Reisterstown
Family Chiropractic

Dr. Howard M. Lipman

PERSONAL INJURY/WORKMEN'S COMPENSATION QUESTIONAIRE

File#_____

NAME_____ Date of Accident _____ Time_____

Where did it happen? _____

Describe the Accident in your own words _____

_____

_____

What was your position in the car? ☐ Driver ☐ Passenger If passenger, were you sitting in: ☐ Front ☐ Right Rear ☐ Left Rear

Did your vehicle strike other vehicle? ☐ Yes ☐ No Was your vehicle struck by other vehicle? ☐ Yes ☐ No

Was the impact from: ☐ the front? ☐ from the right side? ☐ from the left side ☐ from the rear?

At the time of impact, were you: ☐ looking straight ahead? ☐ looking right? ☐ looking left?

Were both hands on the steering wheel? ☐ Yes ☐ No Was your foot on the brake? ☐ Yes ☐ No Did you brace for impact? ☐ Yes ☐ No

Where in the car were you after the accident? _____

Were you wearing seat belts? ☐ Yes ☐ No Did you strike anything in the vehicle at the time of impact? ☐ Yes ☐ No

If yes, specify: ☐ Steering Wheel ☐ Dashboard ☐ Windshield ☐ Side Door ☐ Arm Rests ☐ Side Window ☐ Other _____

Please state part of body struck: ☐ Chest ☐ Chin ☐ Knee ☐ Shoulder ☐ Hand ☐ Head ☐ Other _____

Immediately following the accident, how did you feel? _____

_____

Were you unconscious? ☐ Yes ☐ No In a Daze? ☐ Yes ☐ No Did you go to a Hospital? ☐ Yes ☐ No

If you went to a Hospital, when? At the time of the accident? ☐ Yes ☐ No The Next Day? ☐ Yes ☐ No ☐ Other _____

How did you get to the hospital? Ambulance ☐ Yes ☐ No Private Transportation ☐ Yes ☐ No

Did the Ambulance attendants place you in: Neck collar? ☐ Yes ☐ No Splints? ☐ Yes ☐ No Brace? ☐ Yes ☐ No

Name of Hospital? _____

Attended by Doctor _____ Were you X-rayed at the Hospital? ☐ Yes ☐ No

What was the Diagnosis & X-ray Findings? _____

Were you admitted to the Hospital? ☐ Yes ☐ No How long did you stay? _____

What treatment was rendered? _____

What recommendations were made? ☐ See your own Doctor ☐ See Orthopedic Doctor ☐ Physical Therapy ☐ Do Nothing ☐ Other _____

Have you seen any other Doctor as a result of this accident? ☐ Yes ☐ No Doctor's Name: _____

Describe your pain: ☐ Constant ☐ On and Off ☐ Sharp ☐ Dull ☐ Burning Sensation ☐ Occurs with movement ☐ Other _____

Is your pain worse when: ☐ Arising from a chair ☐ Straining ☐ Coughing ☐ Sneezing ☐ Straining when moving your bowels?

Do you have any numbness or tingling in your: ☐ arms ☐ hands ☐ fingers ☐ legs ☐ feet ☐ toes

What is your most comfortable position? ☐ Sitting ☐ Lying on your left side ☐ Lying on your right side ☐ Lying on your back

☐ Lying on your stomach ☐ Standing ☐ Bent forward ☐ Leaning to the left ☐ Leaning to the right

☐ Other _____ Is it difficult for you to move around in bed? ☐ Yes ☐ No

Does stretching and twisting worsen the pain? ☐ Yes ☐ No

Do any of the following relieve the pain? ☐ Heating Pad (Dry or Moist) ☐ Hot Bath ☐ Shower ☐ Ice Pack

Does a brace (If you tried one) relieve the pain? ☐ Yes ☐ No

Does a change in heel height worsen the pain? ☐ Yes ☐ No Do you feel better moving around? ☐ Yes ☐ No Or Resting? ☐ Yes ☐ No

Do you have a firm mattress? ☐ Yes ☐ No Do your knees ache or hurt? ☐ Yes ☐ No Do you have cramps in: ☐ Leg ☐ Arm

Has there been any changes in your: ☐ Bowel Habits ☐ Bladder Control ☐ Ability to grip ☐ Ability to walk ☐ Muscle size

Have you lost any time from work because of this accident? ☐ Yes ☐ No

If yes, Give the dates of time lost. From _____ To _____

Totally disabled from _____ to _____ Partially disabled from _____ to _____

Do you have PIP coverage? ☐ Yes ☐ No What Company? _____

Have you retained an Attorney ☐ Yes ☐ No If no, would you like to have a referral to an Attorney? ☐ Yes ☐ No

If yes, my attorney is:_____

11710 Reisterstown Rd. Suite 205 * Reisterstown, MD 21136
(410) 517-2400 * Fax (410) 843-9117

Personal Injury Accident Insurance Information

File#_____

Name of Insurance Carrier_____

Phone number you called to report accident_____

Name of Person you spoke to_____

Insurance Policy #: _____

Claim or Case ID #: _____

Did they give you an address to mail information to? Yes No

If they did what was the address:

_____

_____

_____

_____

Are there any other specific instructions they gave you? If yes what are they?

_____

_____

_____

_____

Do you have an attorney? Yes No

If so what is your attorney's name, address, and phone number?

_____

_____

_____

_____

_____

_____

Reisterstown
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Personal and Family Health History

File #:_____

About You:

Name:_____ Today's Date:_____
Date of Birth:_____ Age:_____ Sex: _____ Height:_____ Weight:_____
Physician's Name:_____ Physician's Phone #: _____
Who May we Thank for Referring You? _____
Home Address: _____
Home Phone #: _____ Work Phone #: _____
Cell Phone #: _____ E-Mail Address: _____
Occupation: _____ Employer: _____
Marital Status: Married Single Widowed Divorced Separated
o I give you permission to send me Health Tips via Email

About Your Family:

Spouse's Name: _____ Spouse's Occupation: _____
How Many Children Do You Have?_____

	Patient	Spouse	Child #1	Child#2	Child#3
Circle All that Apply					
1. Was Your Birth Traumatic?	Y	Y	Y	Y	Y
2. Have You Fallen as a Child?	Y	Y	Y	Y	Y
3. Have You Fallen as an Adult?	Y	Y	Y	Y	Y
4. Have You Had a Car Accident?	Y	Y	Y	Y	Y
5. Have You Played Sports?	Y	Y	Y	Y	Y
6. Are You Stressed Out?	Y	Y	Y	Y	Y

What Brings You to Our Office?

Describe Your Symptoms: _____
_____
Date When Symptoms First Appeared: _____
Did it Begin: (circle) *Gradually* *Suddenly* *Progressed over Time*
Was this Problem Due to an Auto Accident or Work Related Injury? (circle) *Yes / No*
What Makes the Symptoms Worse? _____
Quality of Pain: (circle) *Dull/Achy* *Sharp/Stabbing* *Burning* *Throbbing* *Electrical*
Does the Pain Radiate into Your: (circle) *Arm* *Leg* *Head* *Does Not Radiate*
Do You Experience Numbness or Tingling? (circle) *Yes / No*
What Percent of the Time Do You Experience these Symptoms? *100%* *75%* *50%* *25%* *10%*

What Have You Already Tried to Resolve this Problem: (check ALL that apply)
☐ Over the Counter Drugs ☐ Prescription Drugs ☐ Physical Therapy ☐Surgery
☐ Chiropractic ☐ Massage Therapy ☐Acupuncture ☐ Nutritional Supplements

Patient Signature: _____ Date: _____

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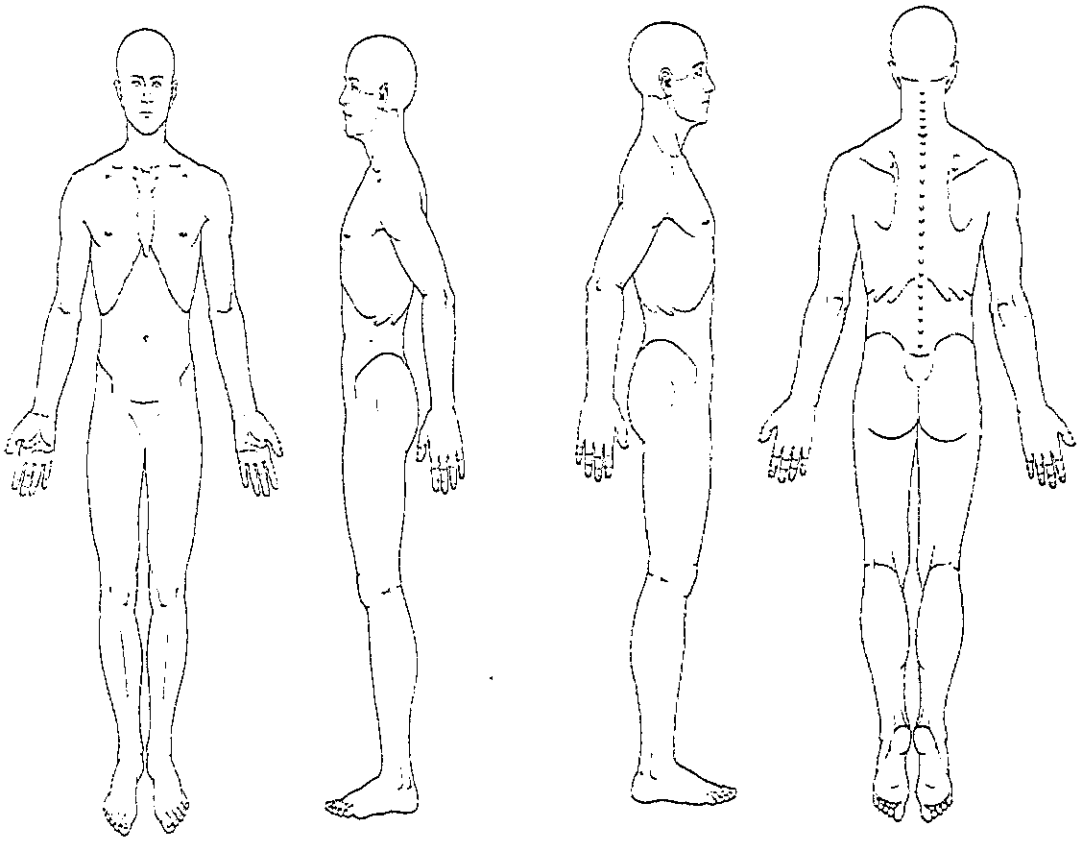
File #:_____

Location of Symptoms

Please indicate any areas of discomfort or pain on the body chart below. Mark the areas where you feel the described sensations using the following symbols. Please include all affected areas and mark areas of radiation (traveling pain)

Pain = **PPP**
Numbness = **NNN**
Burning = **BBB**
Tingling = **TTT**
Cramping = **CCC**
Radiating Pain = /\/\/\/\/



Severity of Pain & Symptoms

Please Mark an "X" on the lines below to indicate the intensity of your Problem

1. Right Now: None ---------- Worst Possible
2. Average: None ---------- Worst Possible
3. At Worst: None ---------- Worst Possible

Patient Signature _____ Date _____

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Informed Consent to Chiropractic Treatment

The nature of Chiropractic treatment: The doctor will use his/her hands or a mechanical device to move your joints. You may feel a "click" or "pop", such as the noise when a knuckle is "cracked", and you may feel movement of the joint. Various ancillary procedures, such as cold packs, electrical muscle stimulation, therapeutic ultrasound, flexion/distraction or therapeutic exercises may also be used.

Possible risks: As with any health care procedure, complications are possible following a chiropractic adjustment. Complications could include fractures of bone, muscular strain, ligamentous strain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or minor complications.

Probability of risks occurring: The risks of complications due to chiropractic treatment have been described as "rare", about as often as the complications that are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury, or stroke, has been estimated from at one in one million to one in twenty million, and can even further be reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered "rare".

Other treatment options (besides chiropractic) which could be considered may include the following:

- *Over- the-counter analgesics:* The risks of these medications include: irritation to the stomach, liver and kidneys as well as other side effects in a number of cases.

- *Medical care*: Typically, anti-inflammatory drugs, tranquilizers and analgesics are utilized. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.

- *Hospitalization:* In conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.

- *Surgery:* In conjunction with medical care adds to the risks of adverse reaction to anesthesia, hospital acquired infections, as well as an extended convalescent period in a significant number of cases.

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue, and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite predictable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

Unusual risks: Unusual risks are many times case specific and will be explained in detail if they occur.

I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. By signing below, I have freely decided to undergo the recommended treatment and hereby give my full consent to treatment.

PATIENT SIGNATURE_____ DATE _____H

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Patient Privacy and Acknowledgement statement

File#_____

Part I – Acknowledgement Statement

I, the undersigned, hereby acknowledge that I have provided Reisterstown Family Chiropractic certain specific Protected Health Information, here after referred to as PHI. This information is provided by me, with the understanding that it will be used for these purposes only:
1-Diagnosis and treatment of my spinal complaints.
2-Billing my insurance carrier
3-Provding requested information to my insurance carrier, this may include: Treatment notes, X-ray findings, examination or evaluation findings and reports.
4-Notifing me of future or missed appointments, by phone, U.S Postal service, or e-mail
5- Announcing or informing me of Practice Events, such as Patient Appreciation Days, special promotion, etc.
6-By Subpoena, court order, or other Legal requiems
I understand that Reisterstown Family Chiropractic provides a sign in sheet daily. This sign in sheet is accessible to Staff members and other Patients entering this office seeking treatment. I also understand that Reisterstown Family Chiropractic displays the names of Patients that refer in other Patients in the Waiting Area. I agree that my name maybe used for this purpose should I refer in a Patient, unless I have provided a request to the contrary in writing.

Part II- My Rights as Patient

I have the right to:
1-Revoke this authorization at anytime, by submitting a written request for such to Reisterstown Family Chiropractic's Appointed Privacy Officer.
2-Request restriction of specific information or disclosure. This request must be made in writing and submitted to Reisterstown Family Chiropractic's Appointed Privacy Officer.
3-Inspect or copy any PHI. This request must be made in writing and submitted to Reisterstown Family Chiropractic's Appointed Privacy Officer.
4-Amend my PHI at anytime, as provided by law. All amendments will be made in writing.
5-Receive an accounting of any and all disclosures
6-Contact Reisterstown Family Chiropractic's Appointed Privacy Officer at any time with concerns or complaints. This contact may be done in Person, via phone @ 410-517-2400, via U.S. Postal Service or via E-mail @ terry@familychirodoc.com.

Part III- Reisterstown Family Chiropractic's Responsibilities

In accordance with Federal HIPAA Laws and Maryland State Privacy Laws, Reisterstown Family Chiropractic is required to:
1-Abide by all Federal and Maryland State Privacy laws and regulations
2-Maintain my Chiropractic and financial records in a discrete and secure location within their office.
3-Notify me in writing of any changes to this acknowledgement, and provide for my signature in a timely fashion an amended statement for my signature.

By subscribing my signature below, I acknowledge receipt of this notice and understand and agree to its terms.

_____ _____
(Signature of Patient or Guardian) (Date)

_____ _____
(Signature of Staff Witness) (Title)

My initials below signify that I have received a copy of my signed agreement for my personal records.

_____

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File#: _____

REISTERSTOWN FAMILY CHIROPRACTIC
FINANCIAL POLICY

AUTO ACCIDENT / PERSONAL INJURY
Patients involved in personal injury accidents may receive 100% coverage for their medical treatment under the Personal Injury Protection (PIP) of their auto insurance policy up to the policy limits.

OFFICE POLICY

**1. You are required to provide our office with the following insurance information by your second visit: the name of your auto insurance carrier, their address, phone number, as well as the claim and policy numbers.

**2. If you have an attorney, you will need to provide us with their information by your second visit. You and your attorney will be required to sign an attorney's lien.

**3. Regardless of who is at fault for the accident, a claim will be established with the insurance carrier for the car in which you were seated or your auto insurance carrier if either policy contained PIP/MedPay benefits. This office may submit any bills to the involved insurance carrier and/or attorney. If your bill for treatment is not paid in full by the auto insurance carrier, we may bill your health insurance carrier for any outstanding charges.

**4. You are personally responsible for your bill. However, we may choose not to require payment at the time of service, as long as we are billing the correct insurance carrier and/or attorney and receiving payment.

**5. If you or your attorney receives an insurance payment for services rendered by our office, that payment is due in our office within 10 business days. Your attorney, as well as yourself will not be permitted to make "payments" on an insurance check mailed to you. In addition, if you have a remaining balance due on your account when your case settles, you have 10 business days to render payment of that balance.

**6. If any insurance claim or personal information changes during the course of treatment, you are required to inform this office immediately. (Such as insurance policy/plan updates or terminates, you have moved, or changed your phone number, etc.)

**7. If you receive a bill, the payment is due upon receipt. All accounts with a balance over 45 days will be assessed a 1% late charge per month on the unpaid monthly balance. Payment plans can be arranged through the Billing department (410-517-2400). In the event that an account becomes assigned to a collection agency, the patient will pay 100% of collection agency fees, 100% of court costs, and 100% of attorney's fees.

_____8. There are a certain number of appointments available each day and often patients who are injured are unable to be scheduled the same day that they call. With this in mind, if you are unable to keep a scheduled appointment, we ask that you give us the courtesy of a phone call at least 24hrs prior to a missed appointment. Failure to do so will result in a $50.00 missed appointment fee. This fee will not be paid by the insurance company it will be a charge for you the patient.

**** I HAVE READ, UNDERSTAND, AND ACCEPT THESE POLICIES IN FULL.

Please sign below and Initial above.

PATIENT SIGNATURE_____ DATE_____

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