HEALTH FIRST REHAB, INC
dba Lewis Bay Chiropractic

Patient Name:
Patient D.O.B.:

Chiropractic Physician
☐ Robert Harmon, DC
☐ Joshua Lindauer, DC
☐ Michelle Starr, DC
☐

Informed Consent for Chiropractic Services

I have been <u>informed</u> of the following:

1. By signing below, I consent to the services being rendered during this visit by the above-named chiropractic physician (s) or any other chiropractic physician who now or in the future treat me while employed by, working or associated with or covering for the above-named chiropractic physician.
2. I have been informed that the process of delivering a "Chiropractic Adjustment (manipulation)" may be performed manually or with an instrument to the vertebra(e) of the spine and/or associated structures (ribs, legs, arms etc.), often, but not necessarily resulting, in an audible pop or clicking sound;
3. I have been informed that in addition to the Chiropractic Adjustment, one or more "Supportive Therapies" may be applied by the chiropractor or by staff under their direction and supervision incorporating the use of light, sound, vibration, electricity, traction, motion, bracing, heat, cold, and/or nutritional/lifestyle recommendations;
4. I have been informed that coinciding with the process of a Chiropractic Adjustment and/or Supportive Therapies there may be, at times, some temporary soreness and/or stiffness; less frequently aggravation of presenting symptoms or initiation of new symptoms; rarely tissue bruising and/or swelling, more rare joint/bone separation/fracture; and extremely rare, disc, nerve or vascular injury;
5. I have been informed that at times treatment techniques may include skin to skin contact, tissue mobilization and/or stretching of involved or related areas and digital pressure/light touch/brushing over regions both on and/or away from your primary complaint location;
6. I have been informed that certain techniques may require close proximity between clinician and patient;
7. I have been informed of my condition, possible benefits, risks of treatment if any, options, and financial obligations;
8. I have been informed that it is my responsibility to inform the chiropractor of any condition(s) that would otherwise not come to their attention;
9. I have been informed that the chiropractor has made no guarantee of a positive outcome from treatment; and
10. I have been afforded ample opportunity for questions and answers.

<u>Therefore, by signing below:</u>

I <u>consent</u> to the performance of the diagnostic and therapeutic procedures performed by the doctor and or staff under the direction and supervision of the office chiropractor(s) involved in my case;

I <u>consent</u> to the performance of other diagnostic and therapeutic procedures in the future that may be deemed reasonable and necessary by the doctor and or staff under the direction and supervision of the office chiropractor(s) involved in my case;

Patient Signature:_____ Date:_____

Guardian Name (if applicable):_____

Guardian Signature (if applicable):_____Date:_____

Witness Signature:_____Date:_____

Office Policies - Health First Rehab, Inc.

dba. Lewis Bay Chiropractic

Patient Messaging Consent

By supplying my home phone number, mobile phone number, email address, and any other personal contact information, I authorize my health care provider to use my personal information, the name of my care provider, the time and place of my scheduled appointment(s), and other limited information, for the purpose of notifying me of a pending appointment, a missed appointment, overdue wellness exam, balances due, lab results, or other communications via an automated outreach and messaging system. I also authorize my healthcare provider to disclose to third parties who may intercept these messages (individuals you have provided with access to your digital devices or email accounts) limited protected health information (PHI) regarding my healthcare events. I consent to receiving multiple messages per day from the automated outreach and messaging system, when necessary.

Privacy Notice Acknowledgement

In accordance with the ***Health Insurance Portability and Accountability Act of 1996 (HIPAA)***, by signing below, I acknowledge that a copy of the Notice of Privacy Practices for Protected Health Information for this office has been made available to me. I am advised to read this document carefully, for it outlines the use and limitations of the disclosure of my health information and my rights as a patient. I have been given the opportunity to ask any questions that I may have regarding these policies.

Authorization to Release Medical Information

I authorize my healthcare provider(s) to furnish information from my medical records to any company that may be responsible for payment of all or part of my visit and provider charges, including my insurance companies and their representatives, and my information to this provider for continuing care.

Massage Therapy Non-Covered Service Waiver

Massage therapy services performed by a licensed massage therapist in this office are not a covered benefit under your current health plan, as these procedures are not performed directly by a participating physician/provider.

There is a fee of ***$10.00*** per visit for this service. _____**Initial**

Authorization for Direct Payment of Insurance Benefits

I, or my representative, authorize direct payment to the provider(s) and/or clinic rendering any services during this visit of any insurance benefits otherwise payable to me.

Health Insurance/Patient Payment Policy

We will file your insurance claims for you. However, we cannot guarantee or take responsibility for what your health insurance will or will not cover. Ultimately, all services rendered to you are charged directly to you and you are personally responsible for payment. Payment for all services, including copays, coinsurance and deductibles, are expected at the time of service unless prior arrangement are made with us. **If you have a cash balance with our office greater than *45 days*, there will be a finance charge of *5% per month applied to your account***.

Treatment Compliance. Appointment Cancellation Policy

We require 24 hour notice for patient cancellations. Health First Rehab, INC reserves the right to charge *$60* for missed appointments if this policy is abused. This amount is not covered by any insurance plan and will be the patient's responsibility. Further, **greater than 2 missed appointments will be considered non-compliance and subject to discharge from care**.

_____**Initial**

I have read the Health First Rehab, Inc. office policies and will honor them:

Print Name	**Patient Signature**	**Date**

Health First Rehab,Inc.

dba Lewis Bay Chiropractic

HEALTH INSURANCE AFFIDAVIT

Your claim for Personal Injury Protection benefits may be coordinated with your own personal Health Insurance per MGL c.90, Section 34M. In order to properly determine what benefits are payable, it is necessary for you to provide us with the information requested below.
Thank you very much.

1. Do you have Health Insurance? ( ) YES ( ) NO
   a. If **Yes** please answer, or **provide a copy or your health card**, both sides.

Name of plan: _____

☐ **SEE ATTACHED INSURANCE CARDS**

Policy #:_____
Subscriber name: _____
Social Security #:_____

B. If No,

Are you eligible for coverage under anyone else's plan?

( ) YES ( ) NO

If you are eligible under someone else's plan, please complete **section A** as well as the following.

Member name: _____
Relationship to you: _____
Address of member: _____
Member phone #:_____
Member date of birth: _____

Applicant's Signature: _____Date:_____

Patient and Insurance Information

Name: Date:

Address:

Town: State: Zip:

Home Phone: Cell #: Work #:

E-mail address:

Date of Birth: Social Security #

Marital Status: Name of Spouse:

Primary Care MD: Permission to send treatment notes to PCP: ☐ Y ☐ N

Emergency Contact: Relation: Phone:

Your Employer: Occupation:

Address:

Town: State: ZIP:

Health Insurance Info:

Please Give Insurance Card to Receptionist to Copy ☐ **None**

Insurance Company: Phone:

Plan Name:

Address: State:

Policy #: Group #:

Patient Relationship to the insured: Self Spouse Child Other:

Attorney Information:

Name of Law Firm:

Address: Town: State: Zip:

Phone:

Fax:

Email:

Auto Accident /Worker's Compensation

Date of Accident:

Carrier: Policy Number:

Address: City: State: Zip:

Phone: Fax:

Claim # Contact Person/Adjuster:

Name of auto policy holder: Date of Birth: / /

Address: Phone:

Note: All patients must review and sign our office policy regarding insurance billing and patient responsibilities prior to treatment.

PERSONAL INJURY INTAKE QUESTIONNAIRE

PATIENT NAME: _____ ***Today's Date:***

--- Please let us know if you require assistance, be as complete and concise as possible ---

Date of Collision?

Weather/Road Conditions: □ Clear day, dry road □ Rainy, wet □ Snow, Icy
Any additional road hazards: _____
Other Factors: □ ***Alcohol*** □ Speed □ Other: _____

Was your vehicle Totaled? □ Yes □ No Estimated vehicle damage? $ _____.00 □ Estimate pending
Was your vehicle towed from the scene? □ Yes □ No, I was able to drive my vehicle from the scene

Describe the incident in your own words:

MECHANISM OF INJURY

What was *your* position in the car? □ Driver □ Passenger, position: □ Front □ Right Rear □ Left Rear
List other passengers: 1 _____ 2 _____ 3 _____ 4 _____
Did your vehicle strike another vehicle? □ Yes □ No
Was your vehicle struck by another vehicle? □ Yes □ No
Angles of impact… First Collision: □ Front □ Back □ Left □ Right
If Second Collision: □ Front □ Back □ Left □ Right

Were you wearing a seat belt? □ Yes □ No
Did you brace for impact? □ No □ Yes --- □ I braced with my hands □ I braced with my feet
Which way were you facing at the time of impact? □ straight ahead □ Left □ Right
Were the airbags deployed? □ No □ Front airbags deployed □ Side airbags deployed

Did you strike anything in vehicle at time of impact? □ Yes □ No
If yes, describe what part of your body struck what: i.e… head, chest, chin, knees ,shoulders right or left, etc….
□ Steering Wheel _____ □ Dashboard _____
□ Windshield _____ □ Roof _____
□ Door: □ Left □ Right: _____ □ Window: □ Left □ Right: _____
□ Other _____
Did the seat back bend / break ? □ Yes □ No
Any other damage to *INSIDE* of vehicle as result of incident? _____

Were police called to the scene? □ Yes □ No
Was a police report filed? □ Yes □ No
Were any tickets issued? □ Yes, I was issued the following ticket: _____
□ Yes, the other driver was issued the following ticket: _____
□ No, not sure.

TREATMENT

Did you go to hospital □ Yes □ No Were you admitted? □ Yes □ No if yes how long? _____

If you went to hospital, when? □ At time of accident □ Next day

How did you get to hospital? □ Ambulance □ Private transportation

Name of Hospital: _____

What treatment was given? _____

☐ none ☐ placed in a cervical collar ☐ x-rayed ☐ Bandage/ Stitches: region _____

☐ given pain medication/muscle relaxants: please list:_____

☐ given home instructions? please explain: _____

Referral: ☐ Orthopedist/Surgeon ☐ Neurologist ☐ Physical Therapy ☐ Primary Care

Name of Physician: _____

Have you seen any other doctors as a result of this accident? □ Yes □ No

Date:_____ Physician: _____ Treatment: _____

Date:_____ Physician: _____ Treatment: _____

Date:_____ Physician: _____ Treatment: _____

Occupation: _____

Have you lost any time from work due to your injuries? □ No □ Yes --- Dates: _____ thru _____

Have you returned to work? □ No □ Yes --- Date you returned to work? _____/_____/_____

Are your work activities presently restricted due to this accident? □ Yes □ No

If yes, please describe: _____

Are your daily activities presently restricted due to this accident? □ Yes □ No

If yes, please describe: _____

PRIOR ACCIDENTS / MEDICAL HISTORY

Have you ever had same or similar symptoms? □ Yes □ No

If yes, please describe: _____

_____

Have you had previous injuries or accidents? □ Yes □ No

If yes, Date and Description of previous Accident(s), if applicable:

Date:_____ Injuries: _____ Treatment: _____

Date:_____ Injuries: _____ Treatment: _____

Date:_____ Injuries: _____ Treatment: _____

Do you have any residual pain from the previous injuries? □ Yes □No

If yes, please explain: _____

Medical history: □ My medical history is unremarkable for any major accidents, injuries or disease.

Major Illnesses: □ No □ Heart dz □ Hypertension □ Cancer, Type: _____ □ Diabetes, Type: □ I □ II

□ Other: _____

Surgeries: □ No □ Yes, describe: _____

Fractures or dislocations: □ No □ Yes, describe: _____

Allergies: □ No □ Yes, list allergies: _____

Social History: □ Smoke: _____ pk/day □ Drink: _____ per week □ Exercise: _____

Are there any other comments or concerns you wish to discuss with the doctor regarding your injuries? □ No □ Yes

If yes, please explain: _____

_____

Patient Signature: _____ Date:

PATIENT PAIN FORM

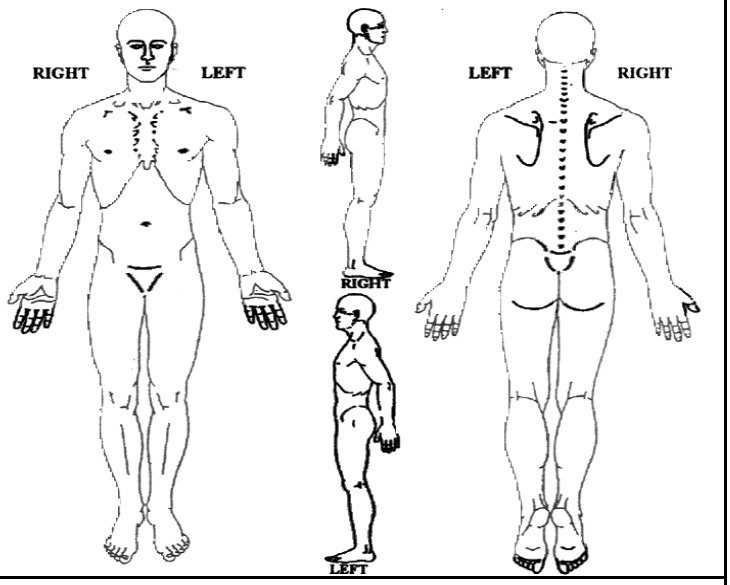
Health First Rehab, INC
dba Lewis Bay Chiropractic

Patient: _____ **Date of Birth:**_____ **Today's Date:** _____

☐ **MVC** ☐ **WC Date of Injury (if applicable):** _____

SHOW US YOUR PAIN
USE THE LETTERS BELOW TO INDICATE THE TYPE AND LOCATION OF YOUR SYMPTOMS TODAY

KEY: **A** = ACHE **B** = BURNING **N** = NUMBNESS **P** = PINS & NEEDLES
S = STABBING **X** = STIFFNESS **T** = THROBBING **O** = OTHER



0 1 2 3 4 5 6 7 8 9 10
(No Pain) (Worst Pain)

1. When did your symptoms first begin?

_____

2. What caused your recent symptoms?

_____

3. Is this an exacerbation of a chronic condition?

☐ **Yes** ☐ **No**

4. Have you had these symptoms in the past?

☐ **Yes** ☐ **No**

Please sign Here:

_____

I experience the above symptoms: ☐ Constantly ☐ Very Often ☐ Occasionally ☐ Infrequently

I feel that my symptoms are: ☐ Getting Better ☐ Getting Worse ☐ Staying About the Same

My symptoms are: ☐ Dull, Achy ☐ Stiffness ☐ Sharp/stabbing ☐ Burning ☐ Throbbing ☐ Numbness ☐ Tingling/Pins and needles

Symptoms radiate/refer to my: ☐ Head ☐ Shoulders (B R L) ☐ Both arms ☐ Right arm ☐ Left Arm ☐ Flank/ribs ☐ Hips (B R L) ☐ Buttocks (B R L) ☐ Both Legs ☐ Left leg ☐ Right Leg

Symptoms are worse with: ☐ Standing ☐ Sitting ☐ Driving ☐ Bending ☐ Lifting ☐ Work Activity

Other, please explain:

Symptoms are relieved with: ☐ Rest/Lying down ☐ Ice ☐ Heat ☐ Stretching ☐ Movement ☐ Massage ☐ Other, please explain:

I am unable to perform the following activities due to pain:

List current medications/Supplements: ☐ See current medication list provided

1. 2. 3. 4. 5.

I am experiencing the following symptoms (please check all that apply) :

☐ Shortness of breath	☐ Nausea /Vomiting	☐ Difficulty sleeping
☐ Difficulty breathing	☐ Fevers / Chills	☐ Difficulty concentrating
☐ Pain with coughing	☐ Light-headed, dizziness	☐ Memory problems
☐ Bowel/bladder changes	☐ Visual changes	☐ Mood swings, irritability
☐ Urinary incontinence	☐ Hearing changes	☐ Loss of appetite/Weight loss
☐ Blood in stool	☐ "Foggy/Hazy" feeling	☐ Fatigue
☐ Other symptoms:		

Name: _____ DOB: _____ DOL: _____ Date: _____

SCORE: _____

The Rivermead Post-Concussion Symptoms Questionnaire*

After a head injury or accident some people experience symptoms which can cause worry or nuisance. We would like to know if you now suffer from any of the symptoms given below. As many of these symptoms occur normally, we would like you to compare yourself now with before the accident. For each one, please circle the number closest to your answer.

0 = Not experienced at all
1 = No more of a problem
2 = A mild problem
3 = A moderate problem
4 = A severe problem

Compared with before the accident, do you now (i.e., over the last 24 hours) suffer from:

Headaches	0	1	2	3	4
Feelings of Dizziness	0	1	2	3	4
Nausea and/or Vomiting	0	1	2	3	4
Noise Sensitivity, easily upset by loud noise	0	1	2	3	4
Sleep Disturbance	0	1	2	3	4
Fatigue, tiring more easily	0	1	2	3	4
Being Irritable, easily angered	0	1	2	3	4
Feeling Depressed or Tearful	0	1	2	3	4
Feeling Frustrated or Impatient	0	1	2	3	4
Forgetfulness, poor memory	0	1	2	3	4
Poor Concentration	0	1	2	3	4
Taking Longer to Think	0	1	2	3	4
Blurred Vision	0	1	2	3	4
Light Sensitivity, Easily upset by bright light	0	1	2	3	4
Double Vision	0	1	2	3	4
Restlessness	0	1	2	3	4

Are you experiencing any other difficulties?

1. _____	0	1	2	3	4
2. _____	0	1	2	3	4

*King, N., Crawford, S., Wenden, F., Moss, N., and Wade, D. (1995) J. Neurology 242: 587-592

Neck Index

ACN Group, Inc. Form NI-100

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name _____ ***Date*** _____

This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

- ☐ I have no pain at the moment.
- ☐ The pain is very mild at the moment.
- ☐ The pain comes and goes and is moderate.
- ☐ The pain is fairly severe at the moment.
- ☐ The pain is very severe at the moment.
- ☐ The pain is the worst imaginable at the moment.

Personal Care

- ☐ I can look after myself normally without causing extra pain.
- ☐ I can look after myself normally but it causes extra pain.
- ☐ It is painful to look after myself and I am slow and careful.
- ☐ I need some help but I manage most of my personal care.
- ☐ I need help every day in most aspects of self care.
- ☐ I do not get dressed, I wash with difficulty and stay in bed.

Sleeping

- ☐ I have no trouble sleeping.
- ☐ My sleep is slightly disturbed (less than 1 hour sleepless).
- ☐ My sleep is mildly disturbed (1-2 hours sleepless).
- ☐ My sleep is moderately disturbed (2-3 hours sleepless).
- ☐ My sleep is greatly disturbed (3-5 hours sleepless).
- ☐ My sleep is completely disturbed (5-7 hours sleepless).

Lifting

- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights but it causes extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can only lift very light weights.
- ☐ I cannot lift or carry anything at all.

Reading

- ☐ I can read as much as I want with no neck pain.
- ☐ I can read as much as I want with slight neck pain.
- ☐ I can read as much as I want with moderate neck pain.
- ☐ I cannot read as much as I want because of moderate neck pain.
- ☐ I can hardly read at all because of severe neck pain.
- ☐ I cannot read at all because of neck pain.

Driving

- ☐ I can drive my car without any neck pain.
- ☐ I can drive my car as long as I want with slight neck pain.
- ☐ I can drive my car as long as I want with moderate neck pain.
- ☐ I cannot drive my car as long as I want because of moderate neck pain.
- ☐ I can hardly drive at all because of severe neck pain.
- ☐ I cannot drive my car at all because of neck pain.

Concentration

- ☐ I can concentrate fully when I want with no difficulty.
- ☐ I can concentrate fully when I want with slight difficulty.
- ☐ I have a fair degree of difficulty concentrating when I want.
- ☐ I have a lot of difficulty concentrating when I want.
- ☐ I have a great deal of difficulty concentrating when I want.
- ☐ I cannot concentrate at all.

Recreation

- ☐ I am able to engage in all my recreation activities without neck pain.
- ☐ I am able to engage in all my usual recreation activities with some neck pain.
- ☐ I am able to engage in most but not all my usual recreation activities because of neck pain.
- ☐ I am only able to engage in a few of my usual recreation activities because of neck pain.
- ☐ I can hardly do any recreation activities because of neck pain.
- ☐ I cannot do any recreation activities at all.

Work

- ☐ I can do as much work as I want.
- ☐ I can only do my usual work but no more.
- ☐ I can only do most of my usual work but no more.
- ☐ I cannot do my usual work.
- ☐ I can hardly do any work at all.
- ☐ I cannot do any work at all.

Headaches

- ☐ I have no headaches at all.
- ☐ I have slight headaches which come infrequently.
- ☐ I have moderate headaches which come infrequently.
- ☐ I have moderate headaches which come frequently.
- ☐ I have severe headaches which come frequently.
- ☐ I have headaches almost all the time.

Calculate Score

Neck Index Score

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Back Index

Patient Name _____ ***Date*** _____

This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

- ☐ The pain comes and goes and is very mild.
- ☐ The pain is mild and does not vary much.
- ☐ The pain comes and goes and is moderate.
- ☐ The pain is moderate and does not vary much.
- ☐ The pain comes and goes and is very severe.
- ☐ The pain is very severe and does not vary much.

Sleeping

- ☐ I get no pain in bed.
- ☐ I get pain in bed but it does not prevent me from sleeping well.
- ☐ Because of pain my normal sleep is reduced by less than 25%.
- ☐ Because of pain my normal sleep is reduced by less than 50%.
- ☐ Because of pain my normal sleep is reduced by less than 75%.
- ☐ Pain prevents me from sleeping at all.

Sitting

- ☐ I can sit in any chair as long as I like.
- ☐ I can only sit in my favorite chair as long as I like.
- ☐ Pain prevents me from sitting more than 1 hour.
- ☐ Pain prevents me from sitting more than 1/2 hour.
- ☐ Pain prevents me from sitting more than 10 minutes.
- ☐ I avoid sitting because it increases pain immediately.

Standing

- ☐ I can stand as long as I want without pain.
- ☐ I have some pain while standing but it does not increase with time.
- ☐ I cannot stand for longer than 1 hour without increasing pain.
- ☐ I cannot stand for longer than 1/2 hour without increasing pain.
- ☐ I cannot stand for longer than 10 minutes without increasing pain.
- ☐ I avoid standing because it increases pain immediately.

Walking

- ☐ I have no pain while walking.
- ☐ I have some pain while walking but it doesn't increase with distance.
- ☐ I cannot walk more than 1 mile without increasing pain.
- ☐ I cannot walk more than 1/2 mile without increasing pain.
- ☐ I cannot walk more than 1/4 mile without increasing pain.
- ☐ I cannot walk at all without increasing pain.

Personal Care

- ☐ I do not have to change my way of washing or dressing in order to avoid pain.
- ☐ I do not normally change my way of washing or dressing even though it causes some pain.
- ☐ Washing and dressing increases the pain but I manage not to change my way of doing it.
- ☐ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
- ☐ Because of the pain I am unable to do some washing and dressing without help.
- ☐ Because of the pain I am unable to do any washing and dressing without help.

Lifting

- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights but it causes extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can only lift very light weights.

Traveling

- ☐ I get no pain while traveling.
- ☐ I get some pain while traveling but none of my usual forms of travel make it worse.
- ☐ I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
- ☐ I get extra pain while traveling which causes me to seek alternate forms of travel.
- ☐ Pain restricts all forms of travel except that done while lying down.
- ☐ Pain restricts all forms of travel.

Social Life

- ☐ My social life is normal and gives me no extra pain.
- ☐ My social life is normal but increases the degree of pain.
- ☐ Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
- ☐ Pain has restricted my social life and I do not go out very often.
- ☐ Pain has restricted my social life to my home.
- ☐ I have hardly any social life because of the pain.

Changing degree of pain

- ☐ My pain is rapidly getting better.
- ☐ My pain fluctuates but overall is definitely getting better.
- ☐ My pain seems to be getting better but improvement is slow.
- ☐ My pain is neither getting better or worse.
- ☐ My pain is gradually worsening.
- ☐ My pain is rapidly worsening.

Calculate Score

Back Index Score

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100