COBERLY CHIROPRACTIC

3025 N. Taft Avenue, Suite A
Loveland, Colorado 80538
Phone: 970.203.0621
Fax: 970.461.2462

Workers' Compensation History

Name: _____ Age: _____ Date: _____ Sex: M / F

Address: _____ City: _____ State: ____ Zip: _____

Social Security Number: _____ Driver's License Number: _____

Employer Name: _____ Telephone Number: _____

Business Address: _____ City: _____ State: ____ Zip: _____

Employer Insurance: _____ Telephone Number: _____

Have you retained legal counsel for this injury? ❑ Yes ❑ No If Yes, list the name and address: _____

_____

Injury Description

Date present injury was received: _____ Time of Injury: _____ ❑ AM ❑ PM Working Overtime? ❑ Yes ❑ No

Who saw the accident? _____

Who reported the accident? _____

What medical attention was rendered? _____

By whom? ❑ Nurse ❑ M.D. ❑ D.O. ❑ D.C. ❑ Other Employee ❑ Other _____

How did the injury occur? _____

Chief complaint _____

Symptoms _____

Since the injury, are your symptoms ❑ improving ❑ the same ❑ getting worse

Indicate on diagram which symptoms you are experiencing and their locations.

A=Ache

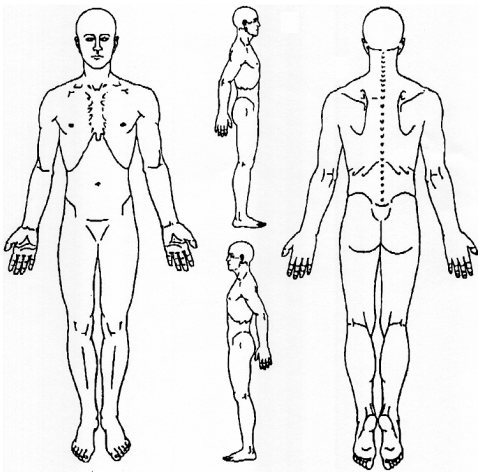
B=Burning

N=Numbness

P=Pins and Needles

S=Stabbing

O=Other



Physical Labor

If working on a machine, provide a description _____

Do you use foot or hand levers? ❑ Yes ❑ No Do you work overhead? ❑ Yes ❑ No

Do you have to reach? ❑ Yes ❑ No If Yes, how much? _____ How often? _____

Do you lift from ❑ Ground ❑ Bench ❑ Platform ❑ Box ❑ Pallet ❑ Other: _____

If working at a machine, do you ❑ Sit ❑ Stand ❑ Kneel Is your work area cluttered? ❑ Yes ❑ No

Is your work area ❑ Oily ❑ Dirty ❑ Slippery ❑ Other _____

In your job, do you push or pull? ❑ Yes ❑ No If Yes, give specifics. _____

Do you use a cart? ❑ Yes ❑ No ❑ Two-wheel ❑ Four-wheel

Total amount of weight being pushed or pulled on a daily basis _____

If off work, do you want to return to your job? ❑ Yes ❑ No

Office Work

If your injury has occurred from office work only, please complete the following:

❑ Sit at desk ❑ Walk ❑ Stand ❑ Stoop ❑ Hold ❑ Carry ❑ Other _____

If your work is at a desk, give specifics of job, computer, typewriter, business machines, phone, and so forth: _____

_____

If walking, where to _____

Do you carry anything or pick anything up? ❑ Yes ❑ No If Yes, what? _____

Present Work History

Were you performing your normal job? ❑ Yes ❑ No What shift were you working? _____

How long have you been at your present job? _____

Has there been a time loss or absenteeism caused from job injury? ❑ No ❑ Yes, explain _____

Average work week _____ Hours _____ Days _____

Previous Work Injury

Have you ever applied for Workers' Compensation benefits before? ❑ Yes ❑ No Date: _____

Reason _____

Was there a time loss from work? ❑ Yes ❑ No From _____ To _____ Year _____

State the degree of recovery _____

Did you retain legal counsel for these injuries? ❑ Yes ❑ No If Yes, give name and address: _____

_____

Authorization

I certify that I have read and understand the above information and that I have answered the above questions to the best of my knowledge. I authorize Dr. Coberly to release any necessary information. I agree to be responsible for payment of all services rendered on my behalf or on behalf of my dependents. I grant my permission to post my name in the office. ❑ Yes ❑ No

_____ _____

Signature of Patient (or parent if a minor) Date

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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 vertebras 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.

Subluxations 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 by handheld instruments. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included.

All health care procedures carry some risk. Risks associated with chiropractic care may include, but are not limited to, muscle or ligament injuries, nerve injuries, vascular injuries and fractures. Alternatives to chiropractic care may include medications, surgery and other alternative treatments.

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.

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

Consent to Evaluate and Adjust a Minor Child

I, _____, being the parent or legal guardian of _____ have read and fully understand the above Informed Consent and herby 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 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: _____

_____

Print Name Signature Date

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Assignment of Benefits

I hereby instruct and direct _____ insurance company to pay by check made out and mailed to Coberly Chiropractic, Inc., 3025 N. Taft Avenue, Suite A, Loveland, CO 80538.

or

if my current policy prohibits direct payment to Dr. Coberly, I hereby also instruct and direct you to make out the check to me and direct payment to 3025 N. Taft Avenue, Suite A, Loveland, CO 80538 for the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

A photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

I authorize Doctor Coberly to initiate a complaint to the insurance commissioner for any reason on my behalf.

_____

Print Name of Policy Holder Signature of Policy Holder Date

_____

Print Name of Witness Signature of Witness Date

Thank You For Your Trust and Confidence

HIPPA HAPPENINGS

This notice describes how your health information may be used and how you can gain access to this information. Please review carefully.

Our Promise to you, our Valued Patient…

This is not meant to alarm you, quite the opposite. We want to assure you that we take the new Federal (HIPPA – Health Insurance Portability and Accountability Act) laws seriously. These laws were written to protect the confidentiality of your health information. We trust you will never delay treatment in our offices because of fear that your personal health information might be unnecessarily disclosed to others outside our office.

Why A Privacy Policy Now?

The most significant variable that has motivated the Federal government to legally enforce the privacy of health information is the rapid evolution of the use of electronic technology in the administration of health care business. The government has appropriately sought to standardize and protect the electronic exchange of your health information. This has challenged us to review not only how your information is used within our computers but also with the Internet, phones, fax machines and any device used to copy or transfer data.

We want to advise you that we have developed policies and procedures for our practice to assure that your personal or health information will be shared only as required and only for the purpose of administering your case. Our office is subject to State and Federal laws regarding the confidentiality of your health information and we will assure adherence to those laws and we want you to understand our procedures and your rights as a valued patient.

Your health information will be communicated only for the purpose of obtaining payment for services and conducting health care business. Be assured that without your written permission, your health information will not be used for any other purpose.

How Your Health Information May Be Used to Provide Treatment

Within our office, your health information will be used to provide you the best care and services possible. This may include administrative and clinical procedures designed to optimize scheduling and coordination between you and all office personnel. In addition, we may share this information with referring physicians, clinical pathology laboratories or other health care professionals providing you want treatment.

To Obtain Payment

Your health information may be included with an invoice for the purpose of collecting payment for services provided to you in our office. We may do this with insurance forms filed for you by mail or electronically. We will make all effort to work with companies with a similar commitment to the security of your health information.

To Conduct Health Care Operations

Your health information may be used during performance evaluations of our staff. Some of our best teaching opportunities use clinical situations experienced by patients receiving care in our office. As a result, your health information may be included in the training programs for students, interns, associates, as well as business and clinical employees. It is also possible that your health information will be disclosed during audits by insurance companies or government appointed agencies as part of their quality assurance and compliance reviews. Your health information may be reviewed during the routine process of certification, licensing, or credentialing activities.

In Patient Reminders

Because we believe regular care is very important to your general health, we will remind you of a scheduled appointment or that it is time for you to contact us and make an appointment. Additionally, we may contact you to follow up on your care and inform you of treatment options or services that may be of interest to you or members of your family. These communications are an important part of our philosophy of partnering with our patients to be sure they receive the best care chiropractic can provide. They may include postcards, newsletters, flyers, telephone or electronic reminders such as e-mail (unless you tell us that you prefer not to receive reminders).

Public Health and National Security

We may be required to disclose to Federal officials or military authorities health information necessary to complete an investigation related to public health and or national security.

For Law Enforcement

As permitted or required by state or Federal law, we may disclose your health information to a proper authorities for the purpose of law enforcement including, under certain circumstances, if you are a victim of a crime or in order to report a suspected crime.

Family, Friends and Caregivers

We may share your health information with those you tell us will be assisting you with your home hygiene, care, treatment or payment. We will be certain to obtain your permission prior to sharing your information. In the event of an emergency, were you unable to tell us what you want, we will use our very best judgment when sharing your health information with anyone participating in your care.

Medical Research

Advancing health care knowledge often involves learning from the careful study of health histories as a part of a research study will happen only under the ethical guidance, requirements and approval of an Institutional Review Board.

Authorization to Use or Disclose Health Information

Other than is stated above or where Federal, State or Local law requires us, we will not disclose your health information other than with your written authorization. *You may revoke that authorization in writing any time*.

Confidential Communications

You have the right to request that we communicate with you in a specific way. You may request that we only communicate your health information privately with or without other family members present or through sealed mail communications. We will make a reasonable effort to honor your request.

Inspect and Copy Your Health Information

You have the right to read, review and copy your health information including complete chart, x-rays and billing records. If you would like a copy of your health information, please let us know. We may need to charge you a reasonable fee to duplicate and assemble your copy.

Amend Your Health Information

You have the right to ask us to update or modify your records if you believe your health information is incorrect or incomplete. We will be happy to accommodate you as long as our office maintains this information. In order to standardize our process, please provide us with your request in writing and describe as completely as possible your reason for the request.

Your request may be denied if the health information record in question was not created by our office, is not a part of our records, or if the records containing your health information have been requested sealed and or delivered to any authority for review.

Documentation of Health Information

You have the right to request from us a description of how and where your health information was used by our office for any reason other than for treatment or payment, or health care operations. Our documentation procedures will enable us to provide information on your health information usage from April 14, 2003 and forward. Please let us know in writing the time period for which you are interested. We will greatly appreciate you limiting your request to no more than six years at a time. We may need to charge you a reasonable fee for your request.

Request a Paper Copy of this Notice

You have the right to request and obtain a copy of the Notice of Privacy Practices directly from our office at any time. Just let us know of your request. We are required by law to maintain the privacy of your health information and to provide to you and your representative this Notice of our Privacy Practices. We are required to practice the policies and procedures described in this notice, but we do reserve the right to change the terms of our notice. Patients would be notified of any such changes.

You have the right to express concerns or complaints to us or the Secretary of Health and Human Services if you believe your privacy rights have been compromised. We encourage you to express in writing, any concerns you may have regarding the privacy of your health information.

Patient Acknowledgement

Patient Name(s):

_____

_____

_____

Thank you very much for taking time to review how we are carefully using your health information. If you have any questions, please let us know. If not, we would really appreciate your acknowledging by signature that you have received, thoroughly reviewed, and understood this policy.

_____ Date _____/_____/_____

Patient Signature