South Florida
SPINE & JOINT CENTER
You want to feel better. We want to get you there.

FEDERAL WC QUESTIONNAIRE

Date: _____

Name: _____

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

Phone Number: _____ Date of Birth: _____ Age: _____

Date of Injury: _____ Time of Injury: _____ AM PM

Claim Number: _____

What agency do you work for? _____Employee Phone: _____

Employee Address: _____

What is your job title? _____ Name of Supervisor: _____

ACCIDENT HISTORY

1. Was the injury reported? Yes No
2. How much time passed before you reported the accident to the supervisor?

_____

3. What is the supervisors name you reported the injury to? _____
4. What did your supervisor do to help you?

_____

5. Which form did the supervisor give you to report the accident? CA1 CA2
6. Did you get a receipt from the Supervisor? Yes No
7. Did you get a claim number? Yes No
8. Were these complaints ever reported in the past? Yes No
   a) If Yes, was it reported? Yes No
   b) What was your complaint or injury? Neck Upper back Low Back
      Shoulder R / L Arm R / L Hand R / L
      Leg R / L Foot R / L
      Other: _____

c) Was time taken off work? Yes No

d) If Yes, for how long? _____

9. Explain in detail, what the physical demands of your job are: _____

_____

_____

10. How long were you working that day before the accident occurred? _____

11. Please describe in detail what you were doing at the time of the accident and how you felt:

_____

_____

12. What area(s) of the body were injured? Neck Upper back Low Back
Shoulder R / L Arm R / L Hand R / L
Leg R / L Foot R / L
Other: _____

13. When the pain began, where did you first feel it? Neck Upper back Low Back
Shoulder R / L Arm R / L Hand R / L
Leg R / L Foot R / L
Other: _____

14. Was the pain immediate or did it worsen over time? _____

15. Did pain develop in other parts of your body as the day(s) progressed? YES NO

If Yes, where? Neck Upper back Low Back Shoulder R / L Arm R / L
Hand R / L Leg R / L Foot R / L Other: _____

16. When did the pain in these other areas develop? _____

17. Since the accident, has the pain gotten better, worse or stayed the same? _____

If it got worse, please describe how: _____

_____

18. Did anyone witness the accident and you getting injured? YES NO

If Yes, who? _____

19. Did you require assistance from anyone following the accident? YES NO

If yes, who? Co-worker Medical professional Other: _____

20. Describe any physical conditions which may have contributed to the incident you reported (examples: limited space, slippery floor, faulty equipment, too dark, etc.…)

_____

_____

21. Do the injuries prevent you from performing your job safely and effectively? YES NO

If Yes, how? _____

_____

22. Were you evaluated at the scene of the accident? YES NO

If Yes, by who? Paramedics EMTs Doctor Other: _____

23. Did you go to the hospital following the incident? YES NO

24. How were you transported to the hospital?

Ambulance Co-Worker Family member Self Other: _____

25. Which Hospital did you go to? _____

26. While at the hospital what was done?

Examination X-rays MRI/CT Prescribed medicine Other: _____

27. Which area(s) were X-rays, MRI or CT scan performed on? _____

_____

28. Did they give you any medications while you were at the hospital? YES NO

If YES, what? _____

29. Did they give you a prescription for any medications when you were released from the hospital?

If YES, what? _____

30. Did they give you discharge papers and instructions when you left? YES NO

If YES, please provide us with a copy

31. Have you missed any work as a result of the accident? YES NO

If YES, how many days? _____

32. Have you seen any other medical professionals since the accident YES NO

If YES, Who did you see? Primary doctor Orthopedic Neurologist Neurosurgeon

Other: _____

What did the other medical professional do for you? _____

_____

33. Are you still treating with that doctor? YES NO

What is their plan of care? _____

34. Have you received any job modifications as a result of the injury YES NO

If YES, what are the modifications? _____

_____

35. Additional information not asked that Is Important for us to know? YES NO

If YES, What? _____

_____

_____

CURRENT COMPLAINT

1) Rate you pain on a scale of 1 to 10, with 10 being the worst:

1 2 3 4 5 6 7 8 9 10

2) Describe the complaint: Throbbing Pulsating Pounding Stinging Burning Shooting Dull Sharp Achy Stabbing Sore Other: _____

3) What makes it BETTER? Rest Exercise Standing Sitting Lying Bending Decr. Work Decr Stress Heat Cold Other_____

4) What makes it WORSE? Rest Exercise Standing Sitting Lying Driving Walking Running Lifting Bending Pushing Pulling Coughing Sneezing Other_____

5) Any pain / referral into arms or legs? YES NO

If YES, where?

_____

HEALTH HISTORY

Any previous trauma? YES NO

If YES, what? _____

Any previous surgeries? YES NO

If YES, what? _____

Are you currently taking any medication(s)? YES NO

If YES, what? _____

Do you smoke? YES NO

If YES, how many packs per day? _____

Do you drink? YES NO

If YES, what and how often? _____

Do you use drugs? YES NO

If YES, what and how often? _____

Do you exercise? YES NO

If YES, what type and how often? _____

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Consent to Treat & X-Ray

Patient Name: _____

I hereby request and consent to the performance of chiropractic adjustments and any other chiropractic procedures, including a comprehensive exam, diagnostic x-ray, physical therapy techniques, on me (or on the patient below or which I am legally responsible) by the licensed Doctor of Chiropractic at this office.

I understand that, as with any health procedure, there are certain conditions that may arise during a chiropractic adjustment. Those complications include but are not limited to fractures, dislocations, muscle strain, cost vertebral strain and separations, some types of manipulations of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including strokes. This is a very rare occurrence (a one in three mil- lion chance). We screen our patients for indications that they are candidates for chiropractic adjustments to the best of our ability. I do not expect the doctor to be able to anticipate all risk and complications during the course of the procedure(s) that the doctor feels at the time, based upon the facts then known, are in the best interest.

I have had an opportunity to discuss with the doctor the nature, purpose, and risk of chiropractic adjustments and other recommended procedures and have had my questions answered to my satisfaction. I understand that the results that the results are not guaranteed.

I have read or have had read to me the above explanation of the chiropractic adjustment and related treatment. By signing below, I state that I have weighed the risks involved in undergoing treatment and I have decided that it is in my best interest to undergo the chiropractic treatment recommended. Having been informed of the risks, I hereby give my consent to the treatments. I intend this consent form to cover the entire course of treatments for my present condition and for any future conditions for which I seek treatment.

Patient signature: _____ Date: ____/_____/_____
Firma Fecha

Consent to X-ray a minor child

I _____authorize the performance of diagnostic X-ray examination of my minor child which the above center or it's associates may consider necessary or advisable in the course of my minor child's examination and treatment. The patient is a minor, _____years of age.

Legal guardian signature: _____ Date: ____/_____/_____
Firma Fecha

Verification Patient is Not Pregnant

This is to certify that, to the best of my knowledge, I am not pregnant and the above center or it's associates have my permission to perform diagnostic X-ray examination. I have been advised that x-rays can be hazardous to an unborn child.

Date of last menstrual period/*Fecha del ultimo period menstrual*: ____/____/_____

Patient signature: _____ Date: ____/_____/_____
Firma Fecha

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OWC/DOL
Medical Records Release Authorization

Addressed to: _____

RE: Patient: _____

DOB: ____/____/_____

SS#: _____

Date of Accident: ____/_____/_____

To Whom It May Concern:

This authorization or photocopy hereof will authorize you to furnish all information you may have regarding my condition, or my minor child's condition, while under your observation or treatment including the history obtained, physical findings, diagnosis and prognosis.

Reports Requested:

☐ Medical Records ☐ X-Ray ☐ CT Scan(s) ☐ MRI ☐ Laboratory

Patient/Guardian Signature: _____

Date: ____/____/_____

AUTHORIZATION TO DISCLOSE AND DISCUSS ALL OWCP FILE DETAILS

I, _____, authorize South Florida Spine & Joint Center and any of their representatives to discuss my case details including, but not limited to, all of my medical information with Joanne Wright, Regional Worker's Compensation Assistant with the National Association of Letter Carriers. This authorization shall stay in effect until my case is finalized/closed.

_____ _____/_____/_____
Patient's Signature Date Signed

_____ _____/_____/_____
Witness Signature Date Signed

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OWCP/DOL
Communications Consent Form

Patients Name: _____ Date: ____/____/_____ DOB: ____/____/_____

I give permission to be contact in the following manner (please fill in phone numbers and check all)

Home #: (_____) _____-_____ ☐ OK to leave message with information ☐ Leave message with call-back number only

Cell #: (_____) _____-_____ ☐ OK to leave message with information ☐ Leave message with call-back number only

Cell Phone Carrier: _____

Ok to leave message at home or on the cell phone with the following family members:
(list name(s) and relationship to patient)

_____

_____

Appointment Reminders:

Our office uses an automated appointment reminder system to contact you prior to your scheduled appointment. Please indicate your preference on how we contact you:

☐ Home Phone ☐ Cell Phone ☐ Text Message

Written Communication

☐ OK to fax to this number: (_____) _____-_____

☐ OK to send to this email: _____

_____ _____/_____/_____
Patient or Legal Representative Signature Date

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Your medical information is the information gathered by your healthcare providers during the time you are being treated by S. FL Spine & Joint Center ("Spine & Joint"). It is private, and no one without a legitimate need to know may have access to it. Spine & Joint is required by law to maintain the privacy of your health information and to provide you with a notice of its legal duties and privacy practices. Spine & Joint will promptly notify affected individuals following a breach of unsecured protected health information. Spine & Joint will not use or disclose your health information except as described in this Notice of Privacy Practices ("Notice"). This Notice applies to all of the medical records generated during your participation in Spine & Joint programs and services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

The following categories describe the ways that Spine & Joint may use and disclose your health information without a specific authorization from you:

Treatment: Spine & Joint will use your health information in the provision and coordination of your healthcare. We may disclose all or any portion of your medical record information to your physician, consulting physician(s), nurses and other healthcare providers who have a legitimate need for such information in the care and continued treatment of the patient.

Payment: Spine & Joint may release medical information about you for the purposes of determining coverage, billing, claims management, medical data processing and reimbursement. The information may be released to an insurance company, third-party payor or other entity (or their authorized representatives) involved in the payment of your medical bill and may include copies or excerpts of your medical record that are necessary for payment of your account. For example, a bill sent to a third party payor may include information that identifies you, your diagnosis, the procedures and supplies used.

Routine Healthcare Operations: Spine & Joint may use and disclose your medical information during routine healthcare operations, including quality assurance, utilization review, internal auditing, licensing or credentialing activities, research and educational purposes.

Business Associates: Spine & Joint may use and disclose certain medical information about you to its business associates. A business associate is an individual or entity under contract with Spine & Joint to perform or assist Spine & Joint in a function or activity that necessitates the use or disclosure of medical information. Examples of business associates include but are not limited to, a medical records copy service, consultants, accountants, lawyers, medical transcriptionists and third-party billing companies. Spine & Joint requires the business associate to protect the confidentiality of your medical information. In addition, Spine & Joint requires any subcontractor of Spine & Joint's business associate to protect the confidentiality of your medical information.

Required by Law: Spine & Joint will disclose medical information about you when required to do so by law.

Public Health Activities: Spine & Joint may disclose your medical information to public health or legal authorities charged with preventing or controlling disease, injury or disability.

Victims of Abuse, Neglect or Domestic Violence: Spine & Joint may disclose your health information to a public health authority that is authorized to receive reports of abuse, neglect, or domestic violence. We may make an effort to obtain your permission before releasing this information, but in some cases may be required or authorized to act without your permission.

Health Oversight, Licensing, Accreditation and Regulatory Activities: Spine & Joint may disclose your health information to health oversight agencies authorized to conduct audits, investigations, and inspections of our facility. For example, billing practices may be audited by the State Auditor and records are subject to review by the Secretary of Health and Human Services and his/her authorized representatives.

Judicial or Administrative Proceedings: Spine & Joint may disclose your health information if we are ordered to do so by a court or an administrative hearing officer that is handling a lawsuit or other dispute or provided with a valid subpoena.

Disclosures for Law Enforcement Purposes: Spine & Joint may disclose your identity to law enforcement. Instances which may result in a disclosure of protected health information to law enforcement include to comply with court orders or assist with ongoing investigations

Coroners, Medical Examiners and Funeral Directors: Spine & Joint may disclose protected health information to a coroner, medical examiner or funeral director for the purposes of identifying a deceased person or other duties as authorized by the law.

Organ and Tissue Donation: Spine & Joint may share health information about you with organ procurement organizations.

Research: In some instances, Spine & Joint can use or share your health information for health research.

To Avert a Serious and Imminent Threat to Health or Safety: Spine & Joint may use or disclose your protected health information when necessary to prevent a serious and imminent threat to your health or safety, or the health or safety or another person or the public.

Specialized Government Functions: If you are an inmate of a correctional institution or under the custody of a law enforcement officer, Spine & Joint may release your medical record information to the correctional institution or law enforcement official. Spine & Joint may also disclose your medical information as required by military command authorities if you are a member of the armed forced.

Workers' Compensation: Spine & Joint may release medical information about you for workers' compensation or similar programs that provide benefits for work-related injuries or illnesses.

PATIENT CHOICES

You have the right and choice to tell us which information to share with your family, close friends, or others involved in your care, and if you would like us to share your information in a disaster relief situation. If you are not able to tell us your preference, for example, if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety. In the case of fundraising, Spine & Joint may contact you for fundraising efforts, but you can tell us not to contact you again.

Except for the situations and exceptions described in this Notice, we will need to obtain your written authorization before using or disclosing your protected health information for other purposes. For example, except as otherwise set forth under State and Federal law, we must obtain your written authorization for most uses or disclosures of any psychotherapy notes related to you, for the use or disclosure of your protected health information for marketing purposes, or for the sale of your protected health information.

PATIENT INFORMATION RIGHTS

Although all records concerning your treatment obtained at Spine & Joint are the property of Spine & Joint, you have the following rights concerning your medical information:

Right to Confidential Communications: You have the right to receive confidential communications of your medical information by alternative means or at alternative locations. For example, you may request that Spine & Joint contact you only at work or by mail.

Right to Inspect and Copy: You have the right to inspect and copy your medical information.

Right to Amend: You have the right to amend your medical information. Any request for amendment should be submitted to Spine & Joint in writing, stating a reason in support of the amendment.

Right to an Accounting: You have the right to obtain an accounting of the disclosures of your medical information made during the preceding six (6) year period.

Right to Request Restrictions: You have the right to request restrictions on certain uses and disclosures of your medical information. Spine & Joint is not required to honor your request except where: (i) the disclosure is for the purpose of carrying out payment or healthcare operations and is not otherwise required by law, and (ii) the medical information pertains solely to a healthcare item or service for which you, or person other than the health plan on your behalf, has paid Spine & Joint in full.

Right to Receive a Paper Copy: You have the right to receive a paper copy of this Notice, even if you have previously agreed to receive the Notice electronically.

Right to Receive Electronic Copies: You have the right to receive electronic copies of your medical information.

Right to Transfer Records: You may initiate the transfer of your records to another person by completing a written authorization form.

Right to Revoke Authorization: You have the right to revoke your authorization to use or disclose your medical information, except to the extent that action has already been taken in reliance on your authorization. A request to exercise any of these rights must be submitted, in writing, to Spine & Joint at 4414 Northlake Blvd., Palm Beach Gardens, FL 33410, or faxed to (561) 686-1622.

FOR MORE INFORMATION OR TO REPORT A PROBLEM

If you have questions and would like additional information you may contact our Office Manager, Shannon Parnell at (561) 686-3201. If you believe your privacy rights have been violated, you may file a written complaint to Shannon Parnell at (561) 686-3201, or with the Secretary of the Department of Health and Human Services. There will be no retaliation for filing a complaint.

CHANGES TO THIS NOTICE

Spine & Joint will abide by the terms of the Notice currently in effect. Spine & Joint reserves the right to change the terms of its Notice and to make the new Notice provisions effective for all protected health information that it maintains. An updated version of the Notice may be obtained at Spine & Joint.

NOTICE EFFECTIVE DATE

This Notice is effective as of May 2016.

I have received or reviewed the Notice of Our Privacy Practice notice of S. FL Spine & Joint Center, and understand the situations in which this practice may need to utilize or release my medical records. I also understand that I agreed to the use of those records when I initially applied for care at this office (my Application for Care) on my first visit, whenever that may have occurred.

He recibido y examinado el aviso de practica de privacidad (4 paginas) del S. FL Spine & Joint Center de Florida, y entiendo las situaciones en las cuelas esta practica pueda tener que utilizar o liberar mis archivos medicos. Tambien entiendo que estuve de acuerdo con el uso de aquellos archivos cuando al principio solicite el cuidado en esta oficina (mi Aplicacion Para el Cuidado) en mi primera visita, siem- pre que esto pueda haber occurrido.

I understand that this office will properly maintain my records, and will use all due means to protect my privacy as outlined in this privacy practices statement.

Entiendo que esta oficina mantendra correctamente mis archivos, y usara todos los medios debidos para proteger mi intimidad como perfi- lado en esta declaracion de practicas de intimidad.

By signing this document you are also agreeing that you've received all the toll free number to report any complains of abuse, neglect, or exploitation.

Firmando este documento usted tambien esta de acuerdo que ha recibido todos los numerous gratuitos para reporta cualquier queja de abuso, negligencia, o explotacion.

The toll free numbers are listed below:

Toreport a complaint regarding the services you receive, please call toll-free 1-888-419-3456.

(Para reportar una queja relacionada al servicio que usted recive, favor de llamar a numero gratuito 1-888-419-3456.)

Toreport abuse, neglect, or exploitation, please call toll-free 1-800-96-ABUSE (962-2873).

(Para reportar abuso, negligencia, o explotacion, favor de llamar al numero gratuito 1-800-962-2873)

_____ _____

Patient signature **Date**

_____

Print Patient Name