

Complete Injury Care

GENERAL HEALTH & INJURY PATIENT FORMS

(570) 622-0809
200 E. ARCH ST. #102
POTTSVILLE, PA 17901

Complete Injury Care

For Office Use Only:		
Patient Number _____	PI _____	Attorney _____
Cash _____	WC _____	GI _____
	Med Pay _____	Date of Accident _____

PATIENT INFORMATION

Today's Date: _____

Name: _____
(First) (Middle) (Last)

Address: _____

City: _____ State: _____ Zip: _____

Social Security #: ____/____/____ Driver License # _____ Sex: () Male () Female

Birth date: ____/____/____ Age: _____ Dominant Hand: () Right () Left

Marital Status: () Single () Married () Widowed () Separated () Divorced

Minor: () Yes () No

Home #: _____ Cell #: _____ Work #: _____

Email Address: _____

Employer / School: _____ Occupation: _____

Employer Address: _____

City: _____ State: _____ Zip: _____

Emergency Contact Person: _____ Relationship: _____

Home #: _____ Cell #: _____

Whom may we thank for referring you to us? _____

Allergies: _____

Past Medical History:	Past Surgical History:	Family History:
_____	_____	_____
_____	_____	_____
_____	_____	_____

Attorney Information (If applicable):

Attorney's Name: _____ Case Manager's Name: _____

Attorney's Address: _____ Phone #: _____

City: _____ State: _____ Zip: _____

Medical Provider Information (If applicable):

Primary Care Physician's Name: _____

Address: _____ Phone #: _____

City: _____ State: _____ Zip: _____

Automobile Insurance Information (If applicable):

Your Car Insurance: _____ Phone # _____

Policy #: _____ Claim #: _____

Do You Have Medical Payment Coverage On Your Policy: () Yes () No Amount \$: _____

Other Driver's Insurance _____ Phone # _____

Policy #: _____ Claim #: _____

Health Insurance Information (If applicable):

Insurance Company: _____ Phone # _____

Address: _____

Name of Insured: _____ Relationship: _____

ID#: _____ Group #: _____ Employer: _____

Social Security #: _____/_____/_____ Date of Birth: _____

Worker's Compensation Information (If applicable):

Insurance Company: _____ Phone # _____

Billing Address: _____

Employer: _____ Phone #: _____

Case Manager: _____ Claim #: _____

Complete Injury Care

Informed Consent

Dear _____,

Every type of healthcare procedure and/or treatment is associated with some degree of risk. This includes chiropractic care. We want you to be informed about potential problems with chiropractic healthcare before consenting to treatment.

Chiropractic adjustments involve the moving of joints in the body with the use of the doctor's hand, use of a machine, use of a mechanical table, or use of a hand held instrument. Frequently, adjustments create a "pop" or "click" sound / sensation in the area being treated.

In this office, we use trained staff to assist the doctor with portions of your consultation, examination, x-ray taking, physical therapy application, and other treatment modalities. If you only want to be seen by the chiropractor in this clinic, please inform the staff immediately and that request will be honored.

NATURE AND PURPOSE OF CHIROPRACTIC PROCEDURES

The practice of chiropractic includes many standard examination and testing procedures. These include: Physical examinations, orthopedic and neurological testing, palpation, specialized instrumentation's, laboratory tests, radiology examinations, physical therapy, and rehabilitative procedures.

There are a number of different adjusting techniques, some utilizing specially designed equipment. Adjustments are usually performed by hand but may be performed by hand-guided instruments. A chiropractic adjustment is the application of a quick precise movement over a very short distance to a specific segmental contact point of vertebra.

If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

All chiropractic physicians providing care at Complete Injury Care are licensed by the Chiropractic Physician's Board of Pennsylvania in accordance with state laws.

POSSIBLE RISKS ASSOCIATED WITH CHIROPRACTIC PROCEDURES

Not only should you understand the benefits of chiropractic care in restoring and maintaining good health, but also you should be aware of the existence of some inherent risks and limitations. These are seldom enough to contraindicate care, but should be considered in making the decision to receive chiropractic care. All health care procedures, including those used in varying degrees, have some risks associated with them. Risks associated with some chiropractic adjusting procedures may include:

- Stroke
- Vertebral disc herniation
- Soft tissue injury
- Rib fractures
- Physical therapy burns
- Soreness

INITIAL _____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

Upon request Complete Injury Care will provide each patient with Privacy Practices of Complete Injury Care. This document describes the Practice’s policies and procedures regarding the use and disclosure of any of my Protected Health Information created, received or maintained by the practice.

CONSENT OF TREATMENT / INFORMATION

I consent to Complete Injury Care (“the Practice’s”) use and disclosure of my Protected Health Information for the purposes of providing treatment to me, for purposes relating to the payment of services rendered to me and for the Practices general healthcare operations purposes. This information may be furnished to your insurance carrier, any third party insurance carrier, any physician you may be referred to and your primary care physician.

For purposes of this Consent, “Protected Health Information” means any information, including my demographic information, created or received by the Practice, which relates to my past, present, or future physical or mental health or condition; the provisions of health care to me; or the past, present, or future payment for the provision of health care services to me; and that either identifies me or from which there is a reasonable basis to believe the information can be used to identify me.

This authorization shall be considered as continuing unless you advise Complete Injury Care in writing. I understand I have the right to request a restriction on the use and disclosure of my Protected Health Information for the purposes of treatment, payment or healthcare operations of the Practice, but the Practice is not required to agree to these restrictions. However, if the Practice agrees to a restriction that I request, the restriction is binding on the practice.

By signing this form I acknowledge that I have received, reviewed, and understand the following documents.

(PRINTED NAME)

(DATE)

(SIGNATURE)