    |
| <input type="checkbox"/> Shopping                     | <input type="checkbox"/> Drying with a towel after a bath or shower       |
| <input type="checkbox"/> Driving to/from work         | <input type="checkbox"/> Life has become a chore just to do normal things |
| <input type="checkbox"/> Sitting in Church            | <input type="checkbox"/> It is depressing to live like this               |
| <input type="checkbox"/> Playing with my children     | <input type="checkbox"/> _____  |
| <input type="checkbox"/> Caring for my children       | <input type="checkbox"/> _____  |
| <input type="checkbox"/> Bending in a movie theatre   | <input type="checkbox"/> _____  |
| <input type="checkbox"/> Sitting in a movie theatre   | <input type="checkbox"/> _____  |
| <input type="checkbox"/> Exercise                     | <input type="checkbox"/> _____  |
| <input type="checkbox"/> Eating                       | <input type="checkbox"/> _____  |
| <input type="checkbox"/> Stooping                     | <input type="checkbox"/> _____  |
| <input type="checkbox"/> Squatting down               | <input type="checkbox"/> _____  |
| <input type="checkbox"/> Kneeling                     | <input type="checkbox"/> _____  |
| <input type="checkbox"/> Brushing my teeth            | <input type="checkbox"/> _____  |

**Please check all that apply to your SCHOOL & EDUCATION Activities because of the accident**

- |  |   |
|--|---|
| <input type="checkbox"/> School was affected by the accident   | <input type="checkbox"/> I have pain carrying my school books             |
| <input type="checkbox"/> I am a student at _____   | <input type="checkbox"/> I hurt sitting in class more than _____ minutes  |
| <input type="checkbox"/> I am in the _____ year/grade  | <input type="checkbox"/> My neck hurts when I look down to read           |
| <input type="checkbox"/> I was <input type="checkbox"/> full time p <input type="checkbox"/> time    | <input type="checkbox"/> I don't learn as quickly as before the crash     |
| <input type="checkbox"/> I am now <input type="checkbox"/> full time p <input type="checkbox"/> time | <input type="checkbox"/> I don't learn things as well as before the crash |
| <input type="checkbox"/> I had to take fewer classes b/c of crash                                    | <input type="checkbox"/> I have difficulty concentrating in class         |
| <input type="checkbox"/> I missed _____ days of school   | <input type="checkbox"/> It takes much longer to study/do my homework     |
| <input type="checkbox"/> I had to drop out of school b/c of crash                                    | <input type="checkbox"/> _____  |
| <input type="checkbox"/> My grades are lower since the crash   | <input type="checkbox"/> _____  |

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date





**IRREVOCABLE ASSIGNMENT, LIEN AND AUTHORIZATION**  
**INSURANCE BENEFITS**

TO WHOM IT MAY CONCERN:

I hereby authorize and direct you, my insurance carrier to pay directly to Dynamic such sums as may be due and owing this office for services rendered me, both by reason of accident or illness and by reason of any other bills that are due this office and withhold such sums from any disability benefits, medical payment benefits, no-fault benefits, health and accident, Workers' Compensation benefits, or any other insurance benefits obligated to reimburse me from any settlement, judgment or verdict on my behalf as may be necessary to adequately protect Dynamic I hereby further give lien to said office against any and all insurance benefits named herein and any and all proceeds of any settlement, judgment or verdict which may be paid to me as a result of the injuries or illness for which I have been treated for by Dynamic. This is to act as an assignment of my rights and benefits to the extent of the office's services provided.

I understand that I remain personally responsible for the total amounts due the office for services rendered. I further understand and agree that this Assignment, Lien and Authorization does not constitute any consideration for the office to await payments, and they may demand payments from me immediately upon rendering services at their option.

I authorize the office to release any information pertinent to my case to any insurance carrier or adjuster to facilitate collection under this Assignment, Lien and Authorization.

I further understand and agree that if Dynamic must take any action to collect an outstanding balance on this account, I will be responsible for payment of and will reimburse this office for all costs of such collection efforts, including but not limited to all court costs and all attorney fees.

\_\_\_\_\_(SEAL)  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Insurance Company Name and Address

\_\_\_\_\_  
Attorney Name, Address, and Phone

**PATIENT ACKNOWLEDGEMENT OF**  
**RECEIPT OF NOTICE**

I hereby acknowledge receipt of the Notice of Privacy Practices for Dynamic regarding my health information. I have been informed and understand the manner in which my health information shall be maintained, utilized and disclosed by Clinic and my respective rights contained there in. I also understand that the Notice furnished to me is subject to change at any time. I am aware that I may obtain a current copy of this Notice at any time by contacting Dynamic 3707 Chamberlain Ln Louisville, KY 40241 (502) 426-9200

My signature herein below constitutes full acknowledgement that I have furnished a copy of the Notice of Privacy Practices for Dynamic

PRINT Patient's Name: \_\_\_\_\_

SIGNATURE of Patient: \_\_\_\_\_ Date: \_\_\_\_\_

SIGNATURE of Parent or Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_





**COMMONWEALTH OF KENTUCKY**  
**DEPARTMENT OF WORKERS' CLAIMS**  
 Claim No. \_\_\_\_\_  
**NOTICE OF DESIGNATED PHYSICIAN**

**EMPLOYEE:** \_\_\_\_\_

Name

\_\_\_\_\_  
 Street Address

\_\_\_\_\_  
 City, State, Zip Telephone Number

\_\_\_\_\_  
 Date of Birth Social Security Number

**EMPLOYER AT TIME OF INJURY OR LAST EXPOSURE:**

\_\_\_\_\_  
 Name

\_\_\_\_\_  
 Street Address

\_\_\_\_\_  
 City, State, Zip

**NATURE OF INJURY OR OCCUPATIONAL DISEASE:** \_\_\_\_\_

**DATE OF INJURY OR LAST EXPOSURE:** \_\_\_\_\_

**FIRST DESIGNATED PHYSICIAN:**

\_\_\_\_\_  
 Name

\_\_\_\_\_  
 Street Address

\_\_\_\_\_  
 City, State, Zip Telephone Number

Accepted by: \_\_\_\_\_

**MEDICAL INFORMATION RELEASE:** I hereby waive any privilege I may have to restrict the release of information or written material reasonably related to the work-related injury/disease for which I have sought treatment, and I consent to the release of this information or written material to the medical payment obligor, my employer, Special Fund, Uninsured Employers' Fund, or attorneys representing me or any of the parties named above.

\_\_\_\_\_  
 Date Employee Signature

**MEDICAL PAYMENT OBLIGOR:**

\_\_\_\_\_  
 Name of Obligor

\_\_\_\_\_  
 Representative

\_\_\_\_\_  
 Street Address

\_\_\_\_\_  
 City, State, Zip Telephone Number

This form identifies the designated physician and must be returned to the medical payment obligor within ten (10) days after treatment begins. An Identification card will be provided to the employee, and that card should be presented when medical treatment is required.



## **INSURANCE COMPLIANCE INFORMATION**

We would like to take a moment to welcome you to our office and assure you that your treatment is our top priority. We find that many patients are very confused when using their insurance and are concerned about their financial obligations. This form is utilized to explain your responsibilities when our office files your insurance.

At Dynamic our staff provides you with all insurance filing at the time of service. We will verify all insurance benefits to assure your chiropractic/medical coverage's in full. However, we need to make you aware that these benefits are not a guarantee of payment and you will ultimately be responsible for all services that are not paid by your insurance company. It is very important that you understand that our office, as a service to our patients, will submit and make all attempts to collect all outstanding payments. We will not enter into any disputes with your insurance company. If your account remains in an outstanding status, our staff may request your help in expediting payment from your insurance company.

Each patient is required to meet their deductible in full before their insurance company will pay their portion. At this time, our staff will notify you of your out of pocket expense at your time of service. Most insurance company policies require a payment of 30%-50% of the patients visit. Our staff is required to collect this amount at the time of service. If your insurance policy requires a co-pay, this amount will be requested at the time of service. It has become a standard that doctors' request all payment in full at the time of service. Our office continues to service our patients the old fashion way and will do the work for you. This allows you to focus on your health.

### **Personal Injury Patient With Health Insurance:**

If you were involved in an automobile accident and have a health care policy, our office will submit all charges at the time of service. You will not be responsible to pay for any deductible or co-pay at the time of service. Any outstanding balance will be reimbursed by your attorney when your case is settled.

### **What To Do When My Insurance Company Sends Me A Check:**

Many insurance companies will send the member (patient) a check to your home instead of our office by accident. If this situation occurs, please be advised that you are to bring the check and accompanying explanation of benefits to the office so that it can be posted to your account.

### **What Do I Do If My Insurance Company Sends Me Forms That I Do Not Know How To Answer?**

Many times an insurance company will send a patient a questionnaire for them to fill out. These forms purposely are used as stall tactics and are quite confusing for you to understand. When you receive these letters, please either call our office or bring them to our office manager for proper clarification.

### **Financial Consent/Patient Agreement:**

I understand and agree to the services that my doctor has offered to me. I agree to be fully responsible for any services that are not paid by my insurance company and understand that my doctor will send all outstanding accounts to a collection agency after 60 days if not reconciled by the responsible party.

I am not an agent or representative of any insurance company or any other business trying to collect information. All injuries/problems mentioned are true and I am here solely for the treatment of the said problems.

Patient Initials: \_\_\_\_\_ Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

## HIPAA/PRIVACY NOTICE

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

In the course of your care as a patient Dynamic, we may use or disclose personal and health related information about you in the following ways:

- Your personal health information, including your clinical records, may be disclosed to another healthcare provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.
- Your healthcare records as well as your billing records may be disclosed to another party, such as an insurance carrier, an HMO, a PPO, or your employer, if they are or may be responsible for the payment of your services.
- Your name, address, phone number, and healthcare records may be used to contact you regarding appointment reminders, information about alternative to your present care, or other health related information that may be of interest to you.

If you are not at home to receive an appointment reminder, a message may be left on your answering machine. Furthermore, you have the right to inspect or obtain a copy of the information we will use for these purposes. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization it will not affect the care provided to you or the reimbursement avenues associated with your care.

Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in the following circumstances:

- If we are providing healthcare to you based on the orders of another healthcare provider.
- If we provide healthcare services to you in an emergency.
- If we are required by law to provide care to you and we are unable to obtain our consent after attempting to do so.
- If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.
- If we are ordered by the courts or another appropriate agency.

Any use or disclosure of your protected health information, other than as outlined above, will only be made upon your written authorization.

We normally provide information about your health to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your healthcare or about the status of your account. If you would like to receive this information at an address other than your home or if you would like the information in a different form, please advise us in writing as to your preferences.

You have the right to inspect and/or copy your health information for seven years from the date that the record was created or as long as the information remains in our files. In addition you have the right to request an amendment to your health information. Requests to inspect, copy or amend our health related information should be provided to us in writing.

We are required by state and federal law to maintain the privacy of your patient file and the protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information.

We are further required by law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice we will notify you in writing as soon as possible following the information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities you should direct your complaint to: Kristin Miracle. If you would like further information about our privacy policies and practices please contact: Kristin Miracle.

This notice is effective as of December 1, 2011. This notice, and any alterations or amendments made hereto will expire seven (7) years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

\_\_\_\_\_  
Name (Print)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

### TERMS OF ACCEPTANCE AND CONSENT FOR CARE

The clinic will attempt to identify and diagnose any ailments you may have that may be corrected through physical medicine, massage therapy, chiropractic care, and/or active/passive rehabilitation. If any condition or disease appears to be present out of our scope of practice, we will refer you to an appropriate physician to diagnose and/or treat that condition. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare cases underlying physical defects, deformities or pathologies, may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare, if he/she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known these things which otherwise might not come to the attention of the physician (deformities, illnesses, etc).

I agree to settle any claim or dispute I may have against or with any of these persons or entities, whether related to the prescribed care or not, by binding arbitration under the current malpractice terms which can be obtained by written request.

I also understand that the fee paid for treatment x-rays is for analysis only. The film itself is the property of this office. Once films are taken, they cannot be released, but may be copied. There is a fee for copying of the xrays.

Also, for your protection, portions of our office where patients do not disrobe are under video surveillance, specifically, but not limited to, the front desk check-out stations.

I have read and I accept the terms above and understand them fully. I hereby give consent to the clinic to evaluate me to determine my condition and treat me for such conditions. I also understand that I may at any time discontinue with the exam and/or x-rays or any treatment if I so choose.

*I also understand that if I suspend or terminate my care at this office, any outstanding charges for professional services rendered to me will be immediately due and payable. I agree that I will be responsible for all attorney and legal fees if legal action becomes necessary to collect this amount.*

I, \_\_\_\_\_ have read and fully understand the above statements.  
(PRINT NAME)

\_\_\_\_\_  
(SIGNATURE)

\_\_\_\_\_  
(DATE)

**FOR MINORS:** I, \_\_\_\_\_ being the parent or legal guardian of \_\_\_\_\_  
(Print Guardian Name) (Print Minor's Name)

have read and fully understand the above terms of acceptance & grant permission for my child to receive treatment.

\_\_\_\_\_  
(SIGNATURE)

\_\_\_\_\_  
(DATE)

#### X-ray Questionnaire: For women only

Our consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze your condition. Should x-rays be necessary we would like to confirm that you are not pregnant at this time.

Name: \_\_\_\_\_

Date of last menstrual period: \_\_\_\_\_

There is a possibility that I a may be pregnant at this time

Yes, I am definitely pregnant

No, I am definitely not pregnant at this time

I request that x-ray films not be taken because:

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date



**Notice: The Workers' Compensation Act requires the employer to pay for the medical services**

**Reasonably necessary for cure and relief from the effects of a workplace injury or disease.**

**The employee may choose the physician (including chiropractors, etc.) who treats him as**

**"designated physician." The designated physician is responsible for the coordination of the employee's medical care and may refer the patient to consulting or treating physicians as required.**

**Except in an emergency, all treatment must be performed by or on referral from the designated**

**physician. The employee may not change his designated physician more than once without the medical payment obligor's consent.**

**Inquires shall be made to the listed representative of the medical payment obligor.**

**This form is not advance authorization from the workers' compensation medical payment obligor for**

**Medical services.**