



Patient Information and Intake Form

Thank you for choosing Connecticut Spine & Rehab, LLC as part of your health care team.

Today's Date _____

First Name _____ Last Name _____ Gender _____

Date of Birth _____ Age _____ Social Security # _____

Marital Status: Single Married Divorced Widowed

Home Address _____

City _____ State _____ Zip Code _____

Home Phone # _____ Cell Phone # _____ Work# _____

E-mail address _____

Emergency Contact:

Name _____ Phone # _____ Relationship _____

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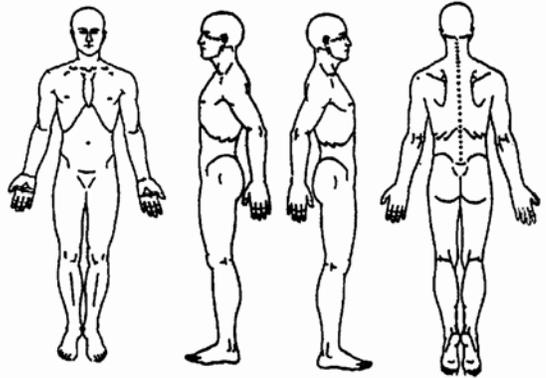


Confidential Patient Information

LIST PRESENT COMPLAINTS:

Please rate current pain level (0-10)

1. _____ /10
2. _____ /10
3. _____ /10
4. _____ /10
5. _____ /10
6. _____ /10



LIST ANY DISEASE OR ILLNESS WITH WHICH YOU HAVE BEEN DIAGNOSED:

(Examples: Diabetes, Heart Disease, High Blood Pressure, Stroke, Asthma, Ulcers, Cancer, Arthritis, Depression)

LIST MEDICATIONS AND/OR DIETARY SUPPLEMENTS YOU TAKE:

What/Frequency/Doctors/Side Effects/Remarks _____

LIST SURGERIES THAT YOU HAVE HAD:

Type/When/Doctor/Results _____

LIST FORMER SERIOUS ACCIDENTS AND FALLS: (AUTO, WORK, HOME, LEISURE, SPORTS, OTHER)

What/When/Symptoms/Treatment/Results _____



Injury Intake Form

CARRIER INFORMATION

Insurance Carrier Name: _____ Carrier Phone No. _____

Address: _____

Policy No. _____ Claim No. _____ Date of Accident: _____

Was the accident reported to your carrier? yes no

Do you have medical coverage with your auto insurance policy? yes no

ATTORNEY INFORMATION

Attorney's Name: _____ Phone No. _____

Address: _____

May we contact your attorney regarding your case? yes no

AUTHORIZATION

I, the undersigned, certify that the information given above is correct. I clearly understand and agree that all services rendered to me that are not covered, are charged directly to me, and that I am personally responsible for payment.

Patient's Signature: _____ Date: _____

Please note: In this instance, we will attempt to bill any back-up insurance you may have prior to billing you directly.



Automobile Accident Questionnaire

Today's Date _____ Date of Accident _____ State of Accident _____
(Connecticut, New York, Etc.)

How was your vehicle hit? rear impact passenger side impact driver side impact front impact

Were you wearing a seat belt? Yes No

Were you the driver or passenger? (if you were a passenger, where were you seated in the car)? _____

Was there a secondary impact (another car, a curb, or barrier, etc.)? _____

Were you prepared for the impact? Yes No

Did any airbags deploy? Yes No (if yes, which ones)? _____

Did you strike any part of your body on the interior of the car? Yes No

(if yes, what body part and where in the car?) _____

Did your seatbelt engage? Yes No

Did you lose consciousness? Yes No (if yes, for how long approximately)? _____

Were you attended to by EMT? Yes No

Were you taken to the hospital? Yes No (if yes, was it by ambulance or other transportation?

Which hospital? _____

Was diagnostic imaging performed at the hospital? Yes No (if yes, what type (x-ray, MRI, CT scan, etc.)
and what body areas? _____

Were you admitted overnight? Yes No

Were you given medications or prescriptions? Yes No (if yes, what type)? _____

Have you had any other medical care since the injury? Yes No (if yes, answer below)

Doctor or clinic name _____ When consulted? _____

Treatment rendered? _____

Have you had any further diagnostic tests since the accident? (MRI, CT scan, Bone Scan, X-Ray, etc.)? _____

Have you missed days from work because of this injury? Yes No (if yes, how many)? _____

Have you had any previous accidents or injuries? Yes No (if yes, what type & when)? _____



Security Agreement & Assignment of an Interest in a Personal Injury Claim

Name: _____

In exchange for good and valuable consideration, services provided by Connecticut Spine & Rehab, LLC, and the promise to provide services by Connecticut Spine & Rehab, LLC, the receipt of which is hereby acknowledged, I hereby:

1. Grant a lien to Connecticut Spine & Rehab, LLC for its professional services, medical bills, and charges for any, and all treatment whatsoever, and costs against any and all settlement or judgment arising from my personal injury claim as a result of my accident. Costs such as medical report fees and record copying fees, which are incurred by Connecticut Spine & Rehab, LLC in providing services to my attorney, and myself will be deducted from any net recovery at the time of settlement or verdict in my personal injury case.
2. Assign and interest to Connecticut Spine & Rehab, LLC for its professional services, medical bills, and charges for any and all treatment whatsoever, and costs against any and all settlement or judgment arising from my personal injury claim as a result of my accident. Costs such as medical report fees and record copying fees, which are incurred by Connecticut Spine & Rehab, LLC in providing services to my attorney, or me will be deducted from any net recovery at the time of settlement or verdict in my personal injury case.
3. Assign my rights to receive health care payments from negligent parties or from insurance companies. Payments are made to Connecticut Spine & Rehab, LLC, 91 Dixwell Ave, New Haven, CT 06511.
4. Authorize and direct my attorney to pay from my personal injury proceeds such sums as may be due and owing for services rendered to me, by any reason which are due to Connecticut Spine & Rehab, LLC and to withhold such sums from any settlement, judgment, or verdict from disbursement to me as may be necessary to adequately protect and pay Connecticut Spine & Rehab, LLC.
5. If the parties cannot agree upon the reasonableness of a bill or costs, or a dispute arises, I agree and understand that my attorney will be required under Professional Rule of Conduct 1.15(b) to hold the amount of money in dispute. If the parties cannot agree upon the reasonableness of a bill or costs, or a dispute arises, then the parties agree, and I, hereby, agree and stipulate to participate in binding arbitration within thirty days of receipt of personal injury proceeds by my attorney. I further agree to have the chairman of the Connecticut Chiropractic Association serve as the sole arbitrator of the disputed dollar amount. The parties agree to be bound by the arbitrator's decision. The parties agree to split (fifty/fifty) the costs of arbitration.

I understand that the bill for chiropractic treatment and services are my responsibility, and I am obligated to pay the bill regardless of the outcome of my case. My financial responsibility is not contingent upon a favorable settlement or judgment of a personal injury claim. I have been informed that by acceptance of partial payment from a third-party, Connecticut Spine & Rehab, LLC does not accept the partial payment as payment in full. When partial payment occurs, it has been explained to me that Connecticut Spine & Rehab, LLC will balance bill me for any outstanding balance. I have reviewed the fee schedule posted in the office and agree to receive services and be responsible for my bill. I acknowledge that this agreement is made for additional protection and in consideration of the courtesy of Connecticut Spine & Rehab, LLC awaiting payment. I have read this document and understand it.

Signature _____

Date _____

Witness _____

Date _____



Notice of Privacy Practices

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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of Connecticut Spine & Rehab, LLC, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of Connecticut Spine & Rehab, LLC. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical staff, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical personnel that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only with Your Consent, Authorization or Opportunity to object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

The following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment, or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.



Your physician is not required to agree to a restriction that you may request. If a physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number. Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name _____

Signature _____ Date _____



Authorization

1. I hereby authorize Connecticut Spine & Rehab, LLC to obtain any information which may have been acquired by examination or other means regarding my physical condition, and thereby release Connecticut Spine & Rehab, LLC of any consequences thereof.
2. I hereby authorize the release of information necessary to file a claim with my insurance company.
3. I understand the Doctor may administer services uncovered by my insurance company, which I will be responsible for.
4. I understand that I am solely responsible for any outstanding balances due to Connecticut Spine & Rehab, LLC upon completion of my treatment.
5. I assign insurance benefits otherwise payable to me, to Connecticut Spine & Rehab, LLC.

Patient Name _____

Patient Signature _____ Date _____



Informed Consent to Chiropractic Treatment

While rare, some patients may experience short term aggravation of symptoms, rib fractures, muscle strains, ligament strains, and dizziness as a result of manual therapy techniques. There are reported cases of stroke associated with many common neck movements including adjustment of the upper cervical spine. The apparent association is noted infrequently; however, you are being warned of this possible association because stroke can cause 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 rare, however, possible. There are rare, reported cases of disc injuries following cervical and lumbar 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. 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.

Patient Name: _____ **Date:** _____

Witness Name: _____ **Date:** _____



Authorization to Release Medical Information

To Provider: _____
(NAME OF DOCTOR, CLINIC, HOSPITAL, ETC.)

Patients Name: _____ D.O.B ____/____/____

Social Security: ____/____/____ D.O.I ____/____/____

You are hereby requested to furnish the following information checked below:

X-rays History Diagnosis Treatment Reports

Concerning my: Accident Injury Other _____

Re Requester: _____

(NAME OF INSURANCE CO., ATTORNEY, DOCTOR, HOSPITAL, EMPLOYER, NEXT OF KIN, ETC.)

For the purpose of: _____

(Specify above: Review, Investigation or Evaluation of an application, or the processing of any claim, or any purpose reasonably related to the above enumerated activities.)

This authorization shall become effective immediately and remain in effect only if necessary for the Requester to complete the required activities undertaken.

I understand that I have a right to receive a copy of this authorization upon my request.

Copy requested and received: Yes No

Signature of Patient: _____

Date: ____/____/____

Signature of Parent, Guardian, or Spouse _____