PANCHESIN CHIROPRACTIC CENTER
5311 SOUTH 12TH AVENUE
TUCSON, ARIZONA 85706
(520) 294-0400

Worker's Compensation Questionnaire

Please answer all questions completely

Dear Patient: This information is considered confidential. We need this information because we care enough to want to know, and your answers will help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. In order for us to understand your condition properly, please be as neat and accurate as possible while completing this form. Thank you.

Name_________________Sex____________Marital Status__________Date of Birth_____________Home Phone____________
Address______________________________ City_________ State______________ Zip______________
Occupation______________________________ Who referred you to our office? ________________________
(Indicate if child, student, housewife, unemployed, retired)
Social Sec. #_____________ Business Phone _____________Company Name____________________ Location___________________
Spouse's First Name _______________ Spouse's Soc. Sec#_____________ Spouse's Employer ________________Location________

Please explain in detail how your accident happened: ____
____
____
____
Have you retained an attorney? _____ Yes _____ No Litigation? _____Yes _____No _____Maybe
If so, his name and address____
Give time and date present injury occurred _____________________ __am __ pm _________20______
Where did you feel pain immediately after the accident? ____
Did you return to work? _____ Yes _____No If so, date returned to work_________________________
Did you consult any other doctor? _____Yes _____No
If so, what was the doctor's name? ______________________ D.C., ___ M.D., ___ D.O., ___D.D.S.
Doctor's diagnosis ____
What treatments did you receive?____
Have you ever injured this area before? _____Yes _____No If so, when?___________________________
If injured before, did you lose time from work? _____Yes _____No
If you lost time from work with injuries prior to this injury, give name of doctor or doctors consulted____

Do any other diseases or accidents affect your employment? _____Yes _____No If so, explain _________
____

In your work do you have to favor any part of your body? ___Yes ___No If so, explain ________________
____
Do you have a history of absenteeism caused from accidents on the job? ___Yes ___No
Have you ever had Workmen's Compensation claim before? ___Yes ___No
Before the injury were you capable of working on an equal basis with others your age? ___Yes ___No
Are your work activities restricted as a result of this accident? ___Yes ___NoSince this injury are your symptoms ___improving? ___ getting worse? ___ the same?

Emergency Contact Name and Phone Number ____
Primary Care Physician Name and Phone Number _______________________________________
Email Address________________________________ Cell Phone _________________________________

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HEALTH QUESTIONNAIRE:

Please indicate for each of the questions below your experience by use of the following codes:
1-never had, 2- previously had, 3- presently have.

MUSCULO-SKELETAL SYSTEM

___ Low back problems
__Pain between shoulders
___Neck problems
___Arm problem
___Leg problem
___Swollen joints
___Painful joints
___Stiff joints
___Sore muscles
___Weak muscles
___Walking problems
___Ruptures
___Broken bones

GENITO-URINARY SYSTEM

___Bladder trouble
___Excessive urination
___Scanty urination
___Painful urination
___Discolored urine

FEMALE

___Vaginal discharge
___Vaginal bleeding
___Vaginal pain
___Breast pain
___Lumps on breast
Are you pregnant?
___yes ___no

GASTRO-INTESTINAL SYSTEM

___Poor appetite
___Excessive hunger
___Difficult chewing
___Difficult swallowing
___Excessive thirst
___Nausea
___Vomiting blood
___Abdominal pain
___Diarrhea
___Constipation
___Black stool
___Bloody stool
___Hemorrhoids
___Liver trouble
___Gall bladder problems
___Weight trouble

NERVOUS SYSTEM

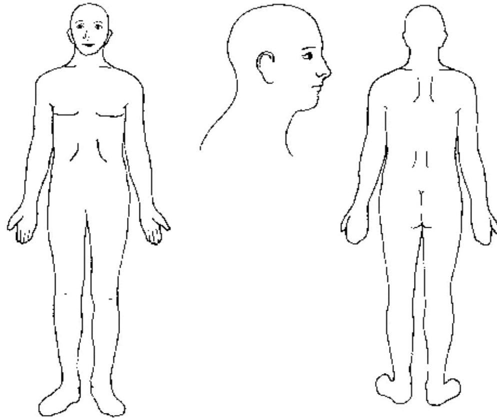
__Numbness
__Loss of feeling
__Paralysis
__Dizziness
__Fainting
__Headaches
__Muscle jerking
__Convulsions
__Forgetfulness
__Confusion
__Depression

CARDIO-VASCULAR-RESPIRATORY SYSTEM

___Chest pain
___Pain over heart
___Difficult breathing
___Persistent cough
___Coughing phlegm
___Coughing blood
___Rapid heartbeat
___Blood pressure
___Heart problems
___Lung problems
___Varicose veins

EYE, EAR , NOSE, & THROAT

___Eye stain
___Eye inflammation
___Vision problems
___Ear pain
___Ear noises
___Hearing loss
___Ear discharge
___Nose pain
___Nose bleeding
___Nose discharge
___Difficult breathing thru nose
___Sore gums
___Dental problems
___Sore mouth
___Sore throat
___Hoarseness
___Difficult speech



____
Patient's Signature

--**DO NOT WRITE BELOW THIS LINE**------------------------------------

____
____
____
____
____
____
____

Patient accepted? ___Yes ___No Doctor's Signature__________________________________

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HEALTH HISTORY QUESTIONNAIRE

Patient Name_________________________________ Date ___________ Patient # __________

1) Please list all past injured joints in your body giving the approximate month and year, and all significant injuries:
____
____
____

2) Please list all past treatment for your current condition:
____
____
____

3) Please list all past surgeries and give approximate date:
____
____
____

4) Please describe any home care or treatment you have done for your current condition:
____
____
____

5) Please list all current medications you are taking, their purpose, dose, times per day, and length of time:
____
____
____

6) Please briefly describe your family health history of your mother and father:
____
____
____

7) Please describe your current work activities:
____
____
____

8) Please list any allergies you may have and treatment you received for them:
____
____
____

Do not write below this line:
………………………………………………………………………………………….

Review of Systems:
____
____
____
____

Panchesin Chiropractic Center's
Dr Thomas Panchesin, 5311 S 12th Ave.,
Tucson, Az., 85706, (520)-294-0400

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental, and social well being, not merely the absence of infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease. We only offer to diagnose either vertebral subluxations or neuro-musculoskeletal conditions. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of another health care provider.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, ____________________________ have read and fully understand the above statements.
(Please print your name)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

____ _____________________________
(Signature) (Date)

Consent to evaluate and adjust a minor child

I, ____ being the parent or legal guardian of _____________________________ have fully read and understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Pregnancy Release

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform and x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child. Date of last menstrual period: ____________________________

____ ___________________________
(Signature) (Date)

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PROFESSIONAL FEE SCHEDULE

Initial Consultation. . . . . .No Charge
Chiropractic Examinations . . . .$55-$100
Chiropractic Office Visits (average) . . . .$55-$101
Chiropractic X-ray Studies (average) . . . .$72-$189
Doctor/Patient Conference $75
Thermoscribe $39

(All fees are standard and primarily based on our professional association's guidelines and on the fee schedule set by the Industrial Commission of Arizona).

Our experience has shown that it is wise to have an understanding with our patients as to our office policies and fees. Therefore, this form has been prepared for your convenience and information. We offer several methods of payment for your Chiropractic Care at our office, and you may choose the plan which best fits your needs. Please red carefully and choose the plan which you prefer. This information will enable us to better serve you and help to avoid misunderstandings in the future. If special arrangements are necessary please consult with the Doctor. Our main concern is your health and well-being, and we will to our best to help you.

PLAN #1 – INSURANCE – If you have insurance which covers Chiropractic care, we will bill your insurance directly. Please bring us an insurance claim form, on or before your second visit, with your portion completed. Until we have the completed, necessary insurance information to verity chiropractic coverage, you will be required to pay for your care. Most patients with "deductible plus 80% pay" insurances donate a nominal fee, periodically, in addition to meeting their yearly deductible. In the event the check should come to you, you are expected to bring the check to us. Reminder, insurance companies balk at "maintenance" and long term rehabilitation. Usually you will not get much help after your initial corrective care. Most ordinary "health" policies are designed and intended to only take care of acute problems so you should plan to "get off" insurance and be on your own when you get down to once a week or less (except, possible, some accident injuries). At this point refer to Health and Life Extension Plan (ask Doctor for details).

PLAN #2 – CASH – Fees are to be paid at the time services are rendered, unless special arrangements have been made in advance.

PLAN #3 – WEEKLY/MONTHLY CASH AGREEMENT – For those non-transient, but active patients who qualify, we will extend knowledgeable credit through this plan; however, should you become inactive by discontinuing your care, your entire unpaid balance will be due immediately. This plan applies to all cases, except Work Injury or Auto injury claim.

PLAN #4 – CASH PREPAY – Ask Doctor for details.

PLAN #5 – INDUSTRIAL – You need to report your accident to your employer, bring in necessary insurance information, and sign industrial forms for billing by second visit. We will bill your insurance directly.

PLAN #6 – AUTO INJURY – You need to supply us with the accident report, your car insurance, health insurance, and liable parties insurance, and attorney if applicable. Until necessary insurance information is gathered and verified for chiropractic care, you will be required to pay for your care. We will bill your insurance directly after verification of coverage. In the event the check should come to you, you are expected to bring the check to us.

I QUALIFY AND UNDERSTAND PLAN # ______ REQUIREMENTS

SIGNATURE____ DATE_____________________

PANCHESIN CHIROPRACTIC CENTER
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Informed Consent for Chiropractic Care

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. You have the right, as a patient to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks and alternatives.

Chiropractic is a science and art which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may effect the restoration and preservation of health. Health is a state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

One disturbance to the nervous system is called a vertebral subluxation. This occurs when one or more of the 24 vertebrae in the spinal column become misaligned and/or do not move properly. This causes alteration of nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxation are corrected and/or reduced by an adjustment. An adjustment is the specific application of forces to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine. Adjustments are usually done by hand but may be performed handheld instruments. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included.

If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

The material risk in an adjustment: As with any healthcare procedure, there are certain complications that may arise during a chiropractic manipulation. This may include: strains, dislocations, fractures, disc injuries and stroke. This list is not all inclusive.

The probability of those risks: Fractures are rare and can result from an underlying weakness in the bones. The other complications listed are considered rare. One source states that stroke is a possible occurrence in 1/1,000,000 cases or higher, even so we employ tests during our examination to identify if you may be susceptible to that kind of injury.

Other treatment options for your condition can include: Medical care with prescription drugs, self management with over-the-counter medication, rest, and/or surgery. There are material risks inherent in each of these options including but not limited to: addiction to medication, side effects of medication, improper self dosages and surgical risks including complications from either the procedure and the anesthesia.

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

________________________ ________________________________ ____________________

Print Name Signature Date

Pregnancy Release:

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x- ray can be hazardous to an unborn child.

Date of last menstrual cycle: ___________________________________

____ ______________________________________

Patient Signature Date

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APPOINTMENT REMINDERS AND HEALTH CARE INFORMATION AUTHORIZATION (HIPAA)

Your chiropractor and members of the practice staff may need to use your name, address, phone number, and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If this contact is made by phone and you are not at home, a message will be left on your answering machine. By signing this form, you are giving us authorization to contact you with these reminders and information.

You may restrict the individuals or organizations to which your health care information is released or you may revoke your authorization to us at any time; however, your revocation must be in writing and mailed to us at our office address. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. In addition, if you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

Information that we use or disclose based on the authorization you are giving us may be subject to re-disclosure by anyone who has access to the reminder or other information and may no longer be protected by the federal privacy rules.

You have the right to refuse to give us this authorization. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives, or other health related information at any time (164.524).

This notice is effective as of _________________________. This authorization will expire seven years after the date on which you last received services from us.

I authorize you to use or disclose my health information in the manner described above. I am also acknowledging that I have received a copy of this authorization.

_________________________________ Patient name printed	_________________________________ Date
_________________________________ Patient Signature	_________________________________ Authorized provider representative
_________________________________ Personal representative Printed	_________________________________ Personal representative signature

____
Description of personal representative's authority to act for the patient

Panchesin Chiropractic Center
5311 South 12th Avenue
Tucson, Az 85706
(520) 294-0400

MARKETING AUTHORIZATION
(HIPAA)

From time to time our practice works with marketing organizations to make you aware of products or services that you may have an interest in purchasing. Your chiropractors and members of the practice staff may need to use your health information including your name, address, phone number, and your clinical records for the purpose of marketing products and services from ___________________________to you. We are specifically requesting authorization to market the following products and or services to you

____
____.

You may restrict the individuals or organizations to which your health care information is released or revoke your authorization to us at any time; however, your revocation must be in writing and mailed to us at our office address. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

Information that we use or disclose on the authorization you are giving us may be subject to re-disclosure by the organization/s listed above and may no longer be protected by the federal privacy rules.

You have the right to refuse to give us this authorization. If you do no give us permission, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

You may inspect or copy the information that we use to contact you for marketing purposes at any time. (164.524). Our practice and staff will receive direct or indirect remuneration from our marketing activities.

This notice is effective as of ________________________. This authorization will expire seven years after the date on which you last received services from us.

I authorize you to use or disclose my health information in the manner described above. I am also acknowledging that I have received a copy of this authorization.

______________________________ Patient name printed	______________________________ Date
______________________________ Patient signature	______________________________ Authorized Provider Representative
______________________________ Personal Representative Printed	______________________________ Personal Representative Signature

____
Description of personal representative's authority to act for the patient

Panchesin Chiropractic Center
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To Our Patients Regarding HIPPA Privacy and Our Office

In 1996, President Clinton enacted the Health Insurance Portability and Accountability Act. It was enacted to make selling and commercial exchange of patient's private health information illegal. In my office, we have for 20 years respected patient privacy long before a law had to be passed. Those areas that we choose to make you aware within this office are the following.

1. There are partial walls and no doors surrounding our adjusting rooms. If there is a private issue that needs to be discussed, you may request a private room, and I will come in as soon as possible to discuss any matter.
2. We place patient's names on our bulletin board when they refer a new patient into this office to say, "Thank You", for referring to our office.
3. We mail Postcards to patients whom refer others to our office to thank them for the referral.
4. We mail Postcards to our patients on their birthday.
5. We type up anonymous patient testimonials with the patient's permission only identifiable by a number, to share your success story with others, thereby enlightening them to what other ailments have been helped by chiropractic.
6. We require the signing of record release authorization forms for your insurance company or attorney to release your records in this office to them for the purpose of getting paid.
7. We occasionally take pictures of our patients to put in our scrap book in our waiting room library, or temporarily place on our walls.

This is summary of our routine practices that embody the marketing release form that is in this packet. We commit to honor your privacy as we always have in the past, and now in accord with the new laws our government has established. Should you have any questions, do not hesitate to ask.

I _____________________________________, authorize Panchesin Chiropractic Center and staff to conduct the above practices with respect to my privacy, and health care.