Health First Rehab, Inc.

923 Route 6A, Unit Y
Yarmoutport, MA 02675
Phone: 508-362-2945
Fax: 508-362-2946

133 Falmouth Road, Unit C
Mashpee, MA 02649
Phone: 508-221-1169
Fax: 508-362-2945

New Personal Injury Patient Paperwork

Please provide the office copies:

1. Insurance Cards
2. Driverôs License
3. Auto Insurance COVERAGE SELECTION PAGE

Please answer the Following Questions:

1. Were you working during the time of the accident?
   - a. ☐ Yes (please call the office to discuss 508-362-2945)
   - b. ☐ No
2. Were their other factors involved?
   - a. ☐ Alcohol (please call the office to discuss 508-362-2945)
   - b. ☐ Speed
   - c. ☐ Other:
3. Did the Police come to the scene?
   - a. ☐ Yes
   - b. ☐ No
4. Was a Police Report Filed?
   - a. ☐ Yes
   - b. ☐ No
5. Have you received a PIP application?
   - a. ☐ Yes
   - b. ☐ No
6. Did you Report the Injury?
   - a. ☐ Yes
   - b. ☐ No

Please provide the office this form on your next visit:

1.Coverage selection page from YOUR insurance company.

Office Policies - Health First Rehab, Inc.

Informed Consent to Treatment

By signing below, I consent to the services being rendered during this visit by Dr. Joshua Lindauer, DC or any other chiropractic physician who now or in the future treat me while employed by, working or associated with or covering for Dr. Lindauer, DC. I am informed that there are some rare but potential risks to chiropractic manipulative therapy, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interest. I have been informed of possible alternative therapies. No guarantee has been made to me as to the result or cures that may be obtained from examination or treatment in this clinic. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Privacy Notice Acknowledgement

In accordance with the ***Health Insurance Portability and Accountability Act of 1996 (HIPAA)***, by signing below, I acknowledge that a copy of the Notice of Privacy Practices for Protected Health Information for this office has been made available to me. I am advised to read this document carefully, for it outlines the use and limitations of the disclosure of my health information and my rights as a patient. I have been given the opportunity to ask any questions that I may have regarding these policies.

Authorization to Release Medical Information

I authorize my healthcare provider(s) to furnish information from my medical records to any company that may be responsible for payment of all or part of my visit and provider charges, including my insurance companies and their representatives, and my information to this provider for continuing care.

Massage Therapy Non-Covered Service Waiver

Massage therapy services performed by a licensed massage therapist in this office are not a covered benefit under your current health plan, as these procedures are not performed directly by a participating physician/provider.

There is a fee of ***$8.00*** per visit for this service. **_____Initial**

Authorization for Direct Payment of Insurance Benefits

I, or my representative, authorize direct payment to the provider(s) and/or clinic rendering any services during this visit of any insurance benefits otherwise payable to me.

Health Insurance/Patient Payment Policy

We will to file your insurance claims for you. However, we cannot guarantee or take responsibility for what your health insurance will or will not cover. Ultimately, all services rendered to you are charged directly to you and you are personally responsible for payment. Payment for all services, including copays, coinsurance and deductibles, are expected at the time of service unless prior arrangement are made with us. **If you have a cash balance with our office greater than *45 days*, there will be a finance charge of *5% per month applied to your account***.

Treatment Compliance. Appointment Cancellation Policy

We require a 24 hour notice for appointment cancellations. Health First Rehab, Inc. reserves the right to charge ***$40.00*** for the missed visit if this policy is abused. This amount is not covered by any insurance plan and will be the patient's responsibility. Further, **greater than 2 missed appointments will be considered non-compliance and subject to discharge from care**.

_____Initial

I have read the Health First Rehab, Inc. office policies and will honor them:

_____	_____	_____
Print Name	**Patient Signature**	**Date**

Health First Rehab, Inc.
Joshua Lindauer, DC

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HEALTH INSURANCE AFFIDAVIT

Your claim for Personal Injury Protection benefits may be coordinated with your own personal Health Insurance per MGL c.90, Section 34M. In order to properly determine what benefits are payable, it is necessary for you to provide us with the information requested below.
Thank you very much.

1. Do you have Health Insurance? ( ) YES ( ) NO
   a. If **Yes** please answer, or **provide a copy or your health card**, both sides.

Name of plan: _____

☐ **SEE ATTACHED INSURANCE CARDS**

Policy #:_____
Subscriber name: _____
Social Security #:_____

B. If No,

Are you eligible for coverage under anyone elseôs plan?

( ) YES ( ) NO

If you are eligible under someone elseôs plan, please complete **section A** as well as the following.

Member name: _____
Relationship to you: _____
Address of member: _____
Member phone #:_____
Member date of birth: _____

Applicantôs Signature: _____Date:_____

Patient and Insurance Information

Name: Date:

Address:

Town: State: Zip:

Home Phone: Cell #: Work #:

E-mail address:

Date of Birth: Social Security #

Marital Status: Name of Spouse:

Primary Care MD: Permission to send treatment notes to PCP: ☐ Y ☐ N

Emergency Contact: Relation: Phone:

Your Employer: Occupation:

Address:

Town: State: ZIP:

Health Insurance Info: **Please Give Insurance Card to Receptionist to Copy** ☐ **None**

Insurance Company: Phone:

Plan Name:

Address: State:

Policy #: Group #:

Patient Relationship to the insured: Self Spouse Child Other:

Attorney Information:

Name of Law Firm:

Address: Town: State: Zip:

Phone:

Fax:

Email:

Auto Accident /Worker's Compensation **Date of Accident:**

Carrier: Policy Number:

Address: City: State: Zip:

Phone: Fax:

Claim # Contact Person/Adjuster:

Name of auto policy holder: Date of Birth: / /
Address: Phone:

Note: All patients must review and sign our office policy regarding insurance billing and patient responsibilities prior to treatment.

PERSONAL INJURY INTAKE QUESTIONNAIRE

PATIENT NAME: _____ ***Today's Date:***

--- Please let us know if you require assistance, be as complete and concise as possible ---

Date of Collision?

Weather/Road Conditions: □ Clear day, dry road □ Rainy, wet □ Snow, Icy
Any additional road hazards: _____
Other Factors: □ ***Alcohol*** □ Speed □ Other: _____

Was your vehicle Totaled? □ Yes □ No Estimated vehicle damage? $ _____.00 □ Estimate pending
Was your vehicle towed from the scene? □ Yes □ No, I was able to drive my vehicle from the scene

Describe the incident in your own words:

MECHANISM OF INJURY

What was *your* position in the car? □ Driver □ Passenger, position: □ Front □ Right Rear □ Left Rear
List other passengers: 1 _____ 2 _____ 3 _____ 4 _____
Did your vehicle strike another vehicle? □ Yes □ No
Was your vehicle struck by another vehicle? □ Yes □ No
Angles of impacté First Collision: □ Front □ Back □ Left □ Right
If Second Collision: □ Front □ Back □ Left □ Right

Were you wearing a seat belt? □ Yes □ No
Did you brace for impact? □ No □ Yes --- □ I braced with my hands □ I braced with my feet
Which way were you facing at the time of impact? □ straight ahead □ Left □ Right
Were the airbags deployed? □ No □ Front airbags deployed □ Side airbags deployed

Did you strike anything in vehicle at time of impact? □ Yes □ No
If yes, describe what part of your body struck what: i.eé head, chest, chin, knees ,shoulders right or left, etcé .
□ Steering Wheel _____ □ Dashboard _____
□ Windshield _____ □ Roof _____
□ Door: □ Left □ Right: _____ □ Window: □ Left □ Right: _____
□ Other _____
Did the seat back bend / break ? □ Yes □ No
Any other damage to *INSIDE* of vehicle as result of incident? _____

Were police called to the scene? □ Yes □ No
Was a police report filed? □ Yes □ No
Were any tickets issued? □ Yes, I was issued the following ticket: _____
□ Yes, the other driver was issued the following ticket: _____
□ No, not sure.

TREATMENT

Did you go to hospital □ Yes □ No Were you admitted? □ Yes □ No if yes how long? _____

If you went to hospital, when? □ At time of accident □ Next day

How did you get to hospital? □ Ambulance □ Private transportation

Name of Hospital: _____

What treatment was given? _____

☐ none ☐ placed in a cervical collar ☐ x-rayed ☐ Bandage/ Stitches: region _____

☐ given pain medication/muscle relaxants: please list:_____

☐ given home instructions? please explain: _____

Referral: ☐ Orthopedist/Surgeon ☐ Neurologist ☐ Physical Therapy ☐ Primary Care

Name of Physician: _____

Have you seen any other doctors as a result of this accident? □ Yes □ No

Date:_____ Physician: _____ Treatment: _____

Date:_____ Physician: _____ Treatment: _____

Date:_____ Physician: _____ Treatment: _____

Occupation: _____

Have you lost any time from work due to your injuries? □ No □ Yes --- Dates: _____ thru _____

Have you returned to work? □ No □ Yes --- Date you returned to work? _____/_____/_____

Are your work activities presently restricted due to this accident? □ Yes □ No

If yes, please describe: _____

Are your daily activities presently restricted due to this accident? □ Yes □ No

If yes, please describe: _____

PRIOR ACCIDENTS / MEDICAL HISTORY

Have you ever had same or similar symptoms? □ Yes □ No

If yes, please describe: _____

_____

Have you had previous injuries or accidents? □ Yes □ No

If yes, Date and Description of previous Accident(s), if applicable:

Date:_____ Injuries: _____ Treatment: _____

Date:_____ Injuries: _____ Treatment: _____

Date:_____ Injuries: _____ Treatment: _____

Do you have any residual pain from the previous injuries? □ Yes □No

If yes, please explain: _____

Medical history: □ My medical history is unremarkable for any major accidents, injuries or disease.

Major Illnesses: □ No □ Heart dz □ Hypertension □ Cancer, Type: _____ □ Diabetes, Type: □ I □ II

□ Other: _____

Surgeries: □ No □ Yes, describe: _____

Fractures or dislocations: □ No □ Yes, describe: _____

Allergies: □ No □ Yes, list allergies: _____

Social History: □ Smoke: _____ pk/day □ Drink: _____ per week □ Exercise: _____

Are there any other comments or concerns you wish to discuss with the doctor regarding your injuries? □ No □ Yes

If yes, please explain: _____

_____

Patient Signature: _____ Date:

Health First Rehab, INC

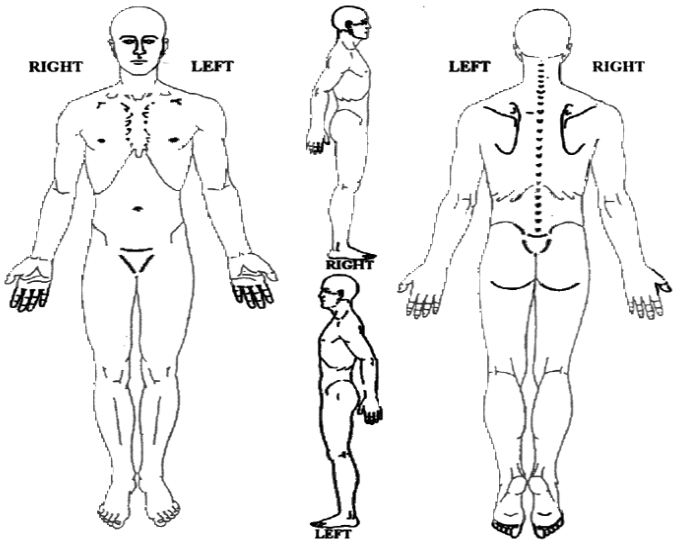
PATIENT PAIN FORM

Patient: _____ **Date of Birth:** _____ **Today's Date:** _____

Date of Injury (if applicable): _____

SHOW US YOUR PAIN
USE THE LETTERS BELOW TO INDICATE THE TYPE
AND LOCATION OF YOUR SYMPTOMS TODAY

KEY: **A** = ACHE **B** = BURNING **N** = NUMBNESS **P** = PINS & NEEDLES
S = STABBING **X** = STIFFNESS **T** = THROBBING **O** = OTHER



Problem List: **(This Section for Office Use Only)**

MOI:

1. _____
NRS: /10
Px w/ cough:
RR:
N/T/W:
BB fxn:

2. _____
NRS: /10
Px w/ cough:
RR:
N/T/W:
BB fxn:

0 1 2 3 4 5 6 7 8 9 10
(No Pain) (Worst Pain)

_____
Patient Signature

I experience the above symptoms: ☐ Constantly ☐ Very Often ☐ Occasionally ☐ Infrequently

I feel that my symptoms are: ☐ Getting Better ☐ Getting Worse ☐ Staying About the Same

My symptoms are: ☐ Sharp/Stabbing ☐ Dull, Achy ☐ Stiffness ☐ Numbness ☐ Tingling ☐ Burning ☐ Other:

Symptoms radiate/refer to my: ☐ head ☐ shoulders ☐ arms ☐ Hips ☐ buttocks ☐ Legs

Symptoms are worse with: ☐ Standing ☐ Sitting ☐ Driving ☐ Bending ☐ Lifting ☐ Work Activity ☐ Other, please explain:

Symptoms are relieved with: ☐ Rest/Lying down ☐ Ice ☐ Heat ☐ Stretching ☐ Movement ☐ Other, please explain:

I am unable to perform the following activities due to pain:

List current medications/Supplements: ☐ See current medication list provided

1. 2. 3. 4. 5.

I am experiencing the following symptoms (please check all that apply) :

☐ Shortness of breath	☐ Nausea /Vomiting	☐ Difficulty sleeping
☐ Difficulty breathing	☐ Fevers / Chills	☐ Difficulty concentrating
☐ Pain with coughing	☐ Light-headed, dizziness	☐ Memory problems
☐ Bowel/bladder changes	☐ Visual changes	☐ Mood swings, irritability
☐ Urinary incontinence	☐ Hearing changes	☐ Loss of appetite/Weight loss
☐ Blood in stool	☐ "Foggy/Hazy" feeling	☐ Fatigue
☐ Other symptoms:		