OUR OFFICE POLICY FOR MOTOR VEHICLE ACCIDENTS

WE NEED FROM YOU:

1.) YOUR automobile insurance declarations page(even if you were a passenger). Please note: if you were a passenger, we will ALSO need the driver's name and address and THEIR automobile declarations page.

2.) Copy of your health insurance card.

3.) Attorney name, address and phone number(if you have retained one).

OUR BILLING PROTOCOL:

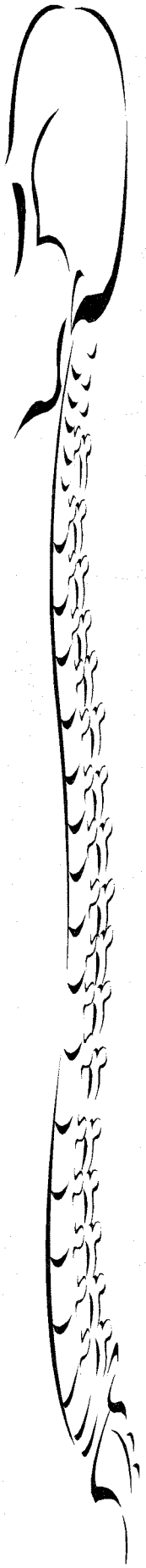
The states of Connecticut requirements in which our office complies with:

1. If you have the "medical payments" option on your automobile insurance policy, this MUST be PRIMARY.

2. If you do NOT carry this option, we still REQUIRE a copy of this declarations page to submit to your health insurance carrier. Without proof of NO med-pay, your health insurance will deny coverage for treatment, therefore, leaving your responsible to pay for treatment rendered in FULL.

3. If you DO NOT have either med pay coverage or health insurance coverage, you can still receive treatment as long as you have retained an attorney. We will require you AND your attorney to sign a letter of protection. This means that Dr. Porzio will get paid for all services rendered at the time of your settlement.

4. WE DO NOT BILL THIRD PARTY INSURANCE CARRIERS. If you do not have med-pay; health insurance OR an attorney, it is YOUR responsibility to submit bills to the third party insurance carrier and you MUST pay for each visit prior to your treatment. (Third party insurance companies pay the patient directly).



PORZIO CHIROPRACTIC CENTER

1153 West Main Street
Waterbury, CT. 06708
(203) 756-7449

ABOUT YOU

Patient's Name: _____
LAST FIRST MI

What You Prefer To Be Called: _____ □ Male □ Female

Birth date: ____/____/____ Age:_____ SS#: _____

Mailing Address: _____

_____
CITY STATE ZIP CODE

Home Phone #: _____

Work Phone#: _____ Ext: _____

Cell Phone#: _____ Carrier: _____

E-Mail Address: _____

How did you hear about our office?: _____

Employer: _____

Employer Address: _____

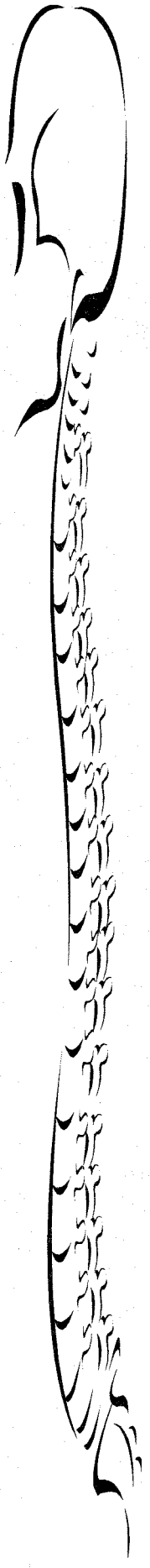
_____
CITY STATE ZIP CODE

Occupation: _____

Status: □ Minor □Single □Married □Divorced □Separated □Widowed

Spouse's Name: _____

Do you have children? □ Yes □ No How many? _____



REASON FOR TODAY'S VISIT

The reason for this visit is a result of (Please circle): auto, work, sports, trauma or chronic

(Explain what happened): _____

_____

Please describe the pain and its location: _____

_____

When did this condition begin? ____/____/____

Is this condition getting worse? □ Yes □ No □ Constant □ Comes and goes

Rate your pain today on a 0-10 scale (Please circle: 0 = no pain and 10 = severe pain)

0 1 2 3 4 5 6 7 8 9 10

Is this condition interfering with your: (Please circle): Work, Sleep, or Daily Routine

If so, please explain: _____

Have you had this similar condition in the past? □ Yes □ No

If so, please explain: _____

Have you been treated by a Medical Physician for this condition? □ Yes □ No

If so, where? _____

Have you ever been treated by a Chiropractor before? □ Yes □ No

If so, whom? _____

IN THE EVENT OF AN EMERGENCY

Who should we contact? _____

Relation: _____

Home Phone #: _____ Cell Phone #: _____

Who is your Medical Doctor? _____ Phone #: _____

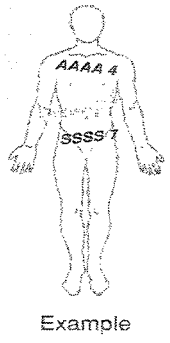
PAIN CHART

SHOW US WHERE IT HURTS

Please mark **area(s)** of injury or discomfort as shown in the example below.

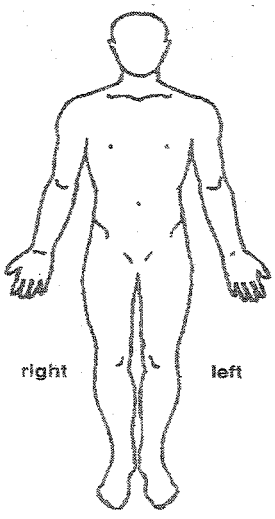
Make all areas with the appropriate symbols and indicate the degree of pain using a scale from **1 (discomfort) to 10 (extreme pain)**

Description →	**Numbness**	**Pins & Needles**	**Burning**	**Aching**	**Stabbing**
Symbol→	*NNNN*	*PPPP*	*BBBB*	*AAAA*	*SSSS*

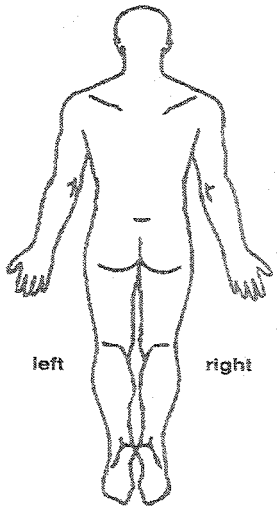


Example

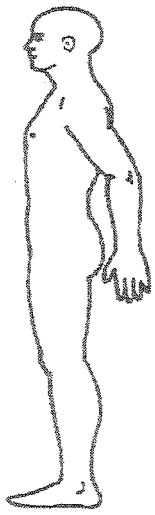

Right



Front



Back


Left

Do you: Take Supplements or Vitamins? □ Yes □ No Exercise? □ Yes □ No

Are you on a special diet? □ Yes □ No Since: ____/____/____

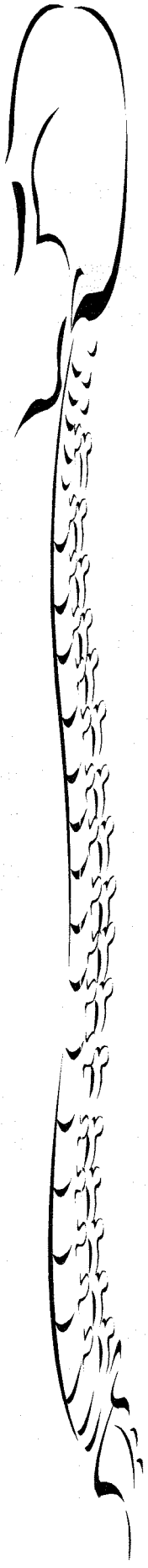
Do you smoke? □ Yes □ No How much? _____ How long? _____

Are you wearing: □ Heel Lifts □ Sole Lifts □ Inner Soles □ Arch Supports

What is the age of your mattress? _____ Is it comfortable? □ Yes □ No

For Women: Are you taking Birth Control? □ Yes □ No

Are you pregnant? □ Yes □ No How long? _____ Nursing? □ Yes □ No



HEALTH HISTORY

Are you taking any of the following medication?

□ Nerve pills □ Pain killers (including aspirin) □ Muscle relaxers □ Stimulants

□ Blood thinners □ Tranquillizers □ Insulin □ Other(s) _____

Do you have or ever had any of the following diseases or conditions?

Y N Heart Attack/Stroke	**Y N** Heart Surgery/Pacemaker	**Y N** Heart Murmur
Y N Congenital Heart Defect	**Y N** Mitral Valve Prolapse	**Y N** Artificial Valves
Y N Alcohol/Drug Abuse	**Y N** Venereal Disease	**Y N** Hepatitis
Y N HIV+/Aids	**Y N** Shingles	**Y N** Cancer
Y N Frequent Neck Pain	**Y N** Emphysema/Glaucoma	**Y N** Anemia
Y N High/Low Blood Pressure	**Y N** Psychiatric Problems	**Y N** Rheumatic Fever
Y N Severe/Frequent Headaches	**Y N** Kidney Problems	**Y N** Ulcers/Colitis
Y N Fainting/Seizures/Epilepsy	**Y N** Sinus Problems	**Y N** Asthma
Y N Diabetes/Tuberculosis	**Y N** Difficulty Breathing	**Y N** Chemotherapy
Y N Lower Back Problems	**Y N** Artificial Bones/Joints	**Y N** Arthritis

Please list any other serious medical condition(s) you have or ever had:

_____

Please list anything that you might be allergic to: _____

List previous surgeries/treatments with dates: _____

List any past serious accidents with dates: _____

Family Health History: _____

_____

- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the office manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, and any other expenses incurred in collecting your account.

- I authorize the staff to perform necessary services needed during diagnosis and treatment. I also authorize the provider and or managed care organization, to release any information required to process insurance claims.

- I understand the information I have provided and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibly to inform this office of any changes to the information I have provided.

Signature: _____ Date: _____

□Adult Patient □Parent/Guardian □Spouse

AUTO RELATED ACCIDENT

Today's Date: ____/____/____

Name: _____

Date & Time of Accident: _____ □ a.m. □ p.m.

Were you the: □ Driver □ Front Passenger □ Rear Passenger

If a traffic violation was issued, to whom was it issued?

_____

Number of people in accident vehicle? _____
Did the police come to the accident site? □ Yes □ No
Was a police report filed? □ Yes □ No
Were there any witnesses? □ Yes □ No
Were you wearing your seatbelt? □ Yes □ No
Was this vehicle equipped with airbags? □ Yes □ No
If yes, did it/they inflate? □ Yes □ No
In relation to the base of you skull, where was the headrest? □ Above □ Below □ At base of skull
What did your vehicle impact? □ Another vehicle □ Other (Please explain) _____
Did any part of your body strike anything in the vehicle? □ Yes □ No
If yes, please describe: _____

_____

Make & model of the vehicle you were occupying?

_____

Name of the location/street on which you were traveling?

_____

In which direction were you headed? □ North □ South □ East □ West
What was the approximate speed of your vehicle? _____ mph
Did the impact of your vehicle come from the: □ Front □ Rear □ Right Side □ Left Side
During impact, were you facing: □ Right □ Left □ Forward
Were you: □ aware of or □ surprised by the impact
If accident vehicle made impact with another vehicle....
Make and model of the other vehicle? _____

_____

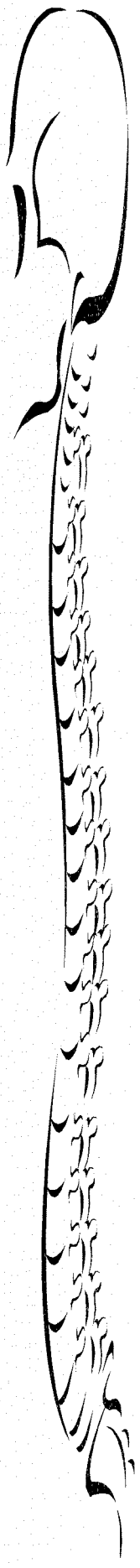
Direction other vehicle was headed? □ North □ South □ East □ West
Speed of the other vehicle? _____ mph
In your words, please describe the accident: _____

_____

_____

Have you retained an attorney? If so, whom? _____

AFTER INJURY



Did accident render you unconscious? □ Yes □ No
If yes, how long? _____

Please describe how you felt immediately after the accident: _____

_____

Have you gone to a Hospital or seen any other Doctor? □ Yes □ No
When did you go? □ Just after accident □ The next day □ 2 days plus
How did you get there? □ Ambulance □ Private Transportation
Name of Hospital and /or Attending doctor: _____

_____

Was he/she a: □ D.C. □ M.D. □ D.O. □ D.D.S.
Describe any treatment you received: _____

_____

Were X-rays taken?	□ Yes	□ No
Was medication prescribed?	□ Yes	□ No
Have you been able to work since this injury?	□ Yes	□ No
Are your work activities restricted as a result of this injury?	□ Yes	□ No

Indicate √ the symptoms that are a result of this accident:

□ Dizziness	□ Difficulty Sleeping	□ Jaw Problems	□ Nausea
□ Memory Loss	□ Irritability	□ Arms/Shoulder Pain	□ Back Pain
□ Headache(s)	□ Fatigue	□ Numb Hands/Fingers	□ Lower back pain
□ Blurred vision	□ Tension	□ Chest pain	□ Back stiffness
□ Buzzing in ear	□ Neck pain	□ Shortness of breath	□ Leg pain
□ Ears ringing	□ Neck stiff	□ Stomach upset	□ Numb Feet/Toes

□ Other _____

Is your condition getting worse? □ Yes □ No □ Constant □ Comes & goes

Indicate your degree of comfort while performing the following activities:

	Comfortable	Uncomfortable	Painful
Lying on back	□	□	□
Lying on side	□	□	□
Lying on stomach	□	□	□
Sitting	□	□	□
Standing	□	□	□
Lovemaking	□	□	□
Walking	□	□	□
Running	□	□	□
Sports	□	□	□
Working	□	□	□
Lifting	□	□	□
Bending	□	□	□
Kneeling	□	□	□
Pulling	□	□	□
Reaching	□	□	□

RECOVERY

To evaluate the effect that continuing work will have on your recovery please complete the following:

How many hours are in your normal work day? _____

Please indicate √ your daily job duties and any activities which you are occasionally asked to perform.

□ Standing	□ Driving	□ Operating equipment
□ Sitting	□ Twisting	□ Work w/ arms above head
□ Walking	□ Crawling	□ Typing
□ Lifting	□ Bending	□ Stooping

□ Other _____

What positions can you work in with minimum physical effort and for how long? _____

Prior to the injury were you capable of working on an equal basis with others your age? _____

Do you work with others who can help you with heavy lifting? _____

While in recovery, is there any light duty work you could request? _____

Robert Porzio, D.C. , P.C.
Chiropractic Kinesiologist
1153 West Main St.
Waterbury, Ct. 06708
Telephone (203) 756-7449
Fax(203) 597-1153

I understand that the charges for my treatment in this office for injuries I received as a result of an accident will be submitted to my auto med pay carrier and/or my health insurance. The standard charged per visit is $140.00: broken down as follows- spinal manipulation-$50.00, manual therapy technique-$50.00, therapy such as electric stimulation with hot packs, percussor and/or acupuncture-$40.00. I understand that I am financially responsible for:

My health insurance co-payment for each office visit.

Any treatments which would be over the approved number of visits for my health insurance treatment plan.

All treatments which go beyond the maximum billable amount of my health insurance and or my auto med pay policy.

Therapy charges that are not covered under my health insurance and which are deemed patient responsibility.

Any vitamins or medical supplies(ie: back supports, braces, etc) which Dr. Porzio feels are necessary for treatment program.

NAME:_____

DATE OF INJURY:_____

TODAY'S DATE:_____

ROBERT J. PORZIO, D. C., P. C.
CHIROPRACTIC KINESIOLOGIST

1153 WEST MAIN STREET
WATERBURY, CONNECTICUT 06708-2792

TELEPHONE (203) 756-7449
FAX (203) 597-1153

Missed Appointment Policy

You, the patient, must notify the office at least two hours prior to your appointment that you are unable to keep your appointment. Failing do due so will result in a fee.

If you can't make your appointment, please let us know as soon as possible so we can offer it to someone else. Your consideration is appreciated because the sooner you call us the greater our chances of providing this time to someone else. If a person fails to show for an appointment and does not provide at least 2 hours' notice prior to cancelling then our health care professionals will charge the rate of **$15.00** for payment of the missed appointment. These charges will not be billed to your insurance provider. Your appointment time is allotted to you so we will charge you for failure to call.

This policy applies to the following missed appointments:

- The appointment was not the person's first visit.
- The individual was previously informed of the policy.
- The cancellation was not due to a medical emergency.
- Failure to cancel in more than 2 hours' notice

This applies to **all** patients

Thank you for your cooperation in helping us provide the best care possible to you!

Print Name _____

Patient or Legal Guardians Signature: _____ ***Date:*** _____

PORZIO CHIROPRACTIC CENTER
1153 West Main Street
Waterbury, CT. 06708
(203) 756-7449

Acknowledgment of Receipt of Privacy Notice

I have been presented with a copy of Porzio Chiropractic Center **Notice of Privacy Policies,** detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I request the following restriction(s) concerning the use of my personal medical information:

_____

_____

_____

Further, I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to medical assignment of benefits apply.

Signed_____

Date:_____

If not signed by patient, please indicate relationship to patient (e.g., Guardian, HealthCare Administrator)

Relationship:_____

Date:_____

_____

Internal Use Only:
If patient or patient's representatives refuses to sign acknowledgment of receipt of notice, please document the date and time the notice was presented to patient and sign below.

Presented on (date and time)_____

By: (name and title):_____