The Khoury Centre For Chiropractic & Wellness

640 Washington Street
Dedham, MA 02026
(781) 329-3344

116 Mechanic Street, Suite 3
Bellingham, MA 02019
(508) 966-3777

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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 (HIPPA), we are required to supply you with a copy of our privacy policies and procedures. We encourage you to read this document carefully, for it outlines the use and limitations of the disclosure of your health information and your rights as a patient. 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 Khoury Chiropractic Inc.'s *Notice of Privacy Practices for Protected Health Information.*

______________________________ ____________________
Patient Name Printed Date

____
Patient Signature

______________________________ ____________________
Witness Name Printed Date

____
Witness Signature

ACCIDENT HISTORY QUESTIONNAIRE

PATIENT INFORMATION

Name: ____ Date: _________________
Address: ____
City:_____________________ State: ___________ Zip Code :_______________________
D.O.B: _____________Age:_______ SS#: ___________________Sex: □ Male □ Female
Height:_________________ Weight:______________________
Home Phone: ___________________________ Work Phone: _____________________________
How did you hear about the office?:_________________________________

Are you: single married widowed divorced separated live with: spouse or alone or other -live with_____________

Do you drink coffee:□ no □ yes how much:_______ Do you drink: alcohol: □ no □ yes how much:________
Do you use drugs: none recreationally addicted
Do you exercise: never daily weekly walks run swim

Current Employment:_________________________ Start date:______________________

Are you being or have been treated for low back pain? □ no □ yes -date you were & diagnosed:_______________________
Do you have diabetes? □ no □ yes if yes, date diagnosed:______________ by: (Physician's name)____
Do you have high blood pressure? □ no □ yes -date you were diagnosed_______________ by:___________________

Do you smoke? □ no □ yes - how much/often: _________________
DR. USE: BP__________ Radial P:__________Temp:____________ RESP:____________

Please list your current medications, date started, type, strength, dosage, duration, and prescribing doctor:
____
____
____
____
____
____
____
____

Do you have allergies?: □ no □ yes to what _______________________ Reaction:_______________________
Major Surgery/Operations? □ no □ yes-please list surgery, date, and result: ____________________________
____
____
____
____
____

Hospitalization (other than above please list date, reason, and hospital) □ no □ yes-pleas list:
____
____

Major Illnesses/Accidents or falls: (please note when): ____
____

____

Have you had any tests recently (radiology, blood work etc. please list test, date, and result): ___________
____

Family history: please list family member & condition:

Relationship	Disease(s) or condition(s)	Deceased?	Cause of death
________________	______________________________	□ Yes □ No	__________________________
________________	______________________________	□ Yes □ No	__________________________
_________________	______________________________	□ Yes □ No	__________________________
_______________	______________________________	□ Yes □ No	__________________________

Date of Accident ______________________ Time of Accident _________________AM/PM

Please Describe the accident in your own words:________________________________

Were you the: □ **Driver** □ **Front Passenger** □ **Rear Passenger** □ **Pedestrian**

ACCIDENT SITE

Road/Street Name ______________________

City/State ______________________________

Driving Conditions: □ Dry □ Wet □ Icy □ Other

Visibility: □ Poor □ Fair □ Good □ Other_______

Was your vehicle moving? □ Yes □ No

Speed of you vehicle: _________________mph

YOUR VEHICLE

Make and model of your car:_________________

Were you wearing a seatbelt? □ Yes □ No

Were shoulder harnesses worn? □ Yes □ No

Did the airbag inflate? □ Yes □ No

Did your seat have a headrest? □ Yes □ No

If yes, what was the position of the headrest?

□ Top of headrest even with **bottom** of head

□ Top of headrest even with **top** of head

□ Top of headrest even with **middle** of neck

Estimate the amount of damage done to your vehicle: _________________________________

OTHER VEHICLE

Make and model other vehicle ______________

Speed of other vehicle _________________mph

IMPACT

Did your car impact another vehicle? □ Yes □ No

Did your body strike anything inside the vehicle?

□ No □ Yes, explain_________________________

Type of Impact: □ Front □ Rear □ Left □ Right □ Other ____________

Head/Body position at the time of impact:

□ Head straight forward □ Body Straight

□ Head up/down □ Body Rotated right/left

□ Head turned right/left □ Other

Did you see the accident coming? □ Yes □ No

Did you brace for impact? □ Yes □ No

Was your car braking? □ Yes □ No

ILLUSTRATION OF THE ACCIDENT

PATIENT CONDITON

Were you unconscious after the accident? □ Yes □ No If yes, for how long?___________________

Could you move all parts of your body? □ Yes □ No If no, which parts couldn't you move and why?____

Were you able to get out of the car and walk unaided? □ Yes □ No, why not? ________________

Did you get any bleeding cuts? □ Yes □ No If yes, where?_______________________________

Did you get any bruises? □ Yes □ No If yes, where? ___________________________________

Please describe how you felt, 1) immediately after the accident?_________________________

2) Later that day?____

3) The next day?____

TREATMENT

Did you go to the hospital immediately after the accident? □ Yes □ No

How did you get there? □ ambulance □ police □ someone else drove me □ drove own car

When did you go? □ Immediately after the accident □ Next day □ 2 days or more after the accident

Hospital Name: ______________________________ Name of Doctor : _______________________

Treatment received: ____

Medications given: ____

X-rays taken: ____

Did you seek any additional treatment? □ Yes □ No If yes, who did you see? ________________

Date of visit?________________ Treatment received: ____________________________________

SYMPTOMS

Have you missed any days at work since the accident? □ Yes □ No **If yes, how many?___________**

If you have had any of the following symptoms since the accident, please check off:

□ Arm/Shoulder pain	□ Foot/toe numbness	□ Dizziness
□ Low back pain	□ Neck stiffness	□ Ear ringing
□ Neck pain	□ Headaches	□ Memory Loss
□ Upper back pain	□ Irritability	□ Jaw problems
□ Chest pain	□ Nausea	□ Sleep difficulty
□ Leg pain	□ Stomach upset	□ Blurred vision
□ Hand/finger numbness	□ Chest pain	□ Shortness of breath

Past health history: Place an x if it applies and describe:

□ None related to current complaints	□ Hospitalized	□ Surgery
□ Other auto accident(s)	□ Work Accident	□ Illness

Describe condition and treatment:____

____

____

Confidential Patient Health Record

"GEORGE'S CEREBROVASCULAR CRANIOCERVICAL FUNCTION TEST"

Instructions: Please circle the correct response.

Historical Information

- Have you ever been diagnosed or told you have any of the following?

1. High Blood Pressure (hypertension) □ Yes □ No
2. Hardening of the arteries (arteriosclerosis) □ Yes □ No
3. Diabetes □ Yes □ No
4. Heart or blood vessel diseases □ Yes □ No
5. Bone spurs on the neck bones (cervical spondylosis) □ Yes □ No
6. Whiplash injury (flexion-extension injury) (cervical spine) □ Yes □ No
7. Have any of your relatives suffered a stroke? □ Yes □ No
8. Were you ever a smoker? If yes, from __________ to ________________ □ Yes □ No
9. Do you take any medications on a regular basis? □ Yes □ No
   - If yes, what? (Coumadin, Heparin, Aspirin, Anti-hypertensive medicine, etc.)
     ____
10. (Women Only) Have you ever taken oral Contraceptives? □ Yes □ No
    - If yes, from ______________________ to ________________________

- Have you ever had any of the following, even short, temporary attacks, in the last year?

1. Blurred Vision □ Yes □ No
2. Double Vision □ Yes □ No
3. Diminished or partial loss of vision in one or both eyes? □ Yes □ No
4. Complete loss of vision in one or both eyes? □ Yes □ No
5. Ringing, buzzing or any noise in the ear(s)? □ Yes □ No
6. Hearing loss in one or both ears? □ Yes □ No
7. Slurred speech or other speech problems? □ Yes □ No
8. Difficulty swallowing? □ Yes □ No
9. Dizziness? □ Yes □ No
10. Temporary lack of understanding? □ Yes □ No
11. Loss on consciousness, even momentary blackouts? □ Yes □ No
12. Numbness or loss of sensation in the face, fingers, hand, arms, legs, or any other parts of your body? □ Yes □ No
13. Any other abnormal sensations in any part of your body? □ Yes □ No
14. Weakness, clumsiness or loss of strength in the face, finger, hands, arms, or legs? □ Yes □ No
15. Sudden collapse without loss of consciousness? □ Yes □ No

Patient Signature ____ Date _____________________

Dear Patient,

It is our desire that you have as pleasant an experience in our office as possible. Our most important concern is your health, but we also need to follow the billing protocol for personal injury care.

Please read the following and sign the bottom of this form.

1. YOUR insurance company is responsible for paying your bills, NOT the company of the person who hit you. If the accident was someone else's fault, your insurance company will seek compensation from their insurance company. After the first $2,000.00 of total Personal Injury Protection (PIP) benefits are paid out, by law we must bill your health carrier. If your health carrier does not provide chiropractic benefit or if you do not have health insurance, your PIP carrier will continue to pay your bills up to a total of $8,000.00.
2. It is your responsibility to obtain the following information from your insurance company: Name, Address, Phone, and Fax number, as well as the claim number, name and extension of the Bodily Injury adjuster NOT the adjuster for your car.
3. Your insurance company will send you a form called a "PIP Application". This form must be filled out by you as soon as it is received. Your insurance company will not pay your bills until this form is on file with them. Failure to send in your PIP application will cause the bills to become your responsibility.
4. If you have decided to utilize the help of an attorney you and your attorney will need to sign a Lien form, which is held on file at this office. The Lien is used should you have any outstanding bills that are awaiting settlement to be paid.
5. At some point during your care your insurance company may send you to another doctor for an evaluation. This is called an IME or an Independent Medical Examination. Please inform this office immediately once you are notified of an IME.
6. Keeping your scheduled appointments are imperative, not only for your recovery but also to ensure your claims will be paid. If an insurance company sees you missing appointments or changing your treatment plan without the recommendation of our doctors, they will assume that you are recovered and no longer need care.

"I understand the above information and agree to comply fully with the office policies of Khoury Chiropractic."

Signed____ Date_____________

Witness____

The Khoury Center for Chirpractic and Wellness
640 Washington Street, Dedham, MA 02026
781-329-3344, fax 781-329-3096
116 Mechanic Street, Bellingham, MA 02019
508-966-3777, fax 508-966-3738

PERSONAL INJURY INSURANCE INFORMATION

PATIENT NAME ____ **DATE of BIRTH** __________________

ADDRESS____

PHONE (H) ____________________ (W) ____________________ DATE of ACCIDENT____________

YOUR AUTO INSURANCE INFORMATION (OR OWNER OF VEHICLE)

NAME OF INSURED____
(IF OTHER THAN YOURSELF)

NAME OF COMPANY____________________________ **CLAIM #** ___________________________________

ADDRESS____

ADJUSTER _________________________________ PHONE # _________________________ EXT # ______
HAVE YOU HAD OR BEEN SCHEDULED FOR AN INDEPENDENT MEDICAL EXAM (IME)? ________

OTHER DRIVER'S INFORMATION

NAME OF DRIVER ____

NAME OF COMPANY ______________________________ ADJUSTER _________________________________

ADDRESS ____ PHONE ______________________________

If applicable:
NAME OF ATTORNEY__________________________________PHONE__________________

By law in Massachusetts we must bill your personal health carrier after $2,000.00 of personal injury benefits have been exhausted.
PERSONAL HEALTH INSURANCE COMPANY_______________________________________
Please provide our receptionist with a copy of your health insurance card.

I HEREBY AUTHORIZE ____________________________ INSURANCE COMPANY TO PAY **KHOURY CHIROPRACTIC** DIRECTLY FOR MY HEALTH CARE COSTS. THIS PAYMENT WILL NOT EXCEED MY INDEBTEDNESS TO KHOURY CHIROPRACTIC, AND I AGREE TO PAY ANY BALANCE OF PROFESSIONAL SERVICES OVER AND ABOVE THIS INSURANCE PAYMENT.

I ALSO AUTHORIZE THE RELEASE OF ANY INFORMATION PERTINANT TO MY CASE TO ANY INSURANCE COMPANY, ADJUSTER OR ATTORNEY INVOLVED IN MY CASE.
(Please read the above paragraph carefully before signing.)

____ ____________________
SIGNATURE DATE

WITNESS ____

IRREVOCABLE ASSIGNMENT OF BENEFITS FORM/LIEN

I hereby grant an irrevocable Equitable Lien and an *Official Legal Liens* as set forth in Ch111§70A through Ch111§70D Mass General Laws to said doctor against any and all proceeds of any settlement, judgment or verdict which may be paid as the result of the injuries for which I have been treated or injuries in connection therewith.

I hereby assign and authorize any and all medical benefits from any insurance plan or any other protection maintained by the patient and/or for the patients behalf to which I am entitled, including but not limited to, Personal Injury Protection Benefits (PIP), optional medical payments benefits, disability insurance, bodily injury insurance, uninsured/underinsured insurance, workers compensation, or any other private insurance or health plan be paid directly to:

Khoury Centre for Health & Wellness
640 Washington Street
Dedham, MA 02026
Tax ID: 04-3520390

For treatment resulting from an accident on ________________ in _______________ and rendered by The Khoury Centre and all medical staff associated with them.

I certify that the information given by me to The Khoury Centre in applying for payment under insurance plans or other protection is correct and complete.

I authorize all procedures related to my diagnoses whether covered or not by insurance plan and I understand that I am financially responsible for all charges in excess of the plans payment schedule or not a covered service or paid by any insurance company.

I hereby authorize the Khoury Centre to release all information necessary including confidential medical records to any insurance company, adjuster or attorney involved in collection of this matter in order to secure payment.

I hereby authorize the Khoury Centre to endorse/sign my name on and deposit any and all checks payable for their services. Should an insurance check be sent to me, I agree to forward it immediately to The Khoury Centre.

I also authorize that The Khoury Centre may file any appropriate complaint on my behalf.

A photocopy of this assignment is considered as effective and valid as the original for any successive services.

I understand this is an Irrevocable and Direct assignment of benefits.

______________________________ ______________________________
Signature of patient or guardian **Date**

______________________________ ______________________________
Printed name of patient or guardian **Witness**

NOTICE OF IRREVOCABLE LIEN AND ASSIGMENT OF BENEFITS AUTHORIZATION

Patients Name and Address: ____

Date of Injury:____________ **Insurance Carrier:** ______________________________**Claim #:** _________________________

Law Office:____

Attorney Name:____

In consideration of the agreement of the provider named above to provide me with injury treatment services, I hereby to the extent of my treatment bills irrevocably assign to my provider all my right, title, and interest to and in all applicable insurance and indemnification reimbursement benefits of applicable insurance companies including but not limited to: automobile PIP coverage; Medical Payment Coverage and health care coverage to which I may be entitled to pay my provider for services rendered to treat me on and after the above date.

I hereby authorize and direct you, my attorney, to pay directly to said doctor such sums as may be due and owing him or her for professional services rendered me both by reason of this accident and by reason of any other bills that are due this office and to withhold such sums from any settlement, judgment or verdict as my be necessary adequately to protect said doctor. I hereby further grant an irrevocable Equitable Lien and an Official Legal Liens as set forth in Ch111§70A through Ch111§70D Mass General Laws to said doctor against any and all proceeds of any settlement, judgment or verdict which may be paid to you, my attorney, or myself as the result of the injuries for which I have been treated or injuries in connection therewith.

I hereby authorize and direct any and all applicable insurance companies to make immediate payment directly to my said provider for all benefits and sums due me that may be due him or her upon receipt by you of my providers itemized statement for treatment services rendered to me. It is further agreed that payment by any insurance company involved as herein directed to my provider of any itemized statement shall be considered the same as if paid by the insurer directly to me.

I fully understand that I am directly and fully responsible to said doctor for all professional bills submitted by him or her for service rendered me and that this agreement is made solely for said doctor's additional protection and in consideration of awaiting payment. I am aware that I remain personally responsible to my provider for the full amount of my unpaid treatment bills and I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

Patient's Signature ____________________________________ **Date:** ______________________

The undersigned being attorney of record for the above patient does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment verdict as may be necessary adequately to protect the said doctor named above.

Attorney's Signature ____________________________________ **Date:** ______________________

Attorney: Please date, sign and return one copy to doctor's office at once. Keep one copy for your records.