APPLICATION FOR TREATMENT

PERSONAL INFORMATION

Name: _____ Today's Date: ____/____/____

Address: _____ City/State/Zip: _____

E-mail Address: _____

Birth Date: ___/___/___ Age: _____ Are you Pregnant: ❒ Yes ❒ No

Employer's Name & Address: _____

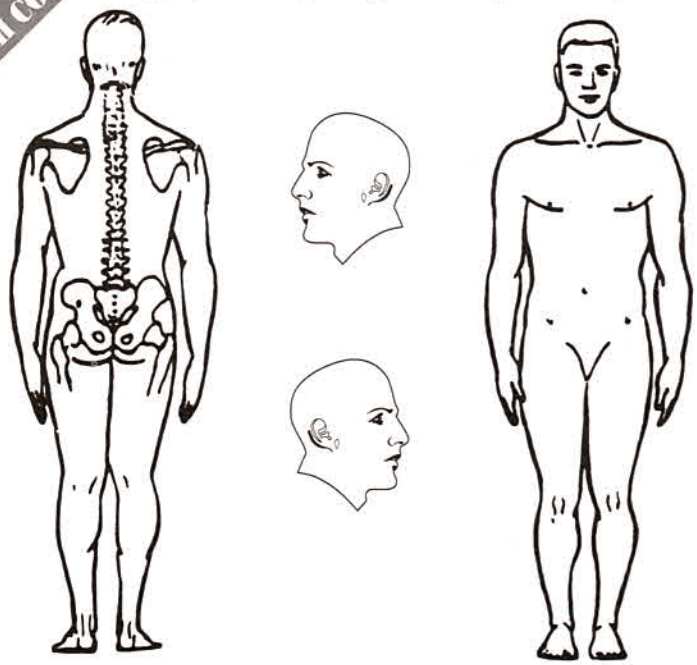
Occupation: _____ Work Phone No.: _____ Home Phone No.: _____

Who referred you to our office: _____

What type of care do you desire: ❒ Temporary Relief ❒ Lasting Correction ❒ Best Care Possible

CURRENT HEALTH CONDITION

Please circle the exact location of any pain you are experiencing. Then describe the type of pain, i.e. dull, sharp, constant, on & off, etc.



In order of importance, list the health problems you are most interested in getting corrected:

1) _____
2) _____
3) _____
4) _____
5) _____

In order of severity, list those body functions that you are unable to perform, or that produce pain upon performance, i.e. walking, sitting, bending, etc.

1) _____
2) _____
3) _____
4) _____
5) _____

When was the first time you noticed this problem:

_____

_____

Describe any accidents, falls, injuries, sudden movements, etc. that may have caused your problem: _____

_____

Have you had any similar health problems or injuries before? ❒ Yes ❒ No If yes, please explain: _____

_____

Names of all other doctors you have seen for this problem: _____

_____

Diagnosis and type of treatment you received (please include where and when you received treatment, and the results):

_____

_____

Has your health problem been: ❒ Improving ❒ Worsening ❒ Staying the Same

Please describe anything you do that improves your condition, or worsens it: _____

_____

Please check off and describe how this problem interferes with your work and/or personal life:

❒ Home Activities Effected: _____

❒ Work Activities Effected: _____

Have you missed any work days? ❒ Yes ❒ No If yes, dates missed: _____

❒ Recreational Activities Effected: _____

❒ Rest or Sleep Effected: _____

(Please complete reverse side.)

PREVIOUS HEALTH HISTORY

During the last year, has a doctor treated you for any health problem? ❒ Yes ❒ No
If yes, please explain: _____

_____

_____

Have you ever received Chiropractic care? ❒ Yes ❒ No If yes, please list the doctor's name, location of office and for what problems: _____

_____

_____

Please check off the drugs you are now taking: ❒ Pain Killers ❒ Muscle Relaxers ❒ Anti-inflammatory
❒ Blood Pressure Medication ❒ Insulin ❒ Birth Control Pills ❒ Tranquilizers ❒ Diet Pills
❒ Nerve Medication ❒ Sleeping Pills ❒ Anti-depressants ❒ Other (please list): _____

_____

List the approximate dates of any accidents, operations or serious injuries (including broken bones) you have had: _____

_____

_____

If you have been in an automobile accident, when? ❒ This Year ❒ Last Year ❒ Past 5 Years ❒ Over 5 Years

Please check off the following that apply to you within the past 2 years: ❒ Went to a Health Spa
❒ Purchased Vitamins ❒ Purchased Health Foods ❒ Received a Massage
Please explain why you choose to do any of the above: _____

_____

FAMILY HEALTH HISTORY

Marital Status: ❒ Married ❒ Single ❒ Widowed ❒ Divorced ❒ Separated

Names & Ages of Children: _____

Name of wife or husband: _____

Spouse's Employer: _____ Business Phone: _____

FINANCIAL RESPONSIBILITY

Who is responsible for your bill? ❒ I am ❒ Spouse (Spouse's Birthdate: ____/____/ ____)
❒ My Employer ❒ Insurance ❒ Other: _____

Type of Insurance: ❒ Worker's Comp. ❒ Health ❒ Automobile

Insurance Company's Name & Address: _____

_____

If you are responsible for your health care fees, payment will be made by: ❒ Cash ❒ Check ❒ Credit Card

Your fees are due and payable at the time examinations, X-rays, and treatments are received, unless other arrangements have been made in advance. X-rays remain property of this clinic.

I, the undersigned, hereby give permission for treatment.

Patient's Signature _____ Social Security No: _____ Date: ____/____/____

PERSONAL INJURY / WORKERS' COMPENSATION QUESTIONNAIRE

NAME: _____ Date of Accident: _____ Time: _____

Where did accident happen? _____

Describe the accident in your own words: _____

_____

_____

What was your position in car? ☐ Driver ☐ Passenger If passenger, were you sitting in ☐ Front ☐ Right Rear ☐ Left Rear

Did your vehicle strike other vehicle? ☐ Yes ☐ No Was your car struck by other vehicle? ☐ Yes ☐ No

Was the impact from: ☐ the front? ☐ from the right side? ☐ from the left side? ☐ from the rear?

At the time of impact were you: ☐ looking straight ahead? ☐ looking right? ☐ looking left?

Were both hands on steering wheel? ☐ Yes ☐ No Was your foot on brake? ☐ Yes ☐ No Were you braced for impact? ☐ Yes ☐ No

Where in the car were you after the accident? _____

Were you wearing seat belts? ☐ Yes ☐ No Did you strike anything in vehicle at time of impact? ☐ Yes ☐ No

If yes specify: ☐ Steering Wheel ☐ Dashboard ☐ Windshield ☐ Side Door ☐ Arm Rests ☐ Side Window

Please state part of body: ☐ Chest ☐ Chin ☐ Knee ☐ Shoulder ☐ Hand ☐ Head

Immediately following the accident how did you feel? _____

_____

Were you unconscious? ☐ Yes ☐ No In a daze? ☐ Yes ☐ No Did you go to hospital? ☐ Yes ☐ No

If you went to hospital, when? At time of accident ☐ Yes ☐ No Next day ☐ Yes ☐ No

How did you get to hospital? Ambulance ☐ Yes ☐ No Private Transportation ☐ Yes ☐ No

Did the ambulance attendants place you in: Neck Collar ☐ Yes ☐ No Splints: ☐ Yes ☐ No Brace: ☐ Yes ☐ No

Name of Hospital _____

Attended by Dr. _____ Were you x-rayed at hospital? ☐ Yes ☐ No

If so, what was the diagnosis? _____

Were you admitted to the hospital? ☐ Yes ☐ No How long did you stay? _____

What treatment was rendered? _____

What recommendations were made? See own doctor? ☐ Yes ☐ No See orthopedic doctor? ☐ Yes ☐ No

Physical Therapy ☐ Yes ☐ No

Have you seen any other doctor as a result of this accident? ☐ Yes ☐ No

Doctor's name _____

Is your pain constant? ☐ Yes ☐ No Is the pain on and off? ☐ Yes ☐ No Sharp? ☐ Yes ☐ No Dull? ☐ Yes ☐ No

Other _____

Is your pain worse when arising from a chair? ☐ Yes ☐ No Is it made worse by straining? ☐ Yes ☐ No By coughing? ☐ Yes ☐ No

By sneezing? ☐ Yes ☐ No By straining when moving your bowels? ☐ Yes ☐ No

Do you have any numbness or tingling in your arms? ☐ Yes ☐ No In your hands? ☐ Yes ☐ No In your fingers? ☐ Yes ☐ No

In your legs? ☐ Yes ☐ No In your feet? ☐ Yes ☐ No In your toes? ☐ Yes ☐ No

What is your most comfortable position? Sitting ☐ Yes ☐ No Lying on your right side ☐ Yes ☐ No Lying on your left side? ☐ Yes ☐ No

Lying on your back ☐ Yes ☐ No On your stomach ☐ Yes ☐ No Standing ☐ Yes ☐ No

Other _____ Is it difficult for you to move around in bed? ☐ Yes ☐ No

Does stretching and twisting worsen the pain? ☐ Yes ☐ No

Do any of the following relieve your pain? ☐ Heating Pad ☐ Hot Bath ☐ Shower ☐ Ice Pack

Does a brace (if you have tried one) help relieve the pain? ☐ Yes ☐ No

Does a change in heel height worsen the pain? ☐ Yes ☐ No Do you feel better moving around? ☐ Yes ☐ No Or resting? ☐ Yes ☐ No

Do you have a firm mattress? ☐ Yes ☐ No Do your knees ache or hurt? ☐ Yes ☐ No Do you have cramps in your leg? ☐ Yes ☐ No

In arm? ☐ Yes ☐ No Have you had any change in your bowel habits? ☐ Yes ☐ No

Have you lost any time from work because of this accident? ☐ Yes ☐ No

If yes, give dates of time lost. From _____ To _____

Totally disabled from _____ to _____ Partially disabled from _____ to _____

BEFORE YOUR ACCIDENT, estimate your total lifting effort ability:

1. How much weight? ☐ Maximum ☐ Average
2. How far could you carry this weight? _____ For how long a period of time? _____
3. Was this lifting done at work? ☐ Yes ☐ No Or at home or elsewhere? ☐ Yes ☐ No
4. How often did you carry this amount of weight? _____

AFTER YOUR ACCIDENT, describe your total lifting ability:

1. How much weight can you now lift without experiencing pain, discomfort, or restriction of motion? _____
2. Did you experience this pain, discomfort or restriction of motion before your accident? ☐ Yes ☐ No
3. How far can you carry this weight now? _____ And for how long a period of time? _____
4. How often can you carry this weight? _____
5. Are you now limited in your lifting ability in some body position that you were previously not? ☐ Yes ☐ No

   If so, specify position _____
6. What symptoms does lifting produce? _____
7. How long do these symptoms last? _____

Are you presently able to:

LIFT	☐ Very Heavy _____ lbs.	☐ Heavy _____ lbs.	☐ Light _____ lbs.	☐ Sitting _____ lbs.
WORK	☐ Very Heavy _____ lbs.	☐ Heavy _____ lbs.	☐ Light _____ lbs.	☐ Sitting _____ lbs.

What positions can you work in with a MINIMUM DEMAND of physical effort?

With Minimum Demand of physical effort, what positions can you work in PART-TIME and for how long?

☐ Standing ☐ Walking ☐ Sitting

With Minimum Demand of physical effort, can you work in a SITTING POSITION with some degree of walking or standing activity?

☐ Yes ☐ No

Do you feel that you cannot perform any physical work activity? ☐ Yes ☐ No

Do you feel that you cannot perform any mental work? ☐ Yes ☐ No

Relate your BEFORE injury capacity (mark 'B') and your AFTER injury capacity (mark 'A') for performing activities:

1. Walking	Normal _____	Limited _____	Difficult _____	Pain _____
2. Standing	Normal _____	Limited _____	Difficult _____	Pain _____
3. Sitting	Normal _____	Limited _____	Difficult _____	Pain _____
4. Bending	Normal _____	Limited _____	Difficult _____	Pain _____
5. Stooping	Normal _____	Limited _____	Difficult _____	Pain _____
6. Lifting	Normal _____	Limited _____	Difficult _____	Pain _____
7. Pushing	Normal _____	Limited _____	Difficult _____	Pain _____
8. Pulling	Normal _____	Limited _____	Difficult _____	Pain _____
9. Climbing	Normal _____	Limited _____	Difficult _____	Pain _____
10. Reaching	Normal _____	Limited _____	Difficult _____	Pain _____
11. Gripping	Normal _____	Limited _____	Difficult _____	Pain _____
12. Kneeling	Normal _____	Limited _____	Difficult _____	Pain _____
13. Balance	Normal _____	Limited _____	Difficult _____	Pain _____
14. Fatigue	Normal _____	Limited _____	Difficult _____	Pain _____

Generally speaking, is your inability to perform these functions due to ☐ Pain ☐ Weakness ☐ Structural limitations ☐ Nerves?

Do you have normal sexual function? ☐ Yes ☐ No

Are you able to take care of your personal self, such as dressing, bathing, etc? ☐ Yes ☐ No Or do you require assistance? ☐ Yes ☐ No

Do you feel your present condition is temporary? ☐ Yes ☐ No Or permanent? ☐ Yes ☐ No

Patient's Signature: _____ Date: _____

Patient Name:_____ Number_____ HWBP_____ Chiropad_____

Activities of Daily Living

Please circle all of the activities below that are affected by your condition. (Those activities that you cannot do or avoid performing, that cause you pain or aggravate your condition when performed.)

General:

- Bending
- Chewing
- Climbing stairs
- Exercising
- Getting in/out of auto
- Getting out of a chair
- Kneeling
- Lifting
- Lifting children
- Lying in bed
- Playing piano
- Reaching behind
- Reaching overhead
- Reading
- Running
- Sexual intercourse
- Sitting
- Sitting in recliner
- Sleeping
- Standing
- Swimming
- Using telephone
- Using typewriter/computer
- Walking

Exercise:

- Baseball
- Basketball
- Cycling
- Golf
- Hockey
- Lifting weights
- Running
- Soccer
- Tennis
- Working out in Gym

Housework:

- Caring for pets
- Carrying groceries
- Cooking
- Doing Laundry
- Dusting
- Ironing
- Making beds
- Vacuuming
- Washing dishes

Personal Grooming:

- Brushing teeth
- Combing hair
- In/out bathtub
- Putting on bra
- Putting on socks
- Shaving

Travel:

- Driving
- Flying
- Riding (passenger)

Yard work:

- Gardening
- Hammering
- Mowing lawn
- Painting
- Raking leaves
- Sawing

Patient's signature: _____Date:_____

For Office Use Only

Smoker _____ Non Smoker _____ Former Smoker_____ H _____ W _____ BP _____ P _____

Health _____

ADL's _____

Prescriptions

Medication

- Active NKM _____
- Allergies NKDA _____

Nutrition

- Active NKNS _____
- Allergies NKNA _____

FAMILY HEALTH HISTORY

To help the doctor determine if your health problem is hereditary: 1) please check off (✓) the health problems of your family members; 2) leave blank those health problems they don't have; 3) circle those relatives who live within 30 miles of you, as some hereditary conditions are affected by a similar climate.

Patient Name: _____ **Date:** _____

HEALTH PROBLEM	MOTHER Age ( )	FATHER Age ( )	BROTHER(S) Age ( )	BROTHER(S) Age ( )	SISTER(S) Age ( )	SISTER(S) Age ( )	SPOUSE Age ( )	CHILDREN Age ( )	CHILDREN Age ( )	CHILDREN Age ( )
Allergies										
Arm Pain – Numbness/Tingling										
Arthritis										
Asthma										
Back Pain										
Bursitis, Tendinitis										
Cancer										
Constipation										
Diabetes										
Disc Problems										
Emphysema										
Epilepsy										
Hand Pain – Numbness/Tingling										
Hay Fever										
Headaches										
Heart Trouble										
High Blood Pressure										
Insomnia										
Kidney Trouble										
Leg Pain – Numbness/Tingling										
Liver Trouble										
Low Blood Pressure										
Migraine										
Neck Pain										
Nervousness										
Neuritis										
Neuralgia										
Pinched Nerves										
Scoliosis										
Shoulder Pain										
Sinus Trouble										
Stomach Trouble										
Whiplash										

If any of your immediate family members (Mother, Father, brother, sister, or children) are deceased, please list their age at death and cause: _____

_____

_____

Dr. Gerald A.Nadeau - Dr. Robert G. Nadeau
336 Center St., Auburn, ME 04210 ~ T: (207) 777-1104 F: (207) 777-7354 ~ drgnadeau@gmail.com

HIPPA NOTICE TO PATIENT

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice.

Patient Name:_____ Date of Birth:_____

Address:_____

Home Phone:_____ Cell Phone:_____ Work Phone:_____

Email Address:_____

I,_____ authorize Nadeau Chiropractic Associates to discuss Information pertaining to my appointments, treatments, financial matters and In case of an Emergency to:

Name: _____

Phone Number: _____

I acknowledge that I have received and had the opportunity to review the Notice of Privacy Practices on the date below on behalf of Nadeau Chiropractic Associates. I understand that this information can and will be used to: Conduct, plan and direct my treatment and follow up among the healthcare providers who may be directly and indirectly involved in providing my treatment. Obtain payment from third party payers.Conduct normal healthcare operations such as quality assessments and accreditation.

I understand that the notice describes the uses and disclosures of my protected health information by Nadeau Chiropractic Associates and informs me of my rights with respect to my protected health information.

_____ _____
Patient's Signature or legal Representative Today's Date

_____ _____
Print Name of Patients Representative *Legal Representative Relationship*

FOR OFFICE USE

We have made every effort to obtain written acknowledgement of receipt of out Notice of Privacy from this patient but it could not be obtained because:
___ The patient refused to sign ___ Due to emergency situation it was not possible to obtain an acknowledgement ___Communication barriers prohibited obtaining the acknowledgement

NADEAU CHIROPRACTIC ASSOCIATES
Dr. Gerald A. Nadeau - Dr. Robert G. Nadeau
336 Center St., Auburn, ME 04210 ~ T: (207) 777-1104 F: (207) 777-7354 ~ drgnadeau@gmail.com

Notice of Receipt of Privacy Notice of Nadeau Chiropractic Associates

By signing below, I acknowledge that I have received and reviewed the Privacy Notice of Nadeau Chiropractic Associates, in force as of April 14, 2003 and all of my questions have been answered to my satisfaction in language that I can understand.

_____ _____
Name of Individual (printed) Signature of Individual

_____ _____
Signature of Legal Representative (e.g., Attorney-In-Fact, Guardian, Parent if a minor): Relationship

Date Signed ____/____/____ Witness:_____

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Irrevocable
Assignment, Lien and Authorization
Insurance Benefits and Attorney

To Whom it May Concern:

I hereby authorize and direct you, my insurance company, and/or my attorney, to pay directly **Nadeau Chiropractic Associates** such sums may be due and owing this Office for services rendered me, both by reason of accident or illness, and by reasons of any other bills that are due this Office, and to withhold such a sums from any disability benefits, medical payment benefits, no-fault benefits, health and accident benefits, Worker's Compensation benefits, or any other insurance benefits obligated to reimburse me or from any settlement, judgment or verdict on behalf as may be necessary to adequately protect said Office. I hereby further give lien to said Office against any and all insurance benefits named herein and any and all proceeds of any settlement, judgment or verdict which may be paid to me as a result of the injuries or illness for which I have been treated by said office. This is to act as an assignment of my rights and benefits to the extent of the Office's services provided.

In the event that my insurance company obligated to make payments to me upon the charges made by this Office for their services refuses to make such payment, upon demand by me of this Office, I hear by assign and transfer to this Office any and all causes of action that I might have or that might exist in my favor against such company and authorize this Office to prosecute said cause of action either in my name or in the Office's name and further I authorize this Office to compromise, settle or otherwise resolve such claim or cause of action as they see fit.

I understand that I remain personally responsible for the total amounts due the Office for their services. I further understand and agree that this Assignment, Lien, and Authorization does not constitute any consideration for the Office to await payments and they may demand payments from me immediately upon rendering services at their option.

I authorize the Office to release any information pertinent to my case to any insurance company, adjuster or attorney to facilitate collecting collections under the Assignment, Lien and Authorization. I agree that the above mentioned Office be given Power of Attorney to endorse/sign my name on any and all checks for payment of my doctor bill.

I further understand and agree that if this Office must take any action to collect an outstanding balance on my account, I will be responsible for payment of and will reimburse the Office for all costs of such collection efforts, including but not limited to all court costs and attorney fees.

Signed_____Date:_____

Witness:_____Date:_____

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Workman Compensation Claims

If you are receiving care from Nadeau Chiropractic Associates because of a work related injury, fall, or as a result of other sudden work related trauma, we will bill your Workman's Compensation insurance carrier, as well as, any and all liability insurers involved. If you do not have health insurance, regular payments must be made if responsibility has not been controverted by Workman's Compensation Insurer.

We will be glad to cooperate with attorneys, insurers, adjusters and other parties involved in your case, and will release information to them with your specific authorization. We cannot, however, suspend monthly billings or assign responsibility for payment of your account to other parties without their written consent.

Because Nadeau Chiropractic Associates has no control over the outcome of any Workman's Compensation decision resulting from your injury, responsibility for payment of your account remains with you.

Should you decide to discontinue care without a proper discharge from Nadeau Chiropractic Associates, all unpaid services will be billed directly to you. If you have an attorney who has signed a lien form acknowledging your outstanding bill here in our office, we will continue to bill you however will withhold any collection procedures of the unpaid amount until settlement has been made. If you do not have an attorney protecting your interest, payment arrangements must be made to clear any remaining balance.

Patient name: _____

Witness: _____

Date: _____

VERIFICATION OF INSURANCE COVERAGE

Nadeau Chiropractic Associates _____ Date/Time _____

PATIENT INFORMATION

Name: _____ DOB: _____ Patient # _____

Relationship to Insured: Self ___ Spouse ___ Child ___

INSURED INFORMATION (POLICY HOLDER)

Name: _____ TID# _____

DOB: _____ Group # _____

INSURANCE PAYER INFORMATION

Carrier Name: _____

Name of Insurance Representative: _____

Phone: _____ Electronic Claims to _____

Mail Claims to: _____

COVERAGE DETAILS

Effective Date: _____
Referral Needed: __ Yes __ No
Deductible: __Yes __ No Amount: $_____
Met? __ Yes __ No Next Due _____
Copay: $% _____
X-Rays Covered: __ Yes __ No
Out of Pocket Amount: $_____
Visit Limit: _____

CPT CODE COVERAGE

97140 Manual Therapy	__ Yes __ No
98943 M8	__ Yes __ No
29200 – 29500	__ Yes __ No
99201 – 99204	__ Yes __ No
Taping Codes	__ Yes __ No

BENEFITS SUMMARY

Pre-Existing Conditions: __ Yes __ No
Carryover Clause for Deductible: __ Yes __ No

REPORTING REQUIREMENTS

Special Reports Needed: __ Yes __ No If yes, when _____

The Doctor's treatment plan will be based upon what he determines is in the best interest for your health and benefit. Please note: We have no influence over your insurance company's reimbursement policies or rationales for denials. We will report clinical information to your Primary Care Physician and insurance company to ensure maximum benefit reimbursement. However, please be aware that you will be responsible for the cost if your insurance company limits the number of adjustments, exams or services, (ie: modalities, exercises, etc.).

We recommend that you verify your chiropractic insurance coverage as well.

Patient Signature: _____ Date: _____

Witness: _____ Date: _____