QUALITY LIFE Health Care, llc
A Chiropractic & Wellness Center

Patient Information Sheet

Patient Name: _____ Date:_____

Address: Street: _____ City :_____ Zip:_____

Telephone: _____ Cell: _____ Cell Carrier:_____

Email: _____

Date of Birth:_____ Sex M F Social Security Number: _____

Married ( ) Single ( ) Widowed ( ) Divorced ( ) Name of Spouse: _____

Employer Name: _____ Address: _____

Employer Telephone Number: _____ Job Description: _____

Health Insurance: Yes ( ) No ( ) Insurance Carrier Name: _____

Insurance I.D. Number: _____ Group Number: _____

Reason For Today's Visit: _____

1.<u>MVA Only :</u>

Date of Collision: _____ Location of Collision: _____

Describe Accident:

_____

_____

_____

Rear End Collision ( ) Head On Collision ( ) Broadside Collision ( ) Pedestrian ( ) Other ( )

Driver ( ) Passenger Front seat ( ) Passenger Rear seat ( ) Wearing Seatbelt Yes ( ) No ( )

If "driver", were your hands on the wheel? **Both/Right/Left**

Did Air bags deploy? **Yes/No**

Did you strike another vehicle? **Yes/No** Did another vehicle strike your vehicle? **Yes/No**

Was your headrest set? **Low/Middle/High**

Were you surprised by the impact? **Yes/No** If no, how did you brace? **With hands/with feet**

Which direction was your head facing at time of impact? **Straight/left/right/behind**

Was your vehicle drivable after the collision? **Yes/No** Was your vehicle towed? **Yes/No**

What type of vehicle were you driving? Make _____ Year _____ Model _____

What was your approximate speed at the time of impact? _____MPH

What type of Vehicle was the other Vehicle? Make_____ Year _____ Model _____

What was the approximate speed of the other vehicle at the time of impact? _____MPH

Did you feel pain immediately after the collision? **Yes/No**

Did you black out at the time of the impact? **Yes/No**

Did you strike anything in the vehicle at the time of impact? **Yes/No**

If yes, what body part did you strike and describe you struck it on? _____

Were the police at the scene of the collision? **Yes/No** Did any one receive a ticket? **Yes/No**

Were you injured as a result of the collision? **Yes/No**

Check what part of your body was injured:

Head ____	Face____	Jaw____	Neck____	Middle Back____	Low back___
Chest ____	Ribs____	Arm R/L	Elbow R/L	Wrist R/L	Hand R/L
Hip R/L	Knee R/L	Ankle R/L	Foot R/L	Other _____	

2. <u>Worker's Comp Only</u>:

Where you injured while at work? **Yes/No**

Date of Injury: _____

3. <u>Slip and Fall Only</u>:

Where you injured due to a slip and fall? **Yes/No**

Date of slip and fall:_____

4. <u>Hospital</u>

Did you go to Emergency room? **Yes/No**

If yes, how were you taken? **Ambulance/Police car/Private Transportation**

Name of Hospital _____ Did you stay overnight? **Yes/No** How long: _____

Where X-rays taken? **Yes/No** If Yes Describe: _____

Was a CT Scan or MRI performed? **Yes/No** If yes describe:_____

Where you given any medication? **Yes/No** If yes, describe:_____

Have you lost any time from Work: **Yes/No** If Yes how much time: _____

Are you still out of work: **Yes/No** Are you on light Duty: **Yes/No**

Have you seen any other doctor for these injuries: **Yes/No**
Doctors Name _____ Address_____
When did you see this doctor? _____ How many times? _____

Please check the level of pain you are experiencing for each symptom:

1. Pain Area: _____

0 (no pain) 0----------5----------10 (worst pain –can't get out of bed)

Burning _____ Stabbing _____ Tingling _____ Achy_____ Sharp_____ Dull _____

2. Pain Area: _____

0 (no pain) 0----------5----------10 (worst pain –can't get out of bed)

Burning _____ Stabbing _____ Tingling _____ Achy_____ Sharp_____ Dull _____

3. Pain Area: _____

0 (no pain) 0----------5----------10 (worst pain –can't get out of bed)

Burning _____ Stabbing _____ Tingling _____ Achy_____ Sharp_____ Dull _____

4. Pain Area: _____

0 (no pain) 0----------5----------10 (worst pain –can't get out of bed)

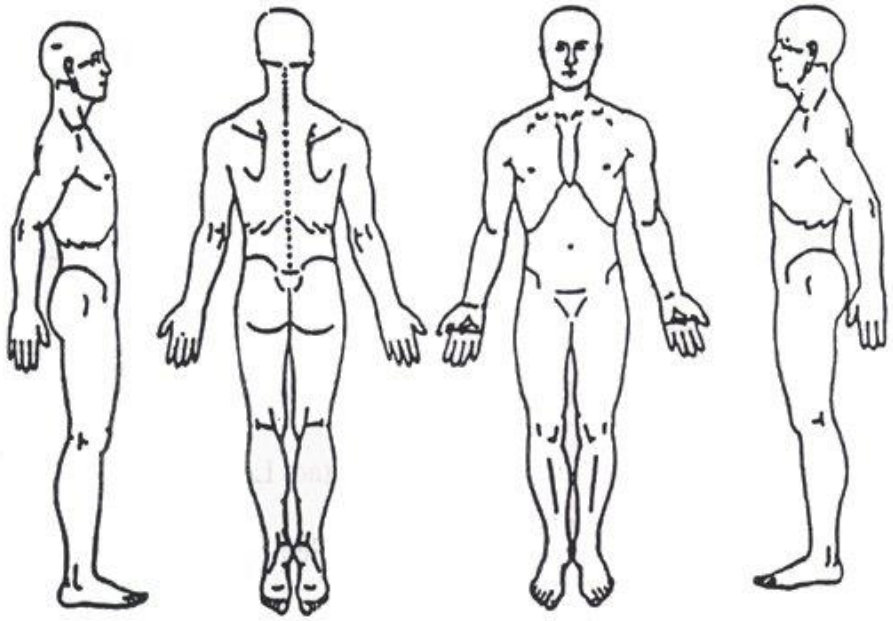
Burning _____ Stabbing _____ Tingling _____ Achy_____ Sharp_____ Dull _____

5. Pain Area: _____

0 (no pain) 0----------5----------10 (worst pain –can't get out of bed)

Burning _____ Stabbing _____ Tingling _____ Achy_____ Sharp_____ Dull _____

Please mark the areas you are having pain with an X:



What activities of daily living cause you to have increased pain: List them here:

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Can you sleep all night? **Yes/No**

Are you having trouble sleeping? **Yes/No**

Is your pain? **Getting Worse/Staying the Same/Getting Better**

Can you get dressed without pain: **Yes/No**

Has your appetite changed? _____

Which of the following cause you to have increased pain:

Sitting _____	Standing _____	Walking _____	Twisting _____
Bending _____	Lifting _____	While in bed ___	Climbing Stairs _____
Turning _____	Turning in Bed _____	Up from Sitting _____	Bowel Movement ____
Urinating _____	Sexual Activity _____	Other _____	

Describe any other movements that cause increased pain:_____

Were you ever injured in a motor vehicle collision before? **Yes/No** If yes, when _____

What parts of your body was injured in that collision?_____

5. **Past Medical History**

Have you ever had any major surgeries? **Yes/No** Date? _____

What type of surgery did you have? _____

Previous Injuries or Trauma? _____

Have you ever broken any bones? Which? _____

Allergies: _____

Have you ever been diagnosed with any of the following: Check as many as appropriate:

Heart Disease_____	High Blood Pressure____	Diabetes_____	High Cholesterol ____
Cancer _____	HIV _____	Asthma _____	Measles_____
Mumps_____	Respiratory Problems_____	Mono_____	STD_____
Osteoarthritis_____	Hepatitis A____ B_____ C_____	COPD_____	Sleep Apnea_____
Blood in Urine_____	Rheumatoid Arthritis_____	Stroke_____	Mental Disorders____
Blood in Stool_____	Digestive Problems _____	GERD_____	TMJ_____

What Medications are you taking – Please List them:

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

Is there anything else in your past medical history that you feel is important to your care here? _____

6. **Family Health History**

Do you have a family history of any of the following?

Cancer_____	Stroke_____	Headaches_____
Cardiac Disease_____	Neurologic Disease _____	Cancer before 40 _____
Psychiatric Disease_____	Diabetes_____	Other_____

Mother: Living ( ) Deceased ( ) Father: Living ( ) Deceased ( )
Brothers: Living ( ) Deceased ( ) Sisters: Living ( ) Deceased ( )

Do you have Children: **Yes/No** How Many? _____ Ages? _____

I have read the above information and certify it to be true and correct to the best of my knowledge, and hearby authorize this office to provide me with chiropractic care, in accordance with this state's statutes. If my insurance will be billed, I authorize payment of medical benefits to Quality Life Health Care, LLC for services performed.

Patient Signature: _____ Date: _____

HIPAA 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.

This Notice of Privacy describes how we may use and disclose your protected health information (PHI) to carry our treatment, payment or health care operations (TPO) for other purposes that are permitted or required by law. "Protected Health Information" is information about you, including demographic information that may identify you and that related to your past, present, or future physical or mental health or condition and related care services.

Use and Disclosures of Protected Health Information: Your protected health information may be used and disclosed by your physician, our staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, pay your health care bills, to support the operations of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your health care information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing, and fund raising activities, and conduction or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.
We may use or disclose your protected health information in the following situations without your authorization. These situations included as required by law, public health issues, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, and organ donation. Required uses and disclosures under the law, we must make disclosures to you when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section164.500.
OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES WILL BE MADE ONLY WITH YOUR CONSENT, AUTHORIZATION OR OPPORTUNITY TO OBJECT UNLESS REQUIRED BY LAW.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

_____ _____

Signature of Patient of Representative Date

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as a cervical arterial dissection that involves an abnormal change in the wall of an artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. This occurs in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately a percentage of these patients will experience a stroke. As chiropractic can involve manually and/or mechanically adjusting the cervical spine, it has been reported that chiropractic care may be a risk for developing this type of stroke. The association with stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

SIGN ONLY AFTER YOU UNDERSTAND AND AGREE TO THE ABOVE

_____

Printed name of Patient

x_____ _____

Signature of Patient Date

x_____ _____

Signature of Representative (if patient is minor or handicapped) Date

x_____ _____

Witness to Patients' Signature Date

HIPAA COMPLIANT AUTHORIZATION FOR THE RELEASE OF PATIENT INFORMATION PURSUANT TO 45 CFR 164.508

TO: QUALITY LIFE HEALTH CARE LLC.
46 Prince Street
Suite 201
New Haven, CT 06473

RE: Patient Name: _____

Date of Birth: _____ Social Security Number: _____

I authorize and request the disclosure of all protected information for the purpose of review and evaluation in connection with a legal claim. I expressly request that the designated record custodian of all covered entities under HIPAA identified above disclose full and complete protected medical information including the following:

☐ All medical records

☐ All physical, occupational and rehab requests, consultations and progress notes.

☐ All disability, Medicaid or Medicare records including claim forms and record of denial of benefits.

☐ All employment, personnel or wage records.

☐ All radiology records and films including CT scan, MRI, MRA, EMG, bone scan, myleogram; nerve conduction study, echocardiogram and cardiac catheterization results, videos/CDs/films/reels and reports.

☐ All pharmacy/prescription records including NDC numbers and drug information handouts/monographs.

☐ All billing records for the period _____ to _____.

I understand the information to be released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), and alcohol and drug abuse. I authorize the release or disclosure of this type of information.
This protected health information is disclosed for the following purposes:

_____

This authorization is given in compliance with the federal consent requirements for release of alcohol or substance abuse records of 42 CFR 2.31, the restrictions of which have been specifically considered and expressly waived.

You are authorized to release the above records to the following representatives of defendants in the above-entitled matter who have agreed to pay reasonable charges made by you to supply copies of such records:

_____
Name

_____
Signature

_____
Street Address

_____
City, State and Zip Code

QUALITY LIFE Health Care, llc
A Chiropractic & Wellness Center

NOTICE OF DOCTOR'S LIEN

I do hereby authorize Quality Life Health Care, LLC to furnish you, my attorney, with a full report of my examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I was recently involved.

I hereby authorize and direct you, my attorney, to pay directly to said provider such sums as may be due and owing him for medical service rendered to me both by reason of this accident and by reason of any other bills that are due to this office and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect said provider. I hereby further give a Lien on my case to said doctor against any and all proceeds of my settlement, judgment or verdict which may be paid to you, my attorney, or myself, as the result of the injuries for which I have been treated or injuries in connection there with.

I agree never to rescind this document and that a rescission will not be honored by my attorney. I hereby instruct that in the event another attorney is substituted in this matter, the new attorney honor this lien as inherent to the settlement and enforceable upon the case as if it were executed by him.

I fully understand that I am directly and fully responsible to said provider for all medical bills submitted for service rendered to me and that this agreement is made solely for said provider's additional protection and in consideration of his awaiting payment. I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

Please acknowledge this letter by signing below and returning to the provider's office. I have been advised that if my attorney does not wish to cooperate in protecting the provider's interest, the provider will not await payment but shall declare the entire balance due and payable.

Patient's Signature _____ Date _____

The undersigned being attorney of record for the above patient does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment, or verdict, as may be necessary to adequately protect said provider above named. Attorney further agrees that in the event this lien is litigated that the prevailing party will be awarded attorney fees and costs.

Attorney's Signature _____ Date _____