CHIMEDICAL MANAGEMENT GROUP, LLC

ChiMedical

• It's not pain management, It's pain solutions! •

CHIROPRACTIC

MEDICAL & PHYSICAL THERAPY

APPLICATION FOR TREATMENT

Phenix City
Forest Park
Decatur

STEPHEN B.COOPER, D.C., FACMUAP
Executive Director
Fellow American College of MUA Physicians

Medical Directors
Richard Cunningham, DO
Ateeqahmed Patel, MD

Sean Lauraitis, D.C.
Edward Hunt, DC, FACMUAP
Ian Porter, DC, FACMUAP
Racine Johnson, DPT
Tommie Miles, DPT
Sheliah Futral, NP-C
Yosan Negga', PA-C

TYPE OF VISIT : PERSONAL INJURY___ WORKERS COMP _____
COMMERCIAL INSURANCE _____ CHIRO HEALTH/CASH _____
OTHER: _____
DATE: _____

NAME _____

Address: _____
City: _____State: _____

Zip: _____ Cell: _____

Home Phone: _____

DOB: _____ Age: _____ Sex Identity:_____

Gender Identity_____ Birth Sex: _____

SSN: _____Email: _____

Employer: _____

Occupation:_____

Race: _____Ethnicity:_____

Hispanic: _____ Non-Hispanic:_____

Education Level: _____ Religion: _____

Marital Status: M S D W Spouse Name: _____

Emergency contact: Name:_____

Phone: _____

Who is allowed to call about your treatment _____

Commercial Insurance Information

Name of Health Insurer :_____

Policy# _____

Group#: _____

Primary#_____

Secondary# _____

If policy is in others name - Relationship: _____

Name: _____

DOB: _____

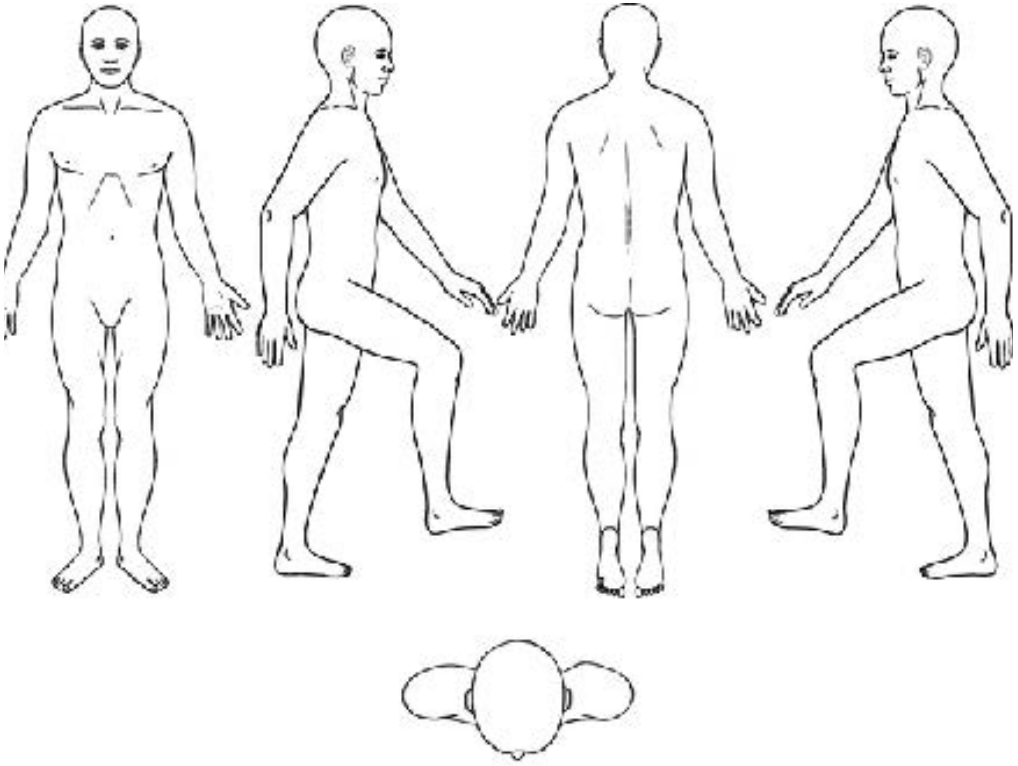
AUTO INSURANCE OR WORK COMP CARRIER:

_____NONE_____

AUTO /WC POLICY #_____
ADJUSTER _____
PHONE NUMBER: _____
KNOWN MEDPAY LIMITS? _____
IF INSURANCE IS IN ANOTHER'S NAME:
_____
DOB: _____ SSN: _____

Federal - OWCP Injury
Employment Agency:_____
Case1# _____
CA1/CA2#: _____**Open/Closed/Denied (O,C,D)**___
Case2# _____
CA1/CA2#: _____**Open/Closed/Denied (O,C,D)**___
Case3# _____
CA1/CA2#: _____**Open/Closed/Denied (O,C,D)**___
Employers Address _____
Supervisor Name: _____**Phone:** _____
Whats Your Job Duty/Craft: _____
Claim Examiner_____ **Phone:** _____

Did your Supervisor give you a CA-17 to bring with you: _____



PLEASE MARK EVERY AREA USING THE KEY BELOW. YOU CAN USE ARROWS TO SHOW SHOOTING PAIN AND NUMBERING 1 THROUGH 6 TO SHOW THE MOST SIGNIFICANT.

B = BURNING
S = SHOOTING
X = PAIN
V = SEVERE PAIN
D = DULL PAIN
N = NUMBNESS
W = WEAKNESS

IF YOU WENT TO THE HOSPITAL, WHICH ONE AND WHAT HAPPENED THERE?

HOSPITAL? _____ CITY/

STATE:_____

CIRCLE WHAT APPLIES TO YOUR HOSPITAL VISIT: EXAMINED X-RAYED

(HEAD, NECK , BACK , SHOULDER, ARM,

HIP, KNEE, _____) MRI CT (HEAD, NECK , BACK , SHOULDER, ARM,

HIP, KNEE, _____)

SURGERY STITCHES (HOW MANY AND WHERE _____)

IV MEDICATION ? _____

SCRIPT FOR ADDITIONAL MEDICATION, OTHER:

_____

PAST HEALTH HISTORY:

HAVE YOU BEEN INVOLVED IN AN AUTO ACCIDENT PRIOR TO THIS ONE

Y N

ARE YOU PREGNANT Y N

HAVE YOU HAD PREVIOUS HOSPITALIZATIONS Y N

HAVE YOU HAD ANY PRIOR SURGERIES Y N

_____

_____

_____

AUTO ACCIDENT , SLIP & FALL AND PERSONAL INJURY THIS SECTION ONLY IT HELPS US TO HELP YOU IF YOU CAN BE VERY THOROUGH AND COMPLETE, FEEL FREE TO ASK FOR HELP					
Date and time of Accident		Location of Accident -		City and State of Accident	
Where were you in the vehicle? Passenger, Front Seat, Driver etc		What Direction were you facing? Looking behind you? Head turned?		Were you wearing a seatbelt? Crossbody or Lap type?	
What were you driving? Vehicle Make and Model		What Type of Vehicle hit you? Make and model or type (Pick-Up) if unknown		How did the vehicle hit you? (T-Boned, Head on, Side swiped etc)	
Did you have time to brace for impact?		Was it a hit and run?		Did your seat break?	
Did the Airbag Deploy?		Were you burned by the airbag?		Were you thrown from the car?	
Do you have any recollection of the accident (unconscious)		Were you pushed into another vehicle?		Were you run off the road?	
Were you knocked off the road - into a ditch ?		Did the vehicle spin around? Did the vehicle flip over? If so , how many times?		Was the vehicle you were in totaled? If not was the damage mild, moderate or severe by what you remember?	
Did any windows break? If so, please list		Did you go to the Emergency Room? (By Ambulance , Drove yourself or did someone take you?)		Any other details we need to know?	
Have you had any previous accidents that we need to know about?		**Describe This Accident if NOT Auto Accident**		Any prior surgeries affected by this accident	

OWCP Injuries- What Employment Related Activity Contributed to this?	**When did you first notice it? Is it continuous? Does it Come and Go?**	**Have you sought medical help in the past? Where and When?**	**Do you have any other jobs or activities that could be responsible for this?**

Medication List	Strength	Purpose	Frequency

Allergy	Reaction	Severity	

Review of Systems	Please Circle All That Apply							
CONSTITUTIONAL	ALCOHOLISM	DIZZINESS	CHEMICAL DEPENDACY	DIABETIC HISTORY	NIGHT SWEATS OR FEVER	CHRONIC FATIGUE HISTORY	NUTRITIONAL PROBLEMS	UNEXPECTED WEIGHT CHANGE
EENT Eye, Ear, Nose & Throat	CATARACT	GLAUCOMA	COLOR BLINDNESS	MOTION SICKNESS	NIGHT BLINDNESS	BLURRY VISION	EPITAXIS - NOSE BLEEDS	SEVERE SINUS
RESPIRATORY	ASTHMA	BRONCHITIS	EMPHYSEMA	INFLUENZA	PLEURISY	PNEUMONIA	TUBERCULOSIS	
CARDIOVASCULAR	HEART ATTACK	HEART DISEASE	HEART MUMMERS	HIGH CHOLESTEROL	HIGH BLOOD PRESSURE	IRREGULAR HEART BEAT	CHEST PAIN / DISCOMFORT	SHORTNESS OF BREATH
GENITOURINARY	BLADDER PROBLEMS	CYSTITIS	GALL BLADDER DISEASE	KIDNEY DISEASE	KIDNEY STONES	NEPHRITIS	PROSTATE PROBLEMS	VAGINAL INFECTIONS - VENERIAL DISEASE
MUSCULOSKELETAL	ARTHRITIS	GOUT	JOINT DEFORMITY	BONE & JOINT DISEASE	OSTEOPOROSIS	MULTIPLE SCLEROSIS	HERNIATED DISC	POSTURAL PROBLEMS - SCOLIOSIS
NEUROLOGICAL	FACIAL WEAKNESS	EQUILIBRIUM	DYSPHAGIA - DIFFICULTY EATING	HEARING DISTURBANCES	SPEECH - SWALLOWING OR TASTE PROBLEMS	EPILEPSY	BLACKOUTS OR MEMORY LOSS	VERTIGO
HEMETOLOGIC / LYMPHATIC	ANEMIA	HEPITITIS	HIV	LYMPHATIC MALIGNANCY	BLEEDING SKIN	SWOLLEN LYMPH NODES	SICKLE CELL	HISTORY OF MUMPS
INTEGUMENT	BRUISING	SKIN COLOR CHANGE	DRY SKIN	SWELLING & EDEMA	ITCHING	LESIONS	RASHES	SKIN

ASSIGNMENT OF BENEFITS: I HEREBY AUTHORIZE THE FOLLOWING INSURANCE COMPANIES OR LIABLE DIRECT PAY PARTIES:

1. _____

2. _____

3. _____

I agree to pay by check or credit card through either mailing the check payable to Phenix City Spine & Joint Center or ChiMed Rehab Phenix City –P.O. Box 1611 Phenix City, AL 36868. or South Atlanta Spine & Joint Center, ChiMed Rehab South Atlanta, Decatur Spine & Joint Center or South Atlanta MUA Center – P.O. Box 1601 Phenix City AL, 36868 This covers the expense benefits allowable and otherwise payable to me under my current policy, as payment towards the total charges for professional services rendered I have agreed to pay, in a current manner, any balance of said applicable charges. I further state and agree that this office is given a limited power of attorney to endorse / sign my name on any and all drafts directed for the payment of my bill. This Assigns all financial benefits of treatment billed from listed companies and any other insurance company determined to be liable after care is issued. Theses companies may be added after original signature as the claim number, responsible party or insurance carrier may change or not be known at time of care.

PATIENT PRINTED NAME:_____

SIGNED NAME: _____ DATE:_____

WITNESS PRINTED NAME: _____

SIGNED NAME: _____DATE:_____

I,_____(Print Name), do hereby authorize any providers managed by ChiMedical Management Group and whomever they may designate as assistants to perform diagnostic tests, including but not limited to radiographs, physical examination and administer treatment as directed, indicated or deemed necessary.

This includes emergency actions that may need to be performed should I be physically incapacitated. Complications to chiropractic care may include rib fracture and stroke, however, specific tests designed to minimize these risks are employed and do minimize these outcomes. I ALSO CERTIFY THAT IN NO WAY HAS ANY GUARANTEE OR ASSURANCES AS TO THE RESULTS THAT MAY BE OBTAINED.I understand and agree that health and medical insurance policies are an arrangement between an insurance carrier and myself (patient). Furthermore, I understand and agree that this office and contracted representatives may prepare or receive any necessary reports and forms to assist me in making collection from any insurance company, and that any amount billed is assigned and authorized to be paid and sent directly to this office will be credited to my account upon receipt. I permit this office to endorse remittances for the conveyance of credit to my account. However, I clearly understand and agree that I have sought treatment, received treatment, and am directly responsible for the bills that accumulate from this treatment.

NAME (PRINTED): _____

SIGNED: _____DATE:_____

WITNESS (PRINTED): _____

SIGNED: _____DATE:_____

Consent for Treatment of a Minor

I hereby authorize any of the ChiMedical Management Clinics and whomever they may designate as an associate or contractor of this clinic to perform diagnostic tests, radiographic studies, physical evaluations, and to administer treatment as he deems necessary to , a minor child under my guardianship. I also accept all terms and conditions named herein with regards to payment of the account and lien arrangements and am responsible for the execution of these agreements on this minors behalf.

GUARDIAN PRINTED NAME: _____

SIGNED _____

DATE:_____

GUARDIAN DOB: _____

SSN: _____

WITNESS PRINTED NAME: _____

This document and all that is contained herein is a specifically designed instrument to detail an irrevocable assignment, enforceable contract and lien. This contract and lien is entered into between The ChiMedical Management Group and its Clinics: Phenix City Spine & Joint Center, LLC, South Atlanta Spine & Joint Center, LLC, Decatur Spine & Joint Center, LLC ChiMed Rehab Phenix City , South Atlanta, Decatur and the South Atlanta MUA Center)) Hereafter known as the clinics and our chosen counselor. (print patient's or guardian name clearly _____ here forth known as "patient" and (print attorney& or insurance company) _____ here forth known as the "attorney" and/or "insurance company" and is binding on these listed parties for the following text. The patient hereby directs the attorney or insurance company that for any balance such as may be due owing to this office for services rendered to the patient to withhold such funds from any disability benefits, medical payment benefits, health and accident benefits, medical or personal injury settlements or any such other insurance benefit obligated to reimburse the patient, or from any settlement, judgment or verdict on my behalf as may be necessary to adequately satisfy any balance owing and protect the interest of the clinics.

I further irrevocably authorize this clinic to obtain a perfected lien attaching any and all insurance benefits, judgments, and settlements named herein. Once I have accepted terms and or conditions or made an agreement with any third party for any amount relating to this injury or claim, this document is to serve as an irrevocable assignment and lien of these benefits or proceeds of the agreement or settlement to the amount necessary to adequately satisfy any balance owing and protect the interests of the clinics.

If there is an attorney representing me, this lien against me is to be enforced against the third party insurance company for direct payment or payment through the attorney at the discretion of the clinic. If the clinic at its discretion does allow payment from the attorney, the patient is bound personally and jointly with the attorney, if retained, or other noted counsel responsible for the total amounts due to said office. The attorney is only released from this binding lien if there is no settlement of any amount for the above mentioned injury or: if the patient acquires new counsel the contract is now binding on the new counsel in its entirety, and if all legal representation in reference to this accident has been terminated prior to the settlement with the previous attorney, the previous attorney mentioned in this document is therefore re-leased from all aspects of this contract upon written notice received in this office by US Mail according to the post marked date. The patient and attorney understand that not honoring the full extent and purpose of this contract constitutes default and binds upon both parties separately and individually all charges, collection costs, attorney fees and finance charges. This contract can only be altered with the amount of settlement by written signed verification from The ChiMedical Management Group, clinics and the bound third party or attorney. (Attorney Name and Insurer may be added after original signer if new party or attorney changes or becomes known after this date. The representative of the clinic is authorized to make this addition or change.

PATIENT PRINTED NAME: _____ SIGNED _____ DATE:_____

WITNESS PRINTED NAME: _____ SIGNED _____ DATE:_____

ATTORNEY PRINTED NAME: _____ SIGNED _____ DATE:_____

INS ADJUSTER PRINTED NAME: _____ COMPANY _____ DATE:_____

I authorize this clinic to release or receive any information pertinent to this injury to or from the attorney and to or from any insurance company or responsible third party attorney or adjuster to facilitate collection under this assignment and contract. The clinic may perfect an AL or GA lien or obtain a letter of protection from any attorney representing me in this case.

Firm Name:_____ Phone: _____

THIS IS A FORMAL REQUEST FOR MEDICAL RECORDS-

X-RAY'S, MRI'S, LAB TESTS AND REPORTS BE SENT TO :

ChiMedical Management Group

3700 S Railroad St., Suite B Phenix City AL 36867

___ PHENIX CITY FAXED TO: 866.537.1711

_____

541 Forest Parkway, Suite 14 Forest Park GA 30297

___ FOREST PARK (South Atlanta) FAXED TO: 678.922.2133

_____

3755 Memorial Drive Decatur GA 30032

_____ DECATUR FAXED TO: 404.393.8885

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REGARDING THE PATIENT: _____

SOCIAL SECURITY NUMBER _____ BIRTH DATE _____

PATIENTS SIGNATURE FOR RELEASE: _____ _____

877.495.7773

HIPAA PRIVACY Statement for the ChiMedical Management Group

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

Understanding your health record information

Each time you visit a hospital, physician or other health care provider, a record of your visit is made. Typically this record contains your symptoms, examination, test results, diagnosis, treatment and a plan for future care and treatment. This information is often referred to as your health and medical record and serves as, but not limited to the following.

◊ A basis for planning your care and treatment

◊ Means of communication along the many health professionals who contribute to your care

◊ Legal documentation describing the care you received

◊ Means by which your third party payer can verify that services billed were actually provided

◊ A tool in educating health care providers

◊ A source of date for medical research

◊ A tool we utilize to assess, analyze and improve the care we render and the out-comes we have achieved.

◊ Ensure its accuracy

◊ Understand who and under what circumstances they may access your health information

◊ Make a more informed decision when signing disclosure statements to authorize access by others.

Your Health Information Rights

Although your health record is the physical property of the health care provider or the facility who compiled it, the information belongs to you. You have the right to:

◊ Obtain an account of the disclosures of your health record

◊ Revoke authorization for future disclosure except that which has already been provided Our Responsibilities:

◊ Maintain privacy of your health information

◊ Provide you with notice as to our legal duties and privacy practices with respect to information we collect and maintain about you

◊ Abide by all the terms of this notice

◊ Notify you if we are unable to agree to a requested restriction

◊ Accommodate reasonable requests you may have to communicate health information by alternative means to alternative locations

We reserve the right to change our practices and make new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you have supplied to us.

We will not use or disclose your health information without your authorization, except as de- scribed in this notice.

For more information, questions, or to report a problem, you may contact our HIPAA Privacy Officer at (412) 446-9100. If you believe your privacy rights have been violated, you may file a complaint with our HIPAA Privacy Officer. There will be no retaliation for filing a complaint.

I have read the HIPAA PRIVACY STATEMENT and Understand:

_____ Sign and Date

◊ Request a restriction on certain uses and disclosures of your information as
provided by CFR 164.522

◊ Obtain a paper copy of notice of information practices upon request

◊ Inspect and copy your health record as provided in 45 CFR 164.524Initial (HIPAA stands for the “health insurance portability and accountability act”)

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