Procedures for Worker's Comp. Patients

Please mark off as completed.

Name of Patient:_____ Date:_____

1. Have them fill out :
    a. Confidential Patient Information Form
    b. Patient Case History Form
    c. Workers Compensation History
    d. Diagnostic Imaging Release
    e. Terms of Acceptance
    f. Health Care Authorization Form
2. Make a copy of their health insurance card and drivers license
3. Ask if they have been seen anywhere else for this injury (emergency room, referred from another doctor, etc.)
    a. If they have, then have them fill out:
        i. Request for Release of Records Form – fax this form to appropriate office
4. Ask if they have filled out a "First Report of Injury" Form
    a. If they have not, have them fill it out right then.
        i. Make sure it is filled out completely. Tell them to be specific as possible when describing how they were injured. *Move to step 5
    b. If they have already filled it out a "First Report of Injury" form elsewhere:
        i. Ask if they are changing doctors or if they were referred.
        ii. If they are changing doctors, they **MUST** fill out a "Notice to Change Physician of Record" form.
        iii. If they were referred, we **MUST have a copy of the approved C-9** form from their doctor for the visit. If they do not have this, or the visit was not approved, we will bill their insurance and they will be responsible for any copays and/or deductibles. (If no insurance, they are fully responsible).
        iv. Ask if they have a claim number from the Bureau of Workers' Compensation, yet.
            1. If yes, get a copy of the card or any paperwork they have.
            2. If they do not have it with them, ask them to bring it the next time they come in. *Place an alert that we need to ask them for it next visit. *Move to step 8
5. If they filled out a "First Report of Injury" in our office, ask Doc to sign and fill out the necessary physician section.
6. Make a copy of the form.
7. Give the original form to the patient and tell them:
    a. They must have their employer sign the form.

b. They will NOT be seen again until they bring the form back completed.
c. WE must file the form with the BWC.
d. Failure to get us the information to file their claim could result in delays and/or denial and we reserve the right to file with their insurance if they do not bring the paperwork back in a timely manner.

8. Have them sign a medical lien.
9. Get their attorney information:
    a. Name
    b. Firm Name
    c. Address
    d. Phone number
    e. Fax number
10. Fax the medical lien to Attorney for signature (use a fax cover sheet)
11. Enter attorney info into computer under Attorney
12. If patient was not referred then Doc/office manager will need to fill out a C-9 form.

Initials_____ Date_____

WARDS CORNER CHIROPRACTIC & SPORTS REHAB

550 Wards Corner Road, Loveland OH 45140
(513) 677-6787 (p) ~ (513) 677-2260 (f)

Confidential Patient Information

Last Name: _____ Birth Date: _____

First Name: _____ Sex: _____

Primary Address: _____ SSN: _____

City: _____ Marital Status: _____

State: _____ Zip Code: _____ Spouses Name: _____

Primary: _____ Ext: _____ Insurance: _____

Other: _____ Ext: _____ ID #: _____

Email: _____ Group #: _____

Preferred Language: _____

Smoking Status: ○ Current/Every Day ○ Current/Some Days ○ Former Smoker ○ Never Smoker ○ Decline to answer

Race: ○ American Indian ○ Asian ○ African American ○ Native Hawaiian ○ White ○ Decline to answer

Ethnicity: ○ Hispanic/Latino ○ Not Hispanic/Latino ○ Decline to answer

****Women Only**: To the best of my knowledge ○ I **am** ○ I **am NOT** pregnant

Communications

Family Physician: _____

May we send your health information to this provider? Yes / No

May we leave messages regarding your personal healthcare information on your and/or your emergency contact's answering device of any kind, i.e. home answering devices or voicemails? Yes / No

Persons we are allowed to communicate your healthcare information with (Please include name and number):

- Spouse: _____
- Children: _____
- Others: _____
- Emergency Contact: _____
- No one: ○

PATIENT CASE HISTORY

List any **Allergies:**

O Animals O Aspirin O Bees O Chocolate O Dairy O Dust O Eggs O Latex O Molds O Penicillin O Ragweed/Pollen

O Rubber O Seasonal Allergies O Shellfish O Soaps O Wheat O X-Ray Dye O Other: _____

List any **Surgeries:**

O Back O Brain O Elbow O Foot O Hip O Knee O Neck O Neurological O Shoulder O Wrist O Other: _____

List **ALL Past Medical History** conditions:

O Ankle Pain O Arm Pain O Arthritis O Asthma O Back Pain O Broken Bones O Cancer O Chest Pain O Depression

O Diabetes O Dizziness O Elbow Pain O Epilepsy O Eye/Vision Problems O Fainting O Fatigue O Foot Pain

O Generic Spinal Condition O Hand Pain O Headaches O Hearing Problems O Hepatitis O High Blood Pressure

O Hip Pain O HIV O Jaw Pain O Joint Stiffness O Knee Pain O Leg Pain O Menstrual Problems O Mid-Back Pain

O Minor Heart Problem O Multiple Sclerosis O Neck Pain O Neurological Problems O Pacemaker O Parkinson's

O Polio O Prostate Problems O Shoulder Pain O Significant Weight Change O Spinal Cord Injury O Sprain/Strain

O Stroke/Heart Attack O Other: _____

List Types/Dosages of **Medication** you are taking: _____

_____

_____

List Types/Reactions of **Medications Allergic** to: _____

_____

_____

List your Family History:

O Arthritis O Asthma O Back Pain O Cancer O Depression O Diabetes O Epilepsy O Genetic,Spinal Condition

O High Blood Pressure O Heart Problems O Multiple Sclerosis O Neurological Problems O Parkinson's O Polio

O Prostate Problems O Stroke/Heart Attack O Other: _____

Do you drink alcohol? No / Yes – how many per day? _____

You drink caffeine? No / Yes – how many per day? _____

Do you exercise? No / Yes (what forms and how often) _____

Have you had any SPINAL X-Rays / MRI's / CT's taken in the last year? ON OY if so, Where? _____

Serious Illness: _____ When? _____

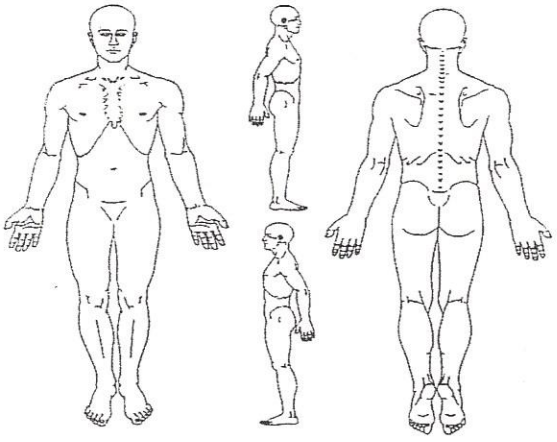
Infectious Diseases: _____ When? _____

Have you had any auto or other accidents? ON OY

Describe: _____

Date of last physical examination: _____

PLEASE MARK YOUR AREAS OF PAIN ON THE DIAGRAM



Main reason for consulting the office:

- O Become pain free
- O Explanation of condition
- O Learn how to care for condition
- O Reduce symptoms
- O Resume normal activity level

What is your complaint: _____ Date problem began: _____

Pain Level (0= no pain through 10= excruciating pain) O0 O1 O2 O3 O4 O5 O6 O7 O8 O9 O10

Activities Affected Level: (0= no affect through 10= no activities) O0 O1 O2 O3 O4 O5 O6 O7 O8 O9 O10

Nature of symptoms: O Burning O Dull O Numb O Radiating O Sharp O Shooting O Stabbing O Tight O Tingling

What aggravates your condition (working, exercise, etc.)? _____

What makes pain better (heat, ice, massage, etc.)? _____

What is your complaint: _____ Date problem began: _____

Pain Level (0= no pain through 10= excruciating pain) O0 O1 O2 O3 O4 O5 O6 O7 O8 O9 O10

Activities Affected Level: (0= no affect through 10= no activities) O0 O1 O2 O3 O4 O5 O6 O7 O8 O9 O10

Nature of symptoms: O Burning O Dull O Numb O Radiating O Sharp O Shooting O Stabbing O Tight O Tingling

What aggravates your condition (working, exercise, etc.)? _____

What makes pain better (heat, ice, massage, etc.)? _____

WARDS CORNER CHIROPRACTIC AND SPORTS REHAB

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(513) 677-6787 (p) ~ (513) 677-2260 (f)

WORKERS COMPENSATION HISTORY

Patient Name: _____

Employers Name: _____

Employers Telephone Number: _____

Address: _____ City: _____ State: _____
Zip: _____

Carrier Name: _____

Telephone Number: _____

Address: _____ City: _____ State: _____
Zip: _____

Have you retained legal counsel for this injury? **Yes** **No**

If yes, give name and address:

_____

Injury Description

Date present injury was received: _____ Time of injury: _____ **A.M** **P.M.** Overtime? **Yes** **No**

Who saw the accident? **Name**_____ **Title**
_____

Who reported the accident? **Name** _____ **Title**
_____

How did the injury occur? _____

If working on a machine, give description: _____

Do you use foot or hand levers? **Yes** **No** Do you work overhead? **Yes** **No**

Do you have to reach? **Yes** **No** Where? _____

Movements on the job: Do you move to your: **Right** **Left** **Up** **Down** **Under** **Over**

Do you pick up or lift? **Yes** **No** If yes, how much? _____ How often?

_____

From where to where? _____

Do you lift from: **Ground Bench Platform Box Pallet Other:** (Please Describe)

_____

Do you lift in and out of a machine? **Yes No** If working at a machine, do you? **Sit Stand Kneel**

Is your work area cluttered? **Yes No** If yes, with what?

_____

Is your work area: **Oily Dirty Slippery Other**

In your job do you push or pull? **Yes No** If yes, give specifics:

_____

Do you use a cart? **Yes No Two-wheel Four-wheel** Type of wheels: **Rubber Steel Plastic**

Condition of cart: **Good Bad Other** _____ Number of carts being pushed or pulled at once:

_____

Total amount of weight being pushed or pulled on a daily basis: _____

Office Work

If your injury has occurred from office work only, please fill out the following:

I...: **Sit at desk Walk Stand Stoop Hold Carry Other**

_____

Give percentage, if applicable: _____ Do you operate office machinery? **Yes No**

If yes, what type? _____

If your work is at a desk, give specifics of job, computer, typewriter, business machine, phone, etc.

_____

_____

_____

If walking, where to and job classification:

_____

Do you carry anything or pick anything up? **Yes No** If yes, what?

_____

Previous Work History

Give a job description of services or work performed for each job classification or source of employment for the preceding 10 (ten) years.

- _____
- _____
- _____
- _____
- _____

Was a pre-employment exam performed or required? **Yes** **No**

If so: **Date:** _____ **Doctor:** _____ **Place:** _____

Have you ever applied for Workers' Compensation benefits before? **Yes** **No** Date: _____

Reason:

_____

Was there a time loss from work? **Yes** **No** **From:** _____ **To:** _____ **Year:** _____

State the degree of recovery: _____

Did you retain legal counsel for these injuries? **Yes** **No**

If yes, give name and address:

_____

Present Work History

What is the job classification of your normal job? _____

Were you performing your normal job? **Yes** **No** What shift were you working? _____

How long have you been at your present job? _____

Has there been a time of loss or absenteeism caused from job injury? **Yes** **No**

If yes, please explain:

_____

Average work week: _____ Hours: _____ Days: _____

Job Conditions

Type of building: _____

Type of floor: **Rough** **Smooth** **Wood** **Concrete** **Steel** **Other:** _____

Type of windows: **Open** **Closed** **No windows**

Type of ventilation in the building: **Blower** **A/C** **Heat** **Exhaust** **None** **Other:** _____

Type of lighting in the building: **Fluorescent** **Overhead** **On machine** **Other:** _____

Are you tired when you go home at night? **Yes** **No**

Do you have any outside jobs? **Yes** **No** If yes, what type?

_____

Do you participate in any company-sponsored programs such as exercise, sports, etc? **Yes** **No**

If yes, please describe:

_____

Type of shop: **Union** **Non-Union**

Has outside help been hired? **Yes** **No** If yes, why?

_____

How many employees are in the plant? _____ How many employees per shift?

_____

How many employees do your job? _____ What is the current injury ratio for that job?

_____

How many employees have been injured doing your job? _____ Do you like your job? **Yes** **No**

If off work, do you want to return to your job? **Yes** **No**

What changes would you make in your job?

_____

_____

_____

The above information is accurate and has been completed to the best of my knowledge:

Patient Signature _____

Date_____

Staff Signature_____

Date_____

DIAGNOSTIC IMAGING CONSULTANTS, INC.
3296 W STATE ROUTE 22-3
LOVELAND, OHIO 45140-4587
FAX: (513) 489-4587

ASSIGNMENT OF BENEFITS FOR RADIOGRAPHIC INTERPRETATION

I understand that to insure the highest quality of interpretation of my x-rays, the services of a certified chiropractic radiologist are being utilized. The fee is separate from that of the chiropractic clinic. I also understand that the fees for this service will be submitted to my insurance carrier, worker's compensation, or attorney in the case of personal injury.

I understand I may receive a billing statement for: insurance denial, professional fees that have been applied to my deductible or the balance due stated by my insurance company as my responsibility.

In the event that I receive payment for the services I agree to promptly remit payment to Diagnostic Imaging Consultants.

I acknowledge and give my consent to have my x-rays interpreted by Dr. Bryan Hosler, DACBR. I understand that any balance due is my responsibility.

SIGNATURE:_____ DATE:_____

Healthcare information is sensitive information. It is being sent to us after the appropriate authorization of the patient. We, the recipient, are obligated to maintain it in a safe, secure, and confidential manner. Re-disclosure without additional patient consent or as permitted by law is prohibited. Unauthorized disclosure could subject penalties described in federal law.

The following signature authorizes the release of medical information and also authorizes the assignment of benefits to:

DIAGNOSTIC IMAGING CONSULTANTS, INC.
3296 W STATE ROUTE 22-3
LOVELAND, OHIO 45140-4587

SIGNATURE:_____ DATE:_____

WITNESS:_____

DIAGNOSTIC IMAGING CONSULTANTS, INC.
3296 W STATE ROUTE 22-3
LOVELAND, OHIO 45140-4587
FAX: (513) 489-4587

***Please make sure all information is completed with each set of films.
***Attach assignments of benefits form signed by patient.

PATIENT NAME _____ CLINIC _____
ADDRESS _____ CITY _____

STATE _____ ZIP _____ PHONE _____

D.O.B. _____ MARITAL STATUS: S M D W

SOCIAL SECURITY NUMBER (REQUIRED): _____ SEX: F M

INSURANCE COMPANY (ONLY) ATTACH COPY OF CARD

INSURED'S NAME _____

RELATIONSHIP TO INSURED: SELF SPOUSE CHILD OTHER

INSURANCE COMPANY _____

ADDRESS _____ PHONE _____

POLICY # _____ GROUP # _____

ATTORNEY (ONLY)

ATTORNEY'S NAME _____

ADDRESS _____

STATE _____ ZIP _____ PHONE _____

PATIENT HISTORY

PRESENT COMPLAINT _____

TRAUMA? *YES NO EXPLAIN* _____

PAST MEDICAL HISTORY _____

REFERRING DOCTORS CONCERNS/QUESTIONS _____

_____

***DATE OF INJURY _____

***DIAGNOSIS CODE NUMBERS _____

HEALTH CARE AUTHORIZATION FORM

THE PATIENT IDENTIFIED BELOW AUTHORIZES Wards Corner Chiropractic, Inc. TO USE AND OR DISCLOSE PROTECTED HEALTH INFORMATION IN ACCORDANCE WITH THE FOLLOWING:

SPECIFIC AUTHORIZATIONS

- o I give Wards Corner Chiropractic, Inc. permission to treat me in an open room where other patients are also being treated. I am aware that other persons in the office may overhear some of my protected health information during the course of care. Should I need to speak with doctor at any time in private; the doctor will provide a room for these conversations.

- o I give Wards Corner Chiropractic, Inc. permission to combine any mailings with my spouse. I, also, give my spouse permission to call for and cancel my appointments.

- o I give permission to Wards Corner Chiropractic, Inc. to use my email address for the Wards Corner Chiropractic newsletter, informing me of heath related information, news happening in our practice and treatment alternatives.

- o I give Wards Corner Chiropractic, Inc. permission to display any pictures that I *give them* of myself or my children on the picture wall.

You have the right to revoke this authorization, in writing, at any time. However, your written request to revoke this authorization is not effective for services already provided.

You may revoke this authorization by mailing or hand delivering a written notice to the Privacy Official of Wards Comer Chiropractic, Inc. The written notice must contain the following information: Your name, Social Security number, date of birth, a clear statement of your intent to revoke this authorization, the date of your request, and your signature. The revocation is not effective until it is received by the Privacy Officer.

A copy of the signed authorization will be provided to you upon request.

This Authorization expires seven years after the patient's last date of service.

_____

Print Patient's Name

_____ _____

Signature of Patient/Guardian Date

WARDS CORNER CHIROPRACTIC AND SPORTS REHAB
550 Wards Corner Road, Suite 101, Loveland, OH 45140
(513) 677-6787 (p) ~ (513) 677-2260 (f)

Patient Name: _____ **Date:** _____

Terms of Acceptance

The goal of our office is to enable patients to gain control of their health. To attain this we believe communication is the key. There are often topics that are hard to understand and we hope this document will clarify those issues for you.

Please read the below and if you have any questions please feel free to ask one of our staff members.

Informed Consent:

A patient, in coming to the chiropractic doctor, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. Some of these conditions may include: musculoskeletal sprain/strain; disc injuries; dislocations; fractures; neurological deficits; Horner's Syndrome, Vertebral Artery Syndrome (V.A.S.); stroke; etc. the chances of this occurring have been estimated by experts to be approximately only 1 per 400,000treatments, to 1 per 1,000,000 treatments. The doctor, of course, will not give any treatment or care if he/she is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known, or to learn through healthcare procedures what he/she is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the chiropractic physician. The patient should look to the correct specialist for the proper diagnostic and clinical procedures. The chiropractic doctor provides a specialized, non-duplicating health care service. Your doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regimen. As part of a comprehensive treatment plan you may be receiving therapeutic modalities and physical agents including heat, cold, electrical stimulation, laser, or ultrasound. These treatments are included in enhance your pain relief, and assist in your rehabilitation. Their risks are very infrequent and usually *minor, but my include skin irritation, small localized blisters, burns, contact site blisters from electrical stimulation patches, localized swelling* or muscular soreness. If inotophoresis is used, in conjunction with a prescribed mediation from you medical doctor, your risks can include allergic reaction to the medication, skin irritation or fluctuations in blood sugar if you are diabetic. I understand that if I am accepted as a patient by a physician at **Wards Corner Chiropractic and Sports Rehab**, I am authorizing them to proceed with any treatment that they deem necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

Women Only:

To the best of my knowledge I **am / am NOT** pregnant and (**give my permission / don't give permission**) to x-ray me for diagnostic interpretation.
(Circle one above) *(Circle one above)*

Consent to Evaluate and Treat a Minor:

I, _____ being the parent or legal guardian of _____, have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Communications:

In the event that we would need to communicate your healthcare information, to whom may we do so?

Spouse: _____

Children: _____

Others: _____

No one: ____

May we leave messages regarding your personal healthcare information on any answering device, i.e. home answering machines or voicemails? Yes [ ] No [ ]

Acknowledgement

I have read and fully understand the above statements. I have reviewed the notice of privacy practices (HIPAA) and have been provided an opportunity to discuss my right to privacy. Upon request I will be given a copy.

Print Name: _____

Signature: _____ Date: _____