WORKER'S COMPENSATION QUESTIONNAIRE

This information will be strictly confidential. Your answers will help us determine if chiropractic care will benefit you. Please print and be as accurate and complete as possible. Thank you.

PATIENT INFORMATION

NAME Last	First	Middle	HOME PHONE		DATE	
ADDRESS			CITY		STATE	ZIP
SOCIAL SECURITY #	AGE		BIRTH DATE	SEX	MARITAL STATUS	NO. OF CHILDREN
EMPLOYER	ADDRESS				BUSINESS PHONE	
OCCUPATION			WHO REFERRED YOU TO OUR OFFICE?			

OCCUPATIONAL HISTORY

NAME	CHART #	TODAY'S DATE	ACCIDENT DATE

Current Employer: _____

Current Occupation: _____

Relevant Prior Employers and Job Information: _____

Name of employer at the time of injury (if different from current): _____

Retraining for a new job: _____

New job's contribution to injury: _____

Limitations of working as a result of injury: _____

What limitations have you experienced as a result of your injury? ***(choose all that apply)***

- ☐ Cannot use left arm
- ☐ Cannot use right arm
- ☐ Cannot use left leg
- ☐ Cannot use right leg
- ☐ Cannot drive due to condition
- ☐ Increased fatigability
- ☐ Lifting exacerbates condition
- ☐ Pain limits amount of movement
- ☐ Cannot sit due to condition
- ☐ Unable to lift more than 10 pounds
- ☐ Unable to lift more than 15 pounds
- ☐ Unable to lift more than 20 pounds
- ☐ Unable to lift more than 25 pounds
- ☐ Unable to lift more than 50 pounds
- ☐ Cannot walk due to condition
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

Your present job involves:

Standing for:	Driving for:	Walking for:	Sitting for:	Lifting (pre-injury)	Lifting (post-injury)
☐ 30 minutes	☐ 30 minutes	☐ 30 minutes	☐ 30 minutes	☐ Less than 5 lbs.	☐ Less than 5 lbs.
☐ 1 hours	☐ 1 hours	☐ 1 hours	☐ 1 hours	☐ 05 - 10 lbs.	☐ 05 - 10 lbs.
☐ 2 hours	☐ 2 hours	☐ 2 hours	☐ 2 hours	☐ 10 - 15 lbs.	☐ 10 - 15 lbs.
☐ 3 hours	☐ 3 hours	☐ 3 hours	☐ 3 hours	☐ 15 - 20 lbs.	☐ 15 - 20 lbs.
☐ 4 hours	☐ 4 hours	☐ 4 hours	☐ 4 hours	☐ 20 - 25 lbs.	☐ 20 - 25 lbs.
☐ 6 hours	☐ 6 hours	☐ 6 hours	☐ 6 hours	☐ 25 - 40 lbs.	☐ 25 - 40 lbs.
☐ 8 hours	☐ 8 hours	☐ 8 hours	☐ 8 hours	☐ 40 - 50 lbs.	☐ 40 - 50 lbs.
☐ >8 hours	☐ >8 hours	☐ >8 hours	☐ >8 hours	☐ >50 lbs.	☐ >50 lbs.

Typing	Using Mouse	Grasping	Crawling	Climbing	
☐ 30 minutes	☐ 30 minutes	☐ 30 minutes	☐ 30 minutes	☐ 30 minutes	☐ Repetitive Motion
☐ 1 hours	☐ 1 hours	☐ 1 hours	☐ 1 hours	☐ 1 hours	
☐ 2 hours	☐ 2 hours	☐ 2 hours	☐ 2 hours	☐ 2 hours	☐ Fine manipulation, pushing, pulling, torquing with hands
☐ 3 hours	☐ 3 hours	☐ 3 hours	☐ 3 hours	☐ 3 hours	
☐ 4 hours	☐ 4 hours	☐ 4 hours	☐ 4 hours	☐ 4 hours	
☐ 6 hours	☐ 6 hours	☐ 6 hours	☐ 6 hours	☐ 6 hours	
☐ 8 hours	☐ 8 hours	☐ 8 hours	☐ 8 hours	☐ 8 hours	
☐ >8 hours	☐ >8 hours	☐ >8 hours	☐ >8 hours	☐ >8 hours	

Have you missed any work as a result of your condition? ☐ Yes ☐ No

If yes, how many days did you miss? _____ **Your last full day of work was:** _____/_____/_____

Are you currently receiving worker's compensation? ☐ Yes ☐ No

Have you had any prior work injuries? ☐ Yes ☐ No

Have you received a prior workers' comp award? ☐ Yes ☐ No

Work Conditions:

Rest breaks _____

% of workday indoors _____

% of workday outdoors _____

Type of surface worked on _____

Exposure to... _____

Other requirements _____

I understand that the information I have provided above is current and complete to the best of my knowledge.

Signature _____

MODE OF INJURY

NAME	CHART #	TODAY'S DATE	DATE OF ONSET	TIME OF INJURY

Complete this section if injuries are a result of a work related accident.

My injury occurred while I was. . .

- ☐ Carrying an object and lost my balance
- ☐ Driving
- ☐ Lifting an object
- ☐ Struck by a falling object _____
- ☐ Engaged in a repetitive motion activity _____
- ☐ Other _____

Did you report this incident in writing at work?
☐ Yes ☐ No

Person reported to: _____ **Date reported:** _____

Did you see another health care provider for treatment related to this injury?
☐ Yes ☐ No

If you were injured by lifting, please complete all of the items which apply in the box below.

I was lifting the object:
- ☐ from the floor
- ☐ from a surface over my head
- ☐ from a surface about waist high

While I was lifting, I:
- ☐ had my back straight
- ☐ had my waist bent
- ☐ was twisted to the side

The object I was lifting was about:
- ☐ 2 - 5 pounds
- ☐ 5 - 10 pounds
- ☐ 10 - 15 pounds
- ☐ 15 - 20 pounds
- ☐ 20 - 25 pounds
- ☐ 25 - 50 pounds
- ☐ More than 50 pounds

The pain I felt immediately after the injury was:
- ☐ a dull ache
- ☐ a sharp pain with radiation of symptoms
- ☐ a grabbing feeling
- ☐ a popping feeling
- ☐ a sharp pain in one spot

If you were injured by falling, please complete the items in the box below.

I fell:
- ☐ from a surface 2-4 feet high
- ☐ from a surface 4-6 feet high
- ☐ from a surface 6-8 feet high
- ☐ from a surface higher than 8 feet
- ☐ onto surface I was walking on

When I fell I hit my:
- ☐ Back
- ☐ Left elbow
- ☐ Right elbow
- ☐ Face
- ☐ Left hand/wrist
- ☐ Right hand/wrist
- ☐ Head
- ☐ Left knee
- ☐ Right knee
- ☐ Tail bone

The surface I fell on can be described as:
- ☐ Containing an object that caused the fall
- ☐ Icy
- ☐ Wet
- ☐ Slick due to liquid
- ☐ Uneven carpet

I landed on:
- ☐ Back
- ☐ Left side
- ☐ Knees
- ☐ Right side
- ☐ Rear end
- ☐ Stomach
- ☐ Outstretched arms

Complete this section if your injuries were NOT work related or auto accident related.

My injury occurred when I:
- ☐ coughed or sneezed
- ☐ looked over my shoulder
- ☐ straightened from bending
- ☐ twisted at the waist
- ☐ slipped and fell

Injury occurred at:
- ☐ Home
- ☐ Mall
- ☐ Retail store
- ☐ Supermarket
- ☐ Work

WORKERS COMPENSATION PATIENT WAIVER

As a workers compensation patient receiving services at Barley Family Health Care & Rehabilitation, I understand it is my responsibility to supply this office with approval for treatment from my employer and workers compensation insurance carrier. I also understand that I need to provide the name and address of the workers compensation insurance carrier to Barley Chiropractic.

In the event that my employer or the insurance carrier denies my claim I will assume full responsibility for payment to this office.

Patient's Signature _____ Date _____
(If a minor, parent's or guardian's signature)

Doctor's Signature: _____ Date _____

REV. 11/01/03

AUTOMOBILE ACCIDENT QUESTIONNAIRE

Please answer all questions completely

Dear Patient: This information is considered confidential. We need this information because we care enough to want to know, and your answers will help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. In order for us to understand you condition properly, please be as neat and accurate as possible while completing this form. Thank you.

NAME	SEX	MARITAL STATUS	DATE OF BIRTH	HOME PHONE
ADDRESS	CITY		STATE	ZIP
OCCUPATION	WHO REFERRED YOU TO OUR OFFICE? (Indicate if child, student, housewife, unemployed, retired)			
SOC. SEC. #	BUSINESS PHONE	COMPANY NAME	LOCATION	
SPOUSE'S FIRST NAME	SPOUSE'S SOC. SEC. #	SPOUSE'S EMPLOYER	LOCATION	
DRIVER OF OTHER VEHICLE (IF ANY)		INSURANCE COMPANY	POLICY NUMBER	
DRIVER OF VEHICLE IN WHICH YOU WERE INJURED (IF APPLICABLE)		INSURANCE COMPANY	POLICY NUMBER	
NAME OF YOUR INSURANCE ADJUSTOR			HAVE YOU RETAINED AN ATTORNEY? ☐ YES ☐ NO	

Please explain in detail how your accident happened: _____

What were the time and date of present injury? _____

Where did you feel pain immediately after the accident? _____

List the extent of injuries as you know them: _____

Did you require post accident hospitalization? ☐ YES ☐ NO

CURRENT COMPLAINT

NAME	CHART #	TODAY'S DATE	DOCTOR

What is your current complaint? (Why are you seeking treatment?)

_____

How severe is this problem?
- ☐ Mild
- ☐ Mild to Moderate
- ☐ Moderate
- ☐ Moderately Severe
- ☐ Severe

How Frequently?
- ☐ Constant
- ☐ Occasional
- ☐ Intermittent
- ☐ Frequent

On a 1-10 scale, how would you rate your pain? (10=most painful, 1=least painful)

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Improvement (%)

☐ 10% ☐ 20% ☐ 30% ☐ 40% ☐ 50% ☐ 60% ☐ 70% ☐ 80% ☐ 90% ☐ 100%

When was the onset of this problem?

☐ gradual ☐ sudden ☐ insidious
☐ about a day ago ☐ several days ago ☐ about a week ago ☐ several weeks ago ☐ about a month ago
☐ several months ago ☐ about a year ago ☐ several years ago

Select each choice that applies to you

Movement
- ☐ Cramps
- ☐ Stiffness
- ☐ Inflexibility
- ☐ Restricted Movement
- ☐ Spasm

Sensation
- ☐ Crawling
- ☐ Prickly
- ☐ Dead
- ☐ Tingling
- ☐ Numb
- ☐ Pins and needles

Please indicate everything that makes you feel better

☐ usually better in the morning ☐ usually better during the day
☐ usually better at night

_____

Select the type of pain that best describes your complaint

- ☐ Achy
- ☐ Burning
- ☐ Dull
- ☐ Excruciating
- ☐ Numb ache
- ☐ Pounding
- ☐ Pulsating
- ☐ Sharp
- ☐ Shooting
- ☐ Stabbing
- ☐ Stinging
- ☐ Throbbing

Please indicate everything that makes you feel worse or aggravates your condition

☐ usually worse in the morning ☐ usually worse during the day ☐ usually worse at night

_____

_____

_____

I understand that the information I have provided above is current and complete to the best of my knowledge.

Signature:_____

AUTOMOBILE ACCIDENT

NAME	CHART #	TODAY'S DATE	ACCIDENT DATE

DESCRIBE THE VEHICLE

Patient's Vehicle Type

☐ Bus ☐ Van
☐ Sports Car ☐ Truck
☐ Coupe ☐ Station Wagon
☐ Sedan ☐ Pick-up truck
☐ Sport-utility

Vehicle Size

☐ Compact ☐ Mini
☐ Full-Size ☐ Sub-compact
☐ Light ☐ Semi
☐ Mid-Size

Position in vehicle

☐ Driver ☐ Rear left passenger
☐ Front mid passenger ☐ Rear mid passenger
☐ Front right passenger ☐ Rear right passenger

DESCRIBE THE ACCIDENT

Action of patient vehicle

☐ Crossing intersection
☐ Stopped at intersection
☐ Stopped for pedestrian
☐ Stopped in traffic
☐ Turning right
☐ Turning left
☐ Traveling speed limit
☐ Faster than speed limit
☐ Slower than speed limit

Patient's vehicle was hit

☐ Head-on
☐ On the left front
☐ On the right front
☐ On the left rear
☐ On the right rear
☐ Was rear-ended
☐ Sideswiped on left
☐ Sideswiped on right

Patient's vehicle hit

☐ Other vehicle head-on
☐ Left front of other vehicle
☐ Left rear of other vehicle
☐ Right rear of other vehicle
☐ Right front of other vehicle
☐ Rear-ended other vehicle
☐ Sideswiped other vehicle on left
☐ Sideswiped other vehicle on right

Damage

☐ Complete
☐ Extensive
☐ Minimal
☐ Moderate

Damage to other vehicle

☐ Complete
☐ Extensive
☐ Minimal
☐ Moderate

Time of Day

☐ Dawn
☐ Daylight
☐ Dusk
☐ Night

Visibility

☐ Fair
☐ Poor
☐ Good

Patient's vehicle was hit by

☐ A compact car ☐ A pick-up truck
☐ A full-sized car ☐ A sport-utility veh.
☐ A mid-sized car ☐ A full-sized van
☐ A subcompact car ☐ A mini-van
☐ A semi-trailer ☐ None of the above
☐ A light truck

Patient's vehicle hit

☐ A compact car ☐ A pick-up truck
☐ A full-sized car ☐ A sport-utility veh.
☐ A mid-sized car ☐ A full-sized van
☐ A subcompact car ☐ A mini-van
☐ A semi-trailer ☐ None of the above
☐ A light truck

Weather Conditions

☐ Clear ☐ Rainy
☐ Cloudy ☐ Snowing
☐ Drizzling ☐ Storming
☐ Foggy ☐ Sunny

Road Conditions

☐ Dry
☐ Damp
☐ Wet
☐ Iced over
☐ Dry with icy patches
☐ Snowed over

DESCRIBE MOMENT OF IMPACT

Body position at impact

☐ Leaning forward
☐ Slouched in seat
☐ Straight
☐ Turned left
☐ Turned right

Head position at impact

☐ Straight
☐ Tilted forward
☐ Turned left
☐ Turned right

Type of Passive Restraint

☐ Airbag
☐ Lap belt
☐ Should belt
☐ Shoulder-lap belt

Position of Headrest

☐ High position
☐ Low position
☐ Not installed

Did airbag deploy?

☐ Deployed
☐ Did not deploy

Did you brace for impact?

☐ Yes ☐ No

Direction body was thrown

☐ Forward then back ☐ To the right ☐ Outside the vehicle

Direction head was thrown

☐ Back then forward ☐ Forward then back ☐ Side to side

I understand that the information I have provided above is current and complete to the best of my knowledge.

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this Chiropractic Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this Chiropractic Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient's Signature:_____

Guardian or Spouse's Signature: _____ Date _____

Welcome

OPTIMUM HEALTH THROUGH CHIROPRACTIC CARE

Patient Information

Thank you for choosing our practice for your chiropractic needs. Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.

(Please Print)

Name _____ Date _____ SS/HIC/Patient ID# _____
First Middle Initial Last

Address _____ City _____ State _____ Zip _____

Sex: ❑ Female ❑ Male Birthdate _____ E-mail _____

Home Phone (_____) _____ Cell Phone (_____) _____ Work Phone (_____) _____

Do you prefer to receive calls at: ❑ Home ❑ Work ❑ Cell ❑ No Preference

❑ Married ❑ Widowed ❑ Single ❑ Minor ❑ Separated ❑ Divorced ❑ Partnered for_____years

Patient Employer/School _____ Occupation _____

Employer/School Address _____ City _____ State _____ Zip _____

Spouse or parent's name _____ Employer _____ Work Phone (_____) _____

Whom may we thank for referring you to us? _____

Person to contact in case of emergency _____ Phone (_____) _____

Responsible Party

Name of person responsible for this account _____

Relationship to patient _____ Phone (_____) _____

Address _____ City _____ State _____ Zip _____

Name of employer _____ Work Phone (_____) _____

Insurance Information

Name of insured _____ Relationship to patient _____

Birthdate _____ Social Security # _____ Date employed _____

Name of employer _____ Work Phone (_____) _____

Address _____ City _____ State _____ Zip _____

Insurance Co. _____ Phone (_____) _____ Group # _____ Employer # _____

Insurance Co. Address _____ City _____ State _____ Zip _____

How much is your deductible? _____ How much have you used? _____ Max. annual benefit? _____

DO YOU HAVE ADDITIONAL INSURANCE? ❑ No ❑ Yes IF YES, PLEASE COMPLETE THE FOLLOWING:

Name of insured _____ Relationship to patient _____

Birthdate _____ Social Security # _____ Date employed _____

Name of employer _____ Work Phone (_____) _____

Address _____ City _____ State _____ Zip _____

Insurance Co. _____ Group # _____ Employer # _____

Insurance Co. Address _____ City _____ State _____ Zip _____

How much is your deductible? _____ How much have you used? _____ Max. annual benefit? _____

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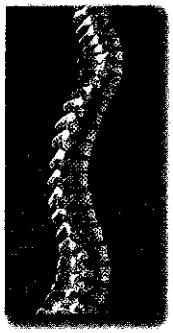

Symptoms

Reason for visit _____ When did you first notice the symptoms? _____

Is this condition getting progressively worse? _____

Where specifically is the problem(s) located? _____

Which activities are difficult to perform? ❑ Sitting ❑ Standing ❑ Walking ❑ Bending ❑ Lying down ❑ Other

Type of pain: ❑ Sharp ❑ Dull ❑ Throbbing ❑ Numbness ❑ Aching ❑ Shooting ❑ Burning ❑ Tingling ❑ Cramps ❑ Stiffness ❑ Swelling ❑ Other

Rate the severity of your pain. (1, mild pain or discomfort, to 10, severe pain): 1 2 3 4 5 6 7 8 9 10

Is the pain constant or does it come and go? _____

What treatment have you already received for your condition?

❑ Medication ❑ Surgery ❑ Physical Therapy ❑ Other _____

Name and address of other doctor(s) who have treated you for your condition:

_____

Health History

Check only those conditions which are applicable:

❑ AIDS/HIV	❑ Cataracts	❑ Hepatitis	❑ Osteoporosis	❑ Suicide Attempt
❑ Alcoholism	❑ Chemical Dependency	❑ Hernia	❑ Pacemaker	❑ Thyroid Problems
❑ Allergy Shots	❑ Chicken Pox	❑ Herniated Disc	❑ Parkinson's Disease	❑ Tonsillitis
❑ Anemia	❑ Depression	❑ Herpes	❑ Pinched Nerve	❑ Tuberculosis
❑ Anorexia	❑ Diabetes	❑ High Cholesterol	❑ Pneumonia	❑ Tumors, Growths
❑ Appendicitis	❑ Emphysema	❑ Kidney Disease	❑ Polio	❑ Typhoid Fever
❑ Arthritis	❑ Epilepsy	❑ Liver Disease	❑ Prostate Problems	❑ Ulcers
❑ Asthma	❑ Fractures	❑ Measles	❑ Prosthesis	❑ Vaginal Infections
❑ Bleeding Disorders	❑ Glaucoma	❑ Migraine Headaches	❑ Psychiatric Care	❑ Venereal Disease
❑ Breast Lump	❑ Goiter	❑ Miscarriage	❑ Rheumatoid Arthritis	❑ Whooping Cough
❑ Bronchitis	❑ Gonorrhea	❑ Mononucleosis	❑ Rheumatic Fever	❑ Other _____
❑ Bulimia	❑ Gout	❑ Multiple Sclerosis	❑ Scarlet Fever	_____
❑ Cancer	❑ Heart Disease	❑ Mumps	❑ Stroke	_____

Dates of last exams _____

(Women) Are you pregnant? ❑ Yes ❑ No Nursing? ❑ Yes ❑ No Taking birth control pills? ❑ Yes ❑ No

List any types of surgeries which you have had and the dates which they occurred:

_____

Please list all medications you are currently taking: _____

Allergies: _____

Daily Habits

What type of exercise do you perform on a daily basis? ❑ None ❑ Moderate ❑ Heavy

What do your daily work habits include? (ex: sitting, standing, light labor, heavy labor, computer work)

_____

What vitamins do you currently take? _____

What kind of other nutritional supplements do you take (if any)? _____

Do you smoke? ❑ No ❑ Yes How much per day? _____

How much liquor do you consume on a weekly basis? _____

How much coffee or caffeinated beverages do you consume on a daily basis? _____

Certification and Assignment

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

I certify that I, and/or my dependent(s), have insurance coverage with _____
Name of Insurance Company(ies)

and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative — Date

_____ _____
Please print name of Patient, Parent, Guardian or Personal Representative — Relationship to Patient

BARLEY FAMILY HEALTH CARE & REHABILITATION

CONSENT TO CHIROPRACTIC SERVICES

1. I, _____, AUTHORIZE THE PERFORMANCE UPON MYSELF OF THE FOLLOWING PROCEDURE(S):

   (EXAMINATION, X-RAY, CHIROPRACTIC ADJUSTMENT)

2. I ALSO CONSENT TO THE PERFORMANCE OF OTHER DIAGNOSTIC AND THERAPEUTIC PROCEDURES IN ADDITION TO OR DIFFERENT FROM THOSE STATED ABOVE, WHETHER OR NOT ARISING FROM PRESENTLY UNKNOWN CONDITIONS, THAT THE ABOVE NAMED DOCTOR, ASSOCIATES, OR ASSISTANTS MAY CONSIDER NECESSARY OR ADVISABLE IN THE COURSE OF MY HEALTH CARE.

3. THE NATURE AND PURPOSE OF THE PROCEDURES, POSSIBLE ALTERNATIVES, THE RISKS INVOLVED, THE POSSIBLE CONSEQUENCES, AND THE POSSIBILITY OF COMPLICATIONS WILL BE EXPLAINED BY THE ABOVE NAMED DOCTOR, ASSOCIATES, OR ASSISTANTS.

4. I ACKNOWLEDGE THAT NO GUARANTEE OR ASSURANCE OF THE RESULTS THAT MAY BE OBTAINED FROM THE PROCEDURE HAS BEEN GIVEN BY THE DOCTOR.

DATE: _____

SIGNED: _____

WITNESS: _____

RELATIONSHIP: _____

DR. JOSEPH P. SHERIDAN **DR. DENNIS A. BARLEY** **DR. TERRY SOUCIE**

ELAINE YOUMAN, P.T. *Certified Chiropractic Sports Physician*

270 Huttleston Ave. (Rt. 6), Fairhaven, MA 02719

Tel: (508) 997-9100 • Fax: (508) 993-5854 • www.chirousa.com

Barley Family Health Care & Rehabilitation

FINANCIAL POLICY

IT IS OUR OFFICE POLICY THAT ALL SERVICES RENDERED ARE CHARGED DIRECTLY TO YOU, THE PATIENT. YOU ARE ULTIMATELY RESPONSIBLE FOR ALL PAYMENTS REGARDLESS OF WHETHER OR NOT THIS OFFICE ACCEPTS INSURANCE ASSIGNMENT.

INITIAL:

_____ THE PRIVILEGE OF INSURANCE ASSIGNMENT BEGINS WHEN ALL YOUR PAPERWORK IS COMPLETE AND SIGNED BY YOU, AND ALL DEDUCTIBLES HAVE BEEN MET.

_____ OUR OFFICE WILL QUALIFY YOUR INSURANCE COVERAGE FOR YOU, BUT BENEFITS QUOTED TO US. DOES NOT GUARANTEE THAT YOUR INSURANCE CO. WILL PAY.

_____ DEDUCTIBLES, COPAYMENTS AND OR COINSURANCE ARE EXPECTED AT THE TIME OF SERVICE. YOUR BALANCE MAY NOT EXCEED $150.00 OR CARE MAY BE TERMINATED.

_____ *CASH PATIENTS:* PAYMENTS ARE EXPECTED AT THE TIME OF SERVICE. PATIENT BALANCES MAY NOT EXCEED $150.00.

_____ SOME INSURANCE COMPANIES DO NOT COVER MAINTENANCE CARE WE WILL VERIFY THAT WITH YOUR INSURANCE COMPANY, AND IF THEY DO NOT YOU WILL BE CONSIDERED A CASH PATIENT AT THAT TIME.

_____ SHOULD YOU DISCONTINUE CARE FOR ANY REASON OTHER THAN DISCHARGED BY THE DOCTOR OR PHYSICAL THERAPIST, ANY AND ALL BALANCES WILL BECOME IMMEDIATELY DUE AND PAYABLE IN FULL BY YOU, REGARDLESS OF ANY CLAIMS SUBMITTED.

_____ THIS OFFICE CHARGES A $25.00 MISSED APPOINTMENT FEE FOR ANY APPOINTMENTS MISSED OR CANCELLED LESS THAN 24 HOURS IN ADVANCE.

IT IS THE GOAL OF THIS OFFICE TO PROVIDE YOU WITH THE FINEST QUALITY CHIROPRACTIC AND PHYSICAL THERAPY CARE AVAILABLE. IF YOU HAVE ANY QUESTIONS IN REGARD TO YOUR HEALTH CARE, OR ANY OF OUR OFFICE POLICIES, PLEASE LET US KNOW. WE WELCOME YOUR REFERRALS AND LOOK FORWARD TO A DOCTOR/PHYSICAL THERAPIST-PATIENT RELATIONSHIP THAT WORKS FOR MUTUAL BENEFIT.

SIGNATURE: _____ DATE: _____

PREGNANCY DISCLAIMER

THIS CERTIFIES THAT CONCERNS REGARDING PREGNANCY AND RADIATION EXPOSURE HAVE BEEN EXPLAINED TO MY SATISFACTION. I UNDERSTAND THE CLINICAL NECESSITY OF HAVING X-RAYS TAKEN AT THIS TIME AND GRANT PERMISSION FOR THIS PROCEDURE. IN SO DOING, I RELEASE THE DOCTOR/CLINIC FROM RESPONSIBILITY FOR POTENTIAL DAMAGE ARISING FROM THIS PROCEDURE.

AT PRESENT TIME: _____ I AM SURE THAT I AM NOT PREGNANT, _____IT IS POSSIBLE THAT I AM PREGNANT
_____I AM PREGANT.

SIGNATURE OF PATIENT: _____ DATE: _____

PRIVACY NOTICE ACKNOWLEDGEMENT

WE ARE VERY CONCERNED WITH PROTECTING YOUR PRIVACY, ESPECIALLY IN MATTERS THAT CONCERN YOUR PERSONAL HEALTH INFORMATION. IN ACCORDANCE WITH THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996(HIPAA), WE ARE REQUIRED TO SUPPLY YOU WITH A COPY OF OUR PRIVACY POLICIES AND PROCEDURES. WE ENCOURAGE YOU TO READ THIS DOCUMENT CAREFULLY. IF YOU EVER HAVE ANY QUESTIONS OR CONCERNS REGARDING THE USE OR DISSEMINATION OF YOUR PERSONAL HEALTH INFORMATION, WE WOULD BE HAPPY TO ADDRESS THEM.

I ACKNOWLEDGE THAT I HAVE RECEIVED A COPY OF BARLEY FAMILY HEALTH CARE AND REHAB'S NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION.

SIGNATURE OF PATIENT: _____ DATE: _____

DR. DENNIS A. BARLEY
DR. TERRY J. SOUCIE

DR. JOSEPH P. SHERIDAN
ELAINE YOUMAN, P.T.