Patient Information

Today's Date: ________________

Patient Information

Name: (First MI Last) ____ **Preferred Name:** _________________

DOB: ___________________ **Sex:** M / F If F, are you pregnant? YES / NO

Address: ____ **Apt:** ________ **City:** __________ **State:** _______

Zip: ________________

Mobile Phone: ______________________________ Email: ____

Preferred Method of Contact: Phone / Email

Who may we thank for referring you to our office? ____

Emergency Contact Information

Name: ____

Phone: ____

Relationship: Child / Parent / Spouse / Other: ____________________

Financial Information

Is today's visit the result of an accident? No / Auto / Work / Other: ________________________

Will we be working with insurance? No / Yes (See details below)

Insurance Company: Blue Cross Blue Shield / Cigna / Medicare / Other: ______________________

Please give insurance card to front desk if you have not already done so.

Parent or Guardian Signature: ____ **Date:** ___________________

It is Usual and Customary to Pay for Services as Rendered Unless Otherwise Arranged

Patient Primary Complaint Form

Major Complaint: ____

When did this episode start (date): _______________ **What event caused it?** ___________________________________

If this is NOT the first time, how long has this been a recurring problem? _______________________________________

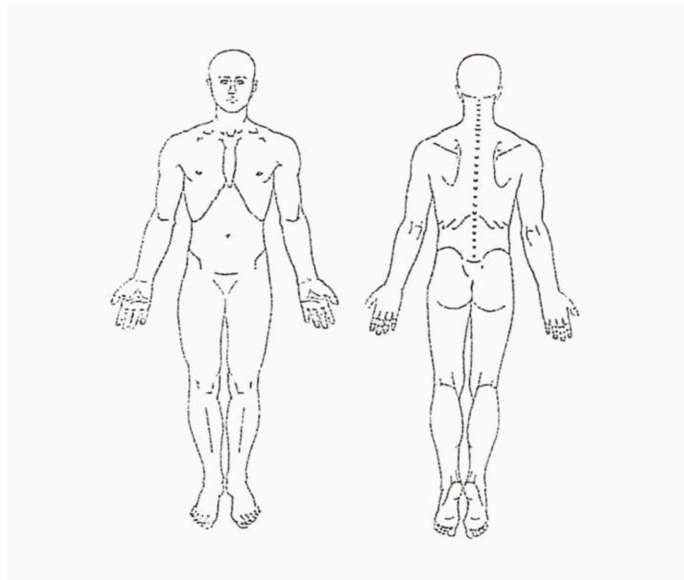
Intensity: None(0) Mild(1-2) Mild-Moderate(2-4) Moderate(4-6) Moderate-Severe(6-8) Severe(8-10)

The complaint is: Constant / Comes and Goes

Is the Complaint: Sharp / Stabbing / Burning / Achy / Dull / Stiff & Sore / Pins & Needles Other: ____________________

Does it radiate/shoot to any area of your body? No / Yes **If YES, where:** _____________________________________

<u>DRAW AREAS OF COMPLAINTS:</u>



What makes it better? Ice / Heat / Rest / Movement / Stretching / OTC Meds / RX Meds / Chiropractic

What makes it worse? Sit / Stand / Walk / Lying / Sleep / Movement / Lifting / Overuse

Who else have you seen for this? No one / DC / MD / PT / Massage / ER / Other: ___________________________

Where: _______________________________________

Diagnostic Tests: None / X-rays / MRI / CT / Other: ____

When & Where? ____

List of Past Surgeries: ____

Any Other Complaints: ____

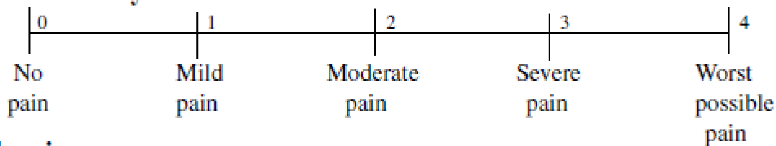
Patient Signature: ____ **Date:** ________________

Functional Rating Index

For use with **Neck and/or Back Problems** only.

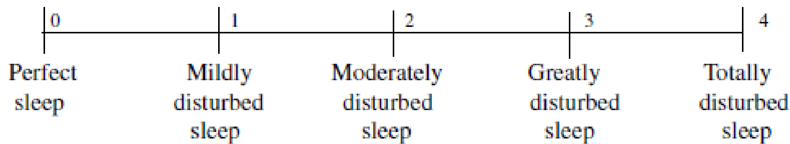
In order to properly assess your condition, we must understand how much your **neck and/or back problems** have affected your ability to manage everyday activities. For each item below, **please circle the number which most closely describes your condition right now.**

1. Pain Intensity



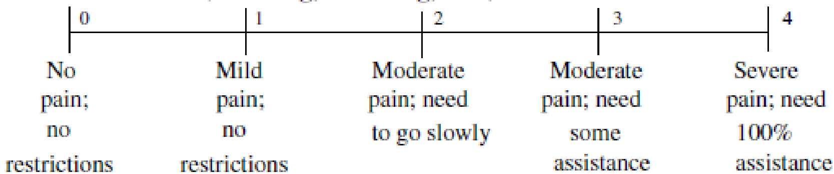
0	1	2	3	4
No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

2. Sleeping



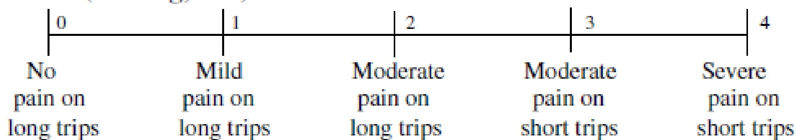
0	1	2	3	4
Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

3. Personal Care (washing, dressing, etc.)



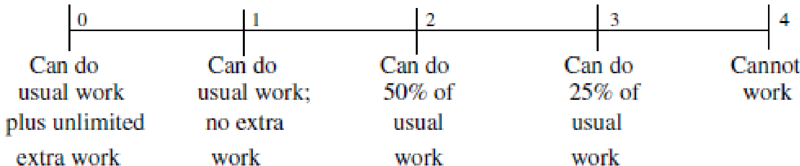
0	1	2	3	4
No pain; no restrictions	Mild pain; no restrictions	Moderate pain; need to go slowly	Moderate pain; need some assistance	Severe pain; need 100% assistance

4. Travel (driving, etc.)



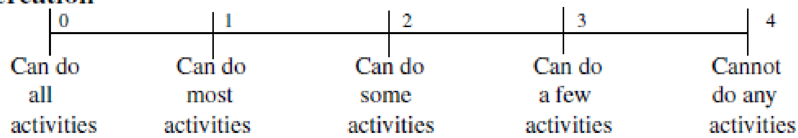
0	1	2	3	4
No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips

5. Work



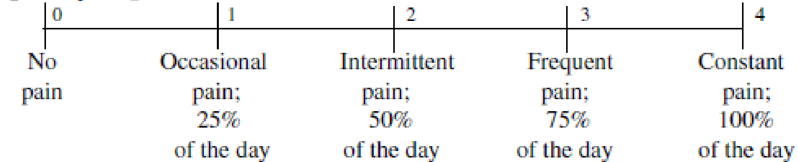
0	1	2	3	4
Can do usual work plus unlimited extra work	Can do usual work; no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work

6. Recreation



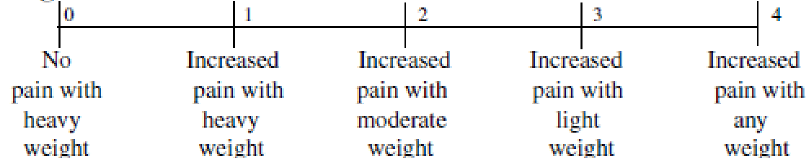
0	1	2	3	4
Can do all activities	Can do most activities	Can do some activities	Can do a few activities	Cannot do any activities

7. Frequency of pain



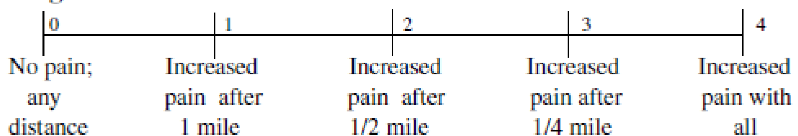
0	1	2	3	4
No pain	Occasional pain; 25% of the day	Intermittent pain; 50% of the day	Frequent pain; 75% of the day	Constant pain; 100% of the day

8. Lifting



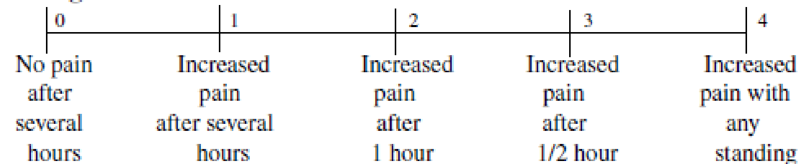
0	1	2	3	4
No pain with heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight

9. Walking



0	1	2	3	4
No pain; any distance	Increased pain after 1 mile	Increased pain after 1/2 mile	Increased pain after 1/4 mile	Increased pain with all walking

10. Standing



0	1	2	3	4
No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after 1/2 hour	Increased pain with any standing

Name ______________________________

PRINTED

____

Signature

____

Date

Total Score __________

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www.chiroevidence.com

Kuchmaner Chiropractic

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THAT INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY.

This Practice is committed to maintaining the privacy of your protected health information ("PHI"), which includes information about your health condition and the care and treatment you receive from the Practice. The creation of a record detailing the care and services you receive helps this office to provide you with quality health care. This Notice details how your PHI may be used and disclosed to third parties. This Notice also details your rights regarding your PHI.

USE AND DISCLOSURE INFORMATION

1. The Practice may use and/or disclose your PHI for the purposes of:

(a) Treatment - To provide you with the health care you require, the Practice will provide your PHI to those health care professionals, whether on the Practice's staff or not, directly involved in your care so that they may understand your health condition and needs. For example, a physician treating you for lower back pain may need to know the results of your last examination by this office.

(b) Payment - To get paid for services provided to you, the Practice will provide your PHI, directly or through a billing service, to appropriate third party payers, pursuant to their billing and payment requirements. For example, the Practice may need to provide the Medicare program with information about health care services that you have received from the Practice so that the Practice can be properly reimbursed. The Practice may also need to tell your insurance plan about treatment you are going to receive so that it can determine whether it will cover the treatment expense.

(c) Health Care Operations - For the Practice to operate in accordance with applicable law and insurance requirements and for the Practice to continue to provide quality and efficient care, it may be necessary for the Practice to compile, use and/or disclose your PHI. For example, the Practice may use your PHI to evaluate the performance of the Practice's personnel in providing care to you.

2. The Practice may also use and/or disclose your PHI in the following instances:

(a) De-identified Information - Information that does not identify you and, even without your name, cannot be used to identify you.

(b) Business Associate - To a business associate if the Practice obtains satisfactory written assurance, in accordance with applicable law, that the business associate will appropriately safeguard your PHI. A business associate is an entity that assists the Practice in undertaking some essential function, such as a billing company that assists the office in submitting claims for payment to insurance companies or other payers.

(c) Personal Representative - To a person who, under applicable law, has the authority to represent you in making decisions related to your health care.

(d) Emergency Situations -

(i) for the purpose of obtaining or rendering emergency treatment to you provided that the Practice attempts to obtain your acknowledgement of our Privacy Notice as soon as possible; or

(ii) to a public or private entity authorized by law or by its charter to assist in disaster relief efforts, for the purpose of coordinating your care with such entities in an emergency situation.

(e) Communication Barriers - If, due to substantial communication barriers or liability to communicate, the Practice has been unable to obtain you acknowledgement of our Privacy Notice and the Practice determines, in the exercise of its professional judgment, that your consent to receive treatment is clearly inferred from the circumstances.

(f) Public Health Activities - Such activities include, for example, information collected by a public health authority, as authorized by law, to prevent or control disease.

AUTHORIZATION

Use and/or disclosures, other than those described above, will be made only with your written authorization.

YOUR RIGHTS

1. You have the right to:

(a) Revoke an Authorization, in writing, at any time. To request a revocation, you must submit a written request to the Practice.

(b) Request restrictions on certain use and/or disclosure of your PHI as provided by law. However, the Practice is not obligated to agree to any requested restrictions. To request restrictions, you must submit a written request to the Practice. In your written request, you must inform the Practice of what information you want to limit, whether you want to limit the Practice's use or disclosure, or both, and to whom you want the limits to apply. If the Practice agrees to your request, the Practice will comply with your request unless the information is needed to provide you with emergency treatment.

(c) Receive confidential communications or PHI by alternative means or at alternative locations. You must make your request in writing to the Practice. The Practice will accommodate all reasonable requests.

PRACTICE'S REQUIREMENTS

1. The Practice:

(a) Is required by federal law to maintain the privacy of your PHI and to provide you with this Privacy Notice detailing the Practice's legal duties and privacy practices with respect to your PHI.

(b) Is required by State law to maintain a higher level of confidentiality with respect to certain portions of your medical information that is provided under federal law. In particular, the Practice is required to comply with the State statutes:

(c) Is required to abide by the terms of this Privacy Notice.

(d) Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for all of your PHI that it maintains.

(e) Will distribute any revised Privacy Notice to you prior to implementation

(f) Will not retaliate against you for filing a complaint.

(g) Abuse. Neglect, or Domestic Violence - To a government authority i f the Practice is required by law to make such a disclosure. If the Practice is authorized by law to make such a disclosure, it will do so if it believes that the disclosure is necessary to prevent serious harm.

(h) Health Oversight Activities - Such activities, which must be required by law, involve government agencies, and may include, for example, criminal investigations, disciplinary actions, or general oversight activities relating to the community's health care system.

(i) Law Enforcement Purposes - In certain instances, your PHI may have to be disclosed to a law enforcement official. For example, your PHI may be the subject of a grand jury subpoena. Or, the Practice may disclose your PHI if the Practice believes that your death was the result of criminal conduct.

(j) Coroner or Medical Examiner - The Practice may disclose your PHI to a coroner or medical examiner for the purpose of identifying you or determining your cause of death.

(k) Organ. Eye, or Tissue Donation - If you are an organ donor, the Practice may disclose your PHI to the entity to whom you have agreed to donate your organs.

(l) Research - If the Practice is involved in research activities, your PHI may be used, but such use is subject to numerous governmental requirements intended to protect the privacy of your PHI.

(m) Avert a Threat to Health or Safety - The Practice may disclose your PHI if is believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to an individual who is reasonably able to prevent or lessen the threat.

(n) Specialized Government Functions - This refers to disclosures of PHI that relate primarily to military and veteran activity.

(o) Workers' Compensation - If you are involved in a Worker's Compensation claim, the Practice may be required to disclose your PHI to an individual or entity that is part of the Worker's Compensation system.

(p) National Security and Intelligence Activities - The Practice may disclose your PHI to provide authorized governmental officials with necessary intelligence information for national security activities and purposes authorized by law.

(q) Military and Veterans - If you are a member of the armed forces, the Practice may disclose your PHI as required by the military command authorities.

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment, or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information, but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we discuss your medical condition with any member of your family?

YES NO

If YES, please name the members allowed:

____

____

This consent was signed by: ____

(PRINT NAME)

Signature: ____ Date: ______________

Auto Accident Questionnaire

Accident Information (please use back of this page if needed)

Date of Accident: _______________ **Approximate Time of Accident:** ________________ **Number of People in Accident Vehicle:** ___________

Location/Street of Accident: ____

Were you the: ☐ Driver ☐ Front Passenger ☐ Rear Passenger – Behind Driver / Middle / Behind Passenger / 2nd Row / 3rd Row

Name of Driver (if not you) ___________________________________ **Name of Driver of Other Vehicle:** _________________________________

Year/Make/Model of Vehicle you were in: ____

Were you wearing a seatbelt? ☐ Yes ☐ No **Is Vehicle Equipped with airbags?** ☐ Yes ☐ No **Did Airbags inflate?** ☐ Yes ☐ No

Where was your vehicle impacted? ☐ Front ☐ Rear ☐ Driver side ☐ Passenger side

During impact, where were you facing? ☐ Forward ☐ Backward ☐ Left ☐ Right

Did any part of your body strike anything in the vehicle? ☐ No ☐Yes If so, describe ____

____

Did you lose consciousness? ☐ No ☐ Yes **For how long?** ____

Were you ☐ Aware ☐ Surprised by the impact?

In your own words, please describe the accident in detail: ____

____

____

Medical Information

Before the Accident

Have you ever had complaints in the involved area(s)? ☐ No ☐ Yes

If yes, were they present at the time of the accident? ☐ No ☐ Yes (describe) ____

Were you able to work without restrictions before the accident? ☐ Yes ☐ No

At the Time of the Accident

Did you feel pain immediately after the accident? ☐ Yes ☐ No – **When?** ☐ Later that Day ☐ Next Day ☐ Later Date: ___________________

Did you go to a hospital or see any other doctor? ☐ No ☐ Yes – **When did you go?** ☐ Immediately ☐ Next Day ☐ Other

How did you get there? ☐ Ambulance ☐ Private Transportation – **Name of Hospital and/or Doctor:** ___________________________________

Were any x-rays taken? ☐ Yes ☐ No **Was any medication prescribed?** ☐ Yes ☐ No

Since the Accident

Are your symptoms: ☐ Getting Better ☐ Staying the Same ☐ Getting Worse

Have you missed any work since this accident? ☐ No ☐ Yes (describe) ____

Are your work activities restricted because of this injury? ☐ No ☐ Yes (describe) ____

Legal Information

Did the police come to the scene of the accident? ☐ No ☐ Yes – **Was a police report filed?** ☐ Yes ☐ No

Have you retained an attorney? ☐ No ☐ Yes – **Name:** ____

Your Auto Insurance Company ____ **Policy #** ____

At-Fault Auto Insurance Company ______________________________________ **Claim #** ____

I have answered these questions to the best of my knowledge and certify them to be true and correct.

Patient or Guardian Signature ____ Date ______________

Print Name (First MI Last) ____ Account # ______________

ASSIGNMENT OF BENEFITS/LIEN

To any insurance company with coverage applicable to my claim(s) and to any attorney representing me:

In consideration of Kuchmaner Chiropractic's willingness to treat me on credit without demand of payment at the time services are rendered, I hereby agree and stipulate as follows:

I irrevocably assign to Kuchmaner Chiropractic any proceeds and compensation that I am or may become entitled to receive as a result of injuries of illness on ____________________, to the extent of the chiropractic services rendered. I make this agreement without prejudice to any rights I may have to prosecute legal claims against any party who may be liable for my injuries or my illness, but I hereby authorize and instruct you to pay directly to Kuchmaner Chiropractic, from any disability benefits, judgments, settlements, or other proceeds of any kind that would otherwise be payable to me, such sums are due or may become due to Kuchmaner Chiropractic for its services rendered.

I appoint Kuchmaner Chiropractic as my attorney in fact to affix my name as an endorsement upon the reverse of any check or draft in which I named payee and to deposit said check or draft and apply the proceeds to any unpaid balance I may have with Kuchmaner Chiropractic.

I acknowledge that I remain personally liable for the total amount due to Kuchmaner Chiropractic for services rendered, including the balance remaining after the application of insurance payments and settlements or judgment proceeds. If Kuchmaner Chiropractic is required to take legal action to recover any unpaid balance on my account, I will reimburse Kuchmaner Chiropractic for its cost of recovery, including reasonable attorney fees.

I authorize Kuchmaner Chiropractic to release to any insurer with applicable coverage or to my attorney any information regarding my injury, illness or treatment as may be necessary to facilitate collection under this assignment and waiver.

____
Patient

____
Date

____
Witness

Notice of Lien

Pursuant to N.C.G.S. 44-49 and 44-50, Kuchmaner Chiropractic herby asserts and gives notice of a lien upon any sums recovered in damages for person injury in any civil action and also upon all funds paid to the above-named patient in compensation for or settlement of injuries sustained, whether in litigation or otherwise.

Kuchmaner Chiropractic hereby requests that if its claims are not paid in full from the foregoing proceeds, a full disclosure and accounting of proceeds in conformity with N.C.G.C. 44-50.1 Kuchmaner Chiropractic agrees to be bound by an confidentiality agreements regarding the contents of the accounting.

Kuchmaner Chiropractic

By: ________________________________

Victor Kuchmaner D.C.
10922 S. Tryon St; Suite B
Charlotte, NC 28273
Phone: 704-588-3433 Fax: 704-588-3459

Medpay Information

A lot of people have benefits (MEDPAY) included in their automobile policies and do not even realize it. Our office highly recommends that you use your Medpay coverage, if you have it, in the event that you've been in an automobile accident, regardless of who is at fault.

Here are three reasons why we recommend filing your Medpay:

1. **Medpay is similar to health insurance.** Using it does not cause your rates to increase. If your rates do increase, it's not because you filed your Medpay, it's most likely because a) it was determined that you were at fault
   b) you received the police citation or ticket, or
   c) you've been involved in numerous reported auto accidents within a brief period of time and therefore are now considered to be "high risk."

2. **Filing your Medpay does not relieve the other party from having to pay in full for your loss.** On the contrary, by filing your Medpay, when you collect from the other driver's liability insurance, a greater amount of the settlement will go directly to you because your bill at our office may be paid in full. If the other driver's liability insurance refuses to make payments to you for whatever reason, filing your Medpay will help ensure that you are not stuck with all the medical bills.

3. **If you have Medpay coverage and choose not to file it, then you are paying for an option, but not receiving any benefit.**

To file your Medpay, simply call your auto insurance company and make a separate Medpay claim. Once you have a phone number and claim number for your Medpay coverage, bring it in to us and we will take care of filing it to your auto insurance company.

Name: ____ Date: __________________