

Chicopee Center Chiropractic

333 Front Street, Suite 2 | Chicopee, MA 01013 | 413-598-8550

Full Legal Name: _____ Preferred Name: _____

D.O.B: _____ Age: _____ Sex: _____ Preferred Pronouns: _____

Address: _____ City/State/Zip: _____

Phone: _____ Mobile Land Email: _____

Legal Sex: _____ Occupation: _____ FT PT Student Unemployed

Single Married Live-In Partner Divorced Widowed Number of Children: _____

Name of Primary Care Physician: _____

Briefly describe any health concerns, including impact they've had on your life: _____

How long have you had these problems? _____

If you are experiencing pain, please describe the nature of the pain. Please check all that apply.

Sharp Dull Stabbing Throbbing Tingling Comes and goes Constant Travels

Since the problem started, is it: About the same Getting Better Getting Worse

What factors aggravate your pain: _____

My pain interferes with: Work Sleep Walking Sitting Hobbies Leisure Time

Which, if any, other providers have you seen for this problem? Please list the provider's name and specialty.

Please list any medications you are currently taking (and reason for medication): _____

If you are currently taking any vitamins and/or supplements, please list: _____

Have you ever been treated by a chiropractor? Yes No If yes, when and where? _____

Please check (✓) all symptoms you've ever had, even if they do not seem related to the current problem:

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Pins/Needles in Arms | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Numbness in Fingers |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Pins/Needles in Legs | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Cold Sweats |
| <input type="checkbox"/> Mood Swings | <input type="checkbox"/> Sleeping Difficulties | <input type="checkbox"/> Bloating | <input type="checkbox"/> Cysts |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Stiff Neck | <input type="checkbox"/> Constipation | <input type="checkbox"/> Light Sensitivity |
| <input type="checkbox"/> Menstrual Pain | <input type="checkbox"/> Fainting | <input type="checkbox"/> Back Pain | <input type="checkbox"/> Low Energy |
| <input type="checkbox"/> Decreased Libido | <input type="checkbox"/> Irritability | <input type="checkbox"/> Cold Hands | <input type="checkbox"/> Fever |
| <input type="checkbox"/> Joint Pain | <input type="checkbox"/> Problems with Urination | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Stomach Upset |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Menstrual Irregularity | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Tension |
| <input type="checkbox"/> Cold Feet/Hands | <input type="checkbox"/> Hot Flashes | <input type="checkbox"/> Heartburn | <input type="checkbox"/> High Cholesterol |

Did/Do you smoke cigarettes? Yes No If yes, how many per day and how long? _____

Do you drink alcohol? Yes No If yes, how many drinks per week? _____

Have you been involved in any accidents? Yes No If yes, type of accident and when? _____

Have you had any type of surgery? Yes No If yes, what type(s) and when? _____

On a scale of 1 – 10 (10 being the most extreme stress) please rate your current stress level: _____

On a scale of 1 – 10 (1 being poor and 10 being excellent) please rate the following:

Diet: _____ Exercise: _____ Sleep: _____ General Health: _____

Is there anything else you'd like to share? _____

The statements I have made on this form are accurate to the best of my recollection. I agree to allow this office to complete a comprehensive examination to further evaluate my concerns and guide my treatment.

Patient Printed Name: _____

Patient Signature: _____ Date Signed: _____

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AUTOMOBILE ACCIDENT INFORMATION

Full Name: _____ Date of Accident: _____

Driver of Vehicle: _____ Owner of Vehicle: _____

Owner's Insurance Company: _____ City / State: _____

Location of Accident: _____ City / State: _____

Were police called to the scene? _____ Was a police report filed? _____

*** If a police report was filed, please bring it with you so we can make a copy for our records. ***

Were you the: Driver Front Passenger Rear Passenger

What type of vehicle were you in? Compact Mid-Size Full-Size Truck SUV

What other type(s) of vehicle(s) were involved? _____

Were you wearing a seatbelt? Yes No If yes, what type? Full Lap Shoulder

Type of accident? Single Vehicle Two-Vehicle Three or More Vehicles

Where was the impact to your vehicle? Rear Front Left Side Right Side Rollover

Did the vehicle have airbags? Yes No Did they deploy during the accident? Yes No

What was your approx. speed at the time of impact? _____ mph Other Vehicle(s)? _____ mph

At the time of impact, your head was: Facing forward Turned right Turned left

Did any part of your body hit the inside of the vehicle? Yes No If yes, which? _____

Did you brace yourself for the accident? Yes No

Were you rendered unconscious? Yes No If yes, for how long? _____

How soon after did you experience pain? _____ Where? _____

Did you go to the hospital? Yes No If yes, how did you get there? _____

Treated with any other providers for this incident? Yes No

If yes, please list their name(s): _____

Were any tests performed (MRI, etc)? Yes No If yes, which and when? _____

Have your injuries prevented you from working? Yes No If yes, for how long? _____

Have you retained an attorney? Yes No If yes, who? _____

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ASSIGNMENT AND AUTHORIZATION - ATTORNEY LIEN

Patient Name: _____ Date of Injury: _____

Attorney Name: _____

I do hereby authorize **Dr. Steven Przedziecki of Chicopee Center Chiropractic** to furnish to you, my attorney, with a full report of his examination, diagnosis, prognosis, etc of myself in regards to the accident in which I was recently involved. I further authorize and direct you, my attorney, to pay directly to Dr. Steven Przedziecki all sums that may be due and owed to him for services rendered to me both by reason of this accident and by reason of any other bills that are due to the doctor's office, and to withhold such sums from any settlement, judgment, or verdict as may be necessary to adequately protect and fully compensate Dr. Przedziecki. I hereby further give a lien on my case to Dr. Przedziecki against any and all proceeds of my settlement, judgment, or verdict which may be paid to you, my attorney, or myself, as a result of the injuries for which I have been treated, or injuries in connection therewith. I expressly understand that I am directly and fully responsible to Dr. Przedziecki and Chicopee Center Chiropractic for all medical bills submitted by them for services rendered to me, and that this agreement is made solely for said doctor's additional protection and in consideration of the doctor awaiting payment. I further understand that such payment is not contingent on any settlement, judgment, or verdict by which I may eventually recover.

I agree to promptly notify Dr. Przedziecki at Chicopee Center Chiropractic of any changes or addition of attorney(s) used by me in connection with this accident, and instruct my attorney to do the same, and to promptly deliver a copy of this lien to any such substituted or added attorney(s). I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment and may declare the entire balance due and payable.

Patient Signature: _____ Date: _____

The undersigned being the 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, or verdict, as may be necessary to adequately protect and fully compensate Dr. Steven Przedziecki for services rendered. By signature below, the attorney further agrees that in the event this lien is litigated that the prevailing party will be awarded attorney's fees and costs.

Attorney Signature: _____ Date: _____

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PAIN DIAGRAM

Please mark the area of injury or discomfort on the chart below, using the appropriate symbols:

Numbness

Pins and Needles

00000000
00000000

Burning

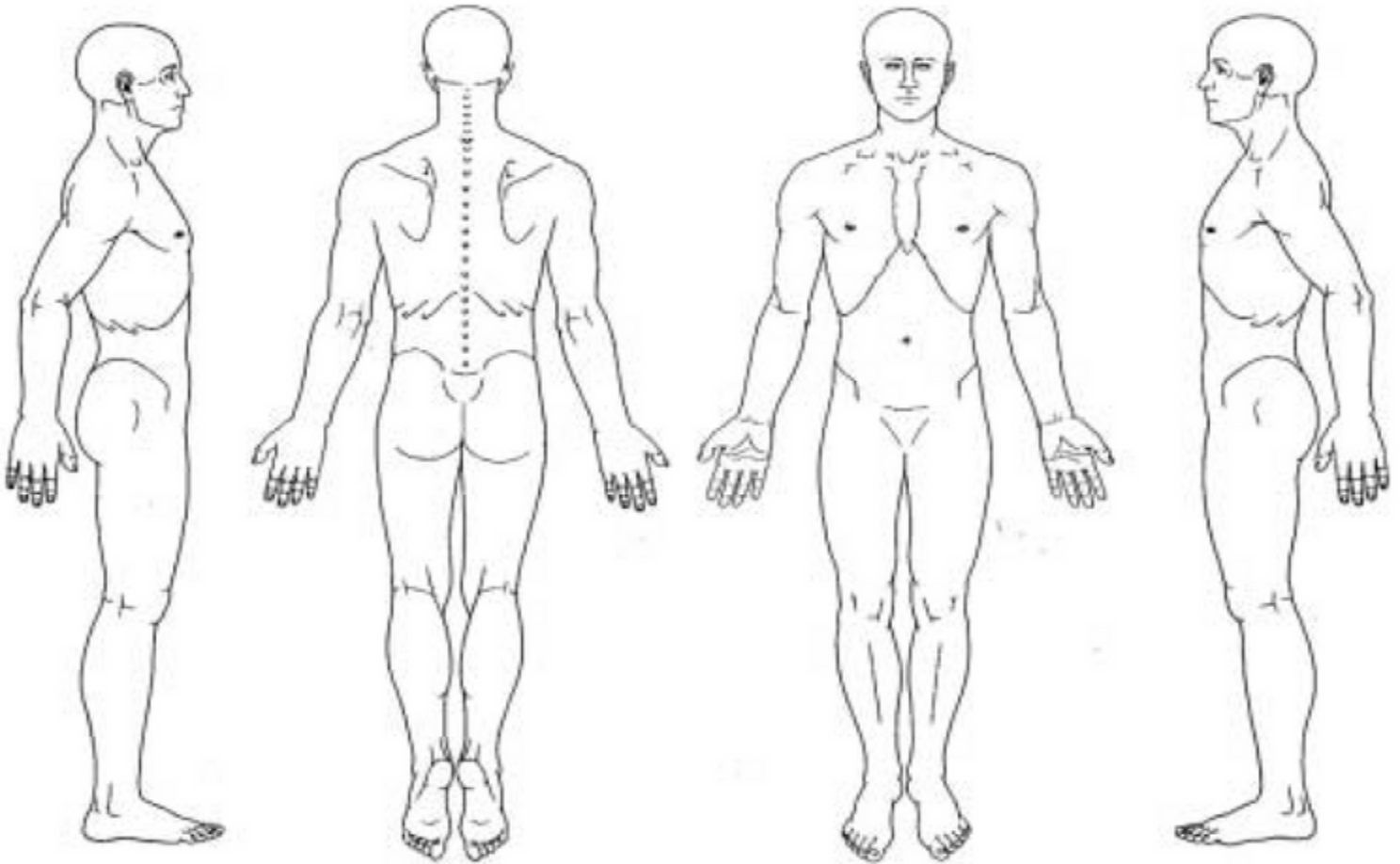
^^^
^^^

Aching

XXXXXX
XXXXXX

Stabbing

⊗⊗⊗⊗
⊗⊗⊗⊗



Please make a slash in the line below to indicate the levels of your pain:

No Pain |-----| Worst Possible Pain

Patient Name: _____

Patient Signature: _____ Date: _____

Chicopee Center Chiropractic

Dr. Steven Przewdziecki

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INFORMED CONSENT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy, on me or the person named below (for whom I am legally responsible) by Dr. Steven Przewdziecki, including those working at the office listed above, whether signatories to this form or not.

I have had an opportunity to discuss with Dr. Steven Przewdziecki, or other office clinic personnel, the nature and purpose of chiropractic adjustments and procedures. I understand the results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic, there are some risks to treatment, including but not limited to, fractures, disk 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 on the facts then known, and is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about this consent. By signing below, I have agreed to the above named procedures. 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 in this office.

Patient Name: _____

Patient Signature: _____ Date: _____

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333 Front Street, Suite 2 | Chicopee, MA 01013 | Ph. 413-598-8550 | Fx. 413-598-8556

AUTHORIZATION TO RELEASE HEALTH RECORDS

Patient Name: _____

Date of Birth: _____ Phone: _____

I understand that I may revoke this consent at any time except to the extent that action has been taken in reliance thereon.

By signing this form, I authorize Chicopee Center Chiropractic to obtain the medical records indicated in the box below.

Patient Signature: _____ Date: _____

For Office Use Only:

Permission is given to _____ to release the requested medical records to Dr. Steven Przewdziecki at Chicopee Center Chiropractic.

Records Requested: _____

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CANCELLATION AND NO-SHOW POLICY

This policy was designed to help the office run more efficiently, in addition to maximizing the number of patients we are able to accommodate. When a patient does not make it to a scheduled appointment, this leaves open time in our schedule that could have allowed another patient to receive the care they need.

Late Cancellation. We ask that you please be courteous and contact our office promptly if you are unable to attend a scheduled appointment. We require at least a 24-hour notice so we have the opportunity to offer the appointment to another patient. Failure to cancel a scheduled appointment without 24-hour notice will be recorded as a late cancellation in your file and a fee of \$40.00 may be charged.

No-Show. A no-show is when a patient misses an appointment without notice. We have a voicemail system which is able to receive messages 24-hours a day. No-shows cause an inconvenience to both patients that are in need of our services and the daily operations of our practice. Failure to present for your scheduled appointment without notice will be recorded as a no-show in your file and a fee of \$50.00 may be charged.

Late Arrival. If you arrive late to your appointment, we will do our best to fit you into the schedule, however, if it is more than five minutes, we may need to reschedule your appointment to another time and the late cancellation fee may apply.

By signing below, I acknowledge my understanding of the terms of this policy. I further understand that these fees have nothing to do with my copayment or deductible and thus cannot be billed to my insurance company.

Patient Name: _____

Patient Signature: _____ Date: _____

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PRIVACY PRACTICES AND OFFICE POLICIES

(a) **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 (HIPAA)*, 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.

(b) **Financial Policy and Responsibility.** You, as the patient, are ultimately responsible for all fees. We do accept insurance assignments and will file your insurance claim for you. You will be responsible for all co-payments or balances as required by your specific insurance plan. If your insurance plan requires a referral from your primary care physician, please be sure to obtain that referral prior to your visit to our office. All copayments, deductibles, and coinsurance are due at the time of service, or upon receipt of a bill. If for any reason your insurance plan denies payment for services rendered, the balance will become the responsibility of the patient.

(c) **Patient Non-Compliance Policy.** It is the goal of our office to provide the most comprehensive care possible. Each patient is given a treatment plan that addresses their individual health concerns and it is essential that patients adhere to their recommended plan of care. During the initial consultation and evaluation, Dr. Przewdziecki will discuss the importance of patient compliance. The office policies on non-compliance will be discussed and explained in full.

By signing below, I acknowledge that I (a) have read and agree to the Authorization for Services and that I have received a copy of Dr. Przewdziecki's Notice of Privacy Practices for Protected Health Information, (b) have read, understood and agree to the information regarding the financial policy and responsibility, and (c) I also agree to the policies regarding treatment non-compliance.

Patient Printed Name: _____

Patient Signature: _____ Date: _____

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NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

- ACKNOWLEDGEMENT FORM -

By signing below, I acknowledge that I have received, read, and agree to Chicopee Center Chiropractic / Dr. Steven Przewdziecki's Notice of Privacy Practices for Protected Health Information.

Patient Name: _____

Patient Signature: _____ Date: _____