NEUROMUSCULOSKELTAL CHIROPRACTIC AND REHABILITION ASSOCIATES

760 W. Lincoln Highway
Exton, PA 19341
Office (610)594-5502 fax 610594-1017

MVA
New Patient and Insurance Information

Name:_____ Date:_____

Address:_____ Apt.#_____

City:_____ State:_____ Zip:_____

Home Phone:_____ Work Phone:_____ Cell#_____

Birth Date:_____ SS#_____

Martial Status M S D Sep Spouse Name:_____ # of Children:_____

Referred by:_____ Age of Children:_____

Employer:_____ Occupation:_____

Address_____

City:_____ State:_____ Zip:_____

HEALTH INSURANCE INFORMATION:
Name of Carrier:_____ ID#_____ Group#_____

Subscriber of Policy: Name_____ **Date of Birth:**_____

Subscriber's Address_____

Relationship to Subscriber:_____

AUTO ACCIDENT INSURANCE INFORMATION:
Carrier_____ Policy #_____

Address_____ City:_____ State_____

CLAIM#_____ Phone #_____

Contact Person_____

Date of Accident:_____ Patient relationship to Insured_____

NEUROMUSCULOSKELETAL CHIROPRACTIC & REHABILITATION ASSOCIATES

DR CARL HILLER **DR JOSEPH VERNA**

PATIENT CONSENT FORM

I, understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- **Conduct plan and direct my treatment and follow-up among multiple healthcare providers who may be involved in that treatment directly and indirectly.**
- **Obtain payment from third-party payers.**
- **Conduct normal healthcare operations such as quality assessments and physician certifications**

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change the Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used and disclosed to carry out treatment, payment or health care operations. I understand that you are required to agree to my requested information.

Print Name:_____

Signature:_____

Date:_____

Witness:_____

Financial Policy/ Agreement/Insurance Coverage

Neuromusculoskeletal Chiropractic & Rehabilitation Associates is dedicated to providing our patients with the best possible care and services while keeping the costs to you from increasing at an unreasonable rate. Our experience has proven, that it is wise to have an understanding with our patients, as to our office policies. We provide several methods of payment for treatment at our office, and you may choose the plan which best fits your needs. Please read carefully and choose the plan you prefer.

Insurance-If you have insurance that covers treatment, you may pay cash for your visit, and will give you a receipt to bill your insurance, or as a courtesy, we will bill your insurance directly. If your insurance does not cover our services, you will be responsibility for incurred costs. All co-payment, co-insurance and deductibles are the patients responsibility and are due at time of visit. HMO insurances require referrals for services. It is the patients responsibility to obtain the referral prior to the time of service. If a referral was not obtained either by paper or electronic, the patient is responsible for payment in full for that date of service or until a referral is presented.

It is important for you to understand your own insurance policy and your health insurance coverage. This is an agreement between you and your insurance company and your Doctor's bill for services provided to you is an agreement between you and your Doctor.

Motor Vehicle/Workers Compensation-We will bill your motor vehicle insurance and /or workers compensation insurance. Please note, should your case be place in review, for either personal injury, worker's compensation or motor vehicle, and your insurance determines care is not reasonable and necessary, or your employer denies your workers comp claim, and you wish to continue treatment, we will bill your personal health insurance (if it covers Chiropractic), and you will be responsible for all your bills. Should your benefits become exhausted with respect to your motor vehicle insurance , we will bill your personal health insurance (if it covers Chiropractic). You will be responsible for your co-pays, co-insurance and deductible. We will gladly accept a letter of protection with your attorney's signature and your signature to cover the outstanding amount to your account.

Cash-Cash plans are available for patients who do not have coverage for our services. Fees are to be paid at time the service is rendered unless special arrangement are made in advance with the billing manager.

All payments are expected at time of service and any outstanding balances are due within 30 days. All balances that reach 90 days past due will be sent to a collection agency. Should your account be sent to a collection agency, you will be financially responsible for all collection fees and legal fees that our office incurs, through this process to collect outstanding delinquent balance. In addition, payment in full will be expected at the time of service for any future services.

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AUTHORIZATION:

I certify that I have read and understand that all information to the best of my knowledge is correct. All questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the Doctor to release any information including diagnosis and the records for treatment or examination rendered to me or my child during the period of such care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the Doctor insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment for all services rendered on my behalf or my dependents.

_____ _____

Signature of Patient (or parent if a minor) **Date**

Name:_____ **Date:**_____

Medical reactions/Allergies _____**NKDA**_____**NKA to tape**_____**NKA to latex**
_____**NKA to IV contrast** _____**NKA to foods**

Substance	**Reaction**

Anticoagulant Medications: (Coumadin, Warfarin, Low Molecular weight Heprin, Lovenox,Fragmin, Innohep) ____**other** ____ **none**

Antiplatelet Medications: (Plavix, Platel, TICLID) ____**other** ____**none**

Medications: (list all current medications including over the counter Herbs/Doses/Schedule)

Have you ever had

Yes	**No**		**Yes**	**No**	
___	___	**Aids/Hiv positive**	___	___	**High Cholesterol**
___	___	**Anemia**	___	___	**Kidney Disease**
___	___	**Anxiety/Depression**	___	___	**Migraines/Headaches**
___	___	**Arthritis**	___	___	**Osteoporosis**
___	___	**Asthma**	___	___	**Psychiatric/Emotional Problems**
___	___	**Bleeding Disorders**	___	___	**Sickle Cell**
___	___	**Cancer/Lymphoma/Leukemia**	___	___	**Ulcers/Gastroesaphogeal/Reflux**
___	___	**Dermotolic/Skin Disorders**	___	___	**Stroke**
___	___	**Diabetes**	___	___	**Thyroid Disease**
___	___	**Emphysema/Bronchitis**	___	___	**Tuberculosis**
___	___	**Epilepsy**	___	___	**Blood Clots/Bleeding Disorders**
___	___	**Gall Bladder Disease**	___	___	**Hospitalization**
___	___	**Glaucoma**	___	___	**Other**_____
___	___	**Heart Disease/Heart Attack**			
___	___	**High Blood Pressure**			

List Type of Surgery & Year Performed:
1._____
2._____
3._____
4._____

List Non-Surgical Hospitalization:
1._____
2._____
3._____
4._____

Please check the box if anyone in your family has the following and list family member

Yes	**No**		**Yes**	**No**	
___	___	**Birth Defects**_____	___	___	**High Blood Pressure**_____
___	___	**Breast Disease**_____	___	___	**High Cholesterol**_____
___	___	**Cancer**_____	___	___	**Osteoporosis**_____
___	___	**Diabetes**_____	___	___	**Stroke**_____
___	___	**Heart Attack**_____	___	___	**Bleeding Disorder**_____
___	___	**Heart Disease**_____	___	___	**Other**_____

Name:_____ Date:_____
Presently Employed: __Yes __No Occupation or Previous Occupation:_____
Tobacco use: ___Yes___No No__ Packs/Day___ No of years
Alcohol use: ___Yes___No How often/Amount/type_____
Street Drugs ___Yes___No
Martial Status M S D W

Skin: __No Significant History
__Psoriasis __ Eczema __Acne __Other

Hematologic:__No Significant History
__Easy Bruising __Clots
__Easy Bleeding __ Anemia_____

HEENT:
__Tinnitus __Dysphagla __Glasses/Contact Lenses
__Visual Disturbances __Hearing Aid __Hair piece/weave
__Discharge __Dentures __Other_____

Neurological:__ No Significant History
__Headaches __Memory Loss __Back/Neck Pain
__Dizziness __Anxiety/Depression __Numbness
__Paralysis __Fatigue __Weakness
__Seizures __Other_____

Cardiovascular: __No Significant History
__Chest Pain __HTN __AICD
__MI __Palpitations __Angina
__Syncope __Pacemaker
__Other_____Name of Cardiologist:_____

Gastrointestinal: __ No Significant History
__Change of appetite __Abdominal Pain __Reflux
__Jaundice __Weight Change __Change in Bowel
__Nausea/vomiting __Other_____

Urinary: __No Significant History OB/GYN__No Significant History
__Dysuria __Polyuria __Renal Failure __Dyshenorrhea __Possibility of Pregnancy
__Frequency/Hesitancy __Hematuria __Cancer __Other

Endrocrine: __No Significant History
__Heat/Cold Intolerance __Adrenial Problems __Scleroderma __Rheumatoid Arthritis
__Thyroid Problems __Pituitary Problems __Lupus

Pulmonary: __ No Significant History
__SOB __Pneumonia __Orthopnea
__TB __Asthma __Hemoptysis
__Cough __DOE __Emphysema
__Sleep Apnea __Oxygen at Home __Other_____

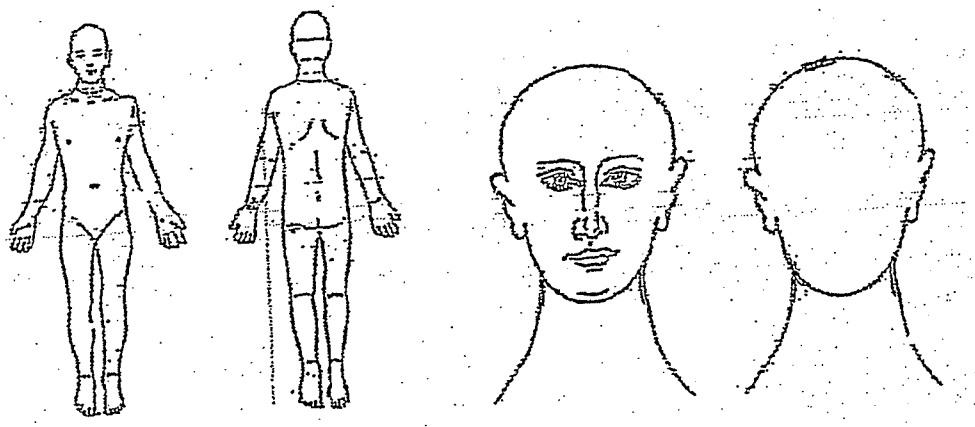
Musculoskeletal:
__No Significant History
__Pain __DVT __Cane/Walker __Arthritis
__Swelling __Wheel Chair
__Prosthesis/Implants/Artificial Joints __Yes __No Type:_____

Name:_____ **Date:**_____

LOCATION OF PAIN OR OTHER SYSTEMS **PAIN INTENSITY**

0 2 4 6 8 10

On Diagram indicate pain location



Circle type of Pain/Symptom
Pressure
Burning
Achy
Stabbing
Numbness
Pins & Needles

Location of Pain:_____
Other related symptoms:_____

What makes pain worse:_____

What makes pain better: _____

Pain History,(When & How did your pain begin, has it changed)_____

Procedures and Medications tried in the past/Were they helpful?_____

Previous Pain Treatments/Doctors_____

What are your goals?_____

What would you do if your pain decreased?_____

AUTOMOBILE ACCIDENT HISTORY

Name:_____Date:_____Date of Injury_____

Was the accident on the job? ___Yes ___No
Where were you seated in the vehicle?_____
Name of person driving vehicle_____

Your Vehicle (year, make, model)_____
Your estimated speed at the time of the accident_____ ___Stopped ___Slowing ___Accelerating
If stopped was your foot on the brake ___Yes ___No

Other Vehicle (year, make, model)_____
Estimated speed of the other vehicle at the time of accident____ __Stopped ___Slowing ___Accelerating

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Road Conditions at the time of the accident:
___Dry ___Damp ___Wet ___Snow ___Ice
Time of day:
___Daylight ___Dawn ___Dusk ___Dark
–

Head restraints,
How far is the top of the headrest or seat back from the back of your head?_____inches
If adjustable, was the position of the headrest altered by the accident? ___Yes ___No
Was the seat back adjusted by the accident? ___Yes ___No

Seat Belts and Air Bags:
Were you wearing a seatbelt? ___Yes ___No ___Don't know
What type? ___Lap seat belt ___Shoulder seat belt ___Shoulder Lap seatbelt
Did your air bag deploy? ___Yes ___No
If yes, were you struck? ___Yes ___No Where?_____

Head and Body Position:
Which way was your body pointed at the point of the impact? ___Straight ___Right ___Left
Which way was your head pointed at the point of the impact? ___Straight ___Right ___Left

_____ _____
Patient Signature Date

ACCIDENT DIAGRAM

In the space below, please describe, to the best of your knowledge, what happened during this accident

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During the Crash:

Position of hands ___One the Wheel ___Two on Wheel ___N/A

Did you strike any parts of the vehicle? ___Yes ___No

If yes, please describe_____

Did vehicle strike any objects after the crash? ___Yes ___No

If yes, please describe_____

Were you aware or surprised of the approaching collision? ___Aware ___Surprised

Were you wearing a hat or glasses? ___Yes ___No

If yes were they still on after the crash ___Yes ___No

Did you lose consciousness (black out) upon impact? ___Yes ___How long? ___No

Did you experience a flash of light or explosion in your head? ___Yes ___No

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After the Crash:

Did you become ___Confused ___Disoriented ___Lightheaded ___Dizzy ___Nauseated
___Blurred vision ___Ring/Buzz in ears

If you still have any of those symptoms, which ones_____

Are you currently suffering from any of the following:

___Restlessness ___Irritable ___Difficulty concentrating ___Difficulty with memory
___Sleeplessness ___Forgetful ___Reduced tolerance to heat ___Reduced tolerance to alcohol

Did the police come to the accident scene ?___Yes ___No **Is there an accident report?** ___Yes ___No

_____ _____

Patient signature **Date**

PLEASE LIST ALL PREVIOUS TREATMENTS FOR CONDITIONS RELATED TO THIS ACCIDENT

1. **Name** _____
Address:_____
Phone #:_____
Specialty:_____
Dates of Care_____
Tests/Treatments_____
Results:_____
_____

2. **Name:**_____
Address:_____
Phone#:_____
Specialty:_____
Dates of Care:_____
Tests/Treatments:_____
Results:_____
_____

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3. **Name:**_____
Address:_____
Phone#:_____
Specialty:_____
Dates of Care:_____
Test/Treatments:_____
Results:_____
_____

4. **Name:**_____
Address:_____
Phone#:_____
Specialty:_____
Dates of Care:_____
Tests/Treatments:_____
Results:_____
_____

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5. **Name:**_____
Address:_____
Phone#:_____
Specialty:_____
Dates of Care:_____
Tests/Treatments:_____
Results:_____
_____

6. **Name:**_____
Address:_____
Phone#:_____
Specialty:_____
Dates of Care:_____
Tests/Treatments:_____
Results:_____
_____

Patient Signature:_____ **Date:**_____

RECISSION OF ATTORNEY ASSIGNMENT OF BENEFITS

Patient:_____

Insured_____

Date of Injury:_____

Claim#/Policy#_____

I, being insured on this policy, specifically direct you, my insurance company, to rescind and cancel any assignment given to you by any third party including my attorney, EXCEPT to my physician as follows:

Dr._____

Address:_____

_____

As the owner and beneficiary of this policy, I further direct that reimbursement for ALL services to be paid to the physician/provider above named, under the terms of my contract. No other third party, including my attorney, should receive payment of my medical bills, except the treating physician for the remainder of this claim.

Thank you for your cooperation in this matter.

Patient/Insured Signature_____ **Date**_____

AGREEMENT FOR PAYMENT OF CHIROPRACTIC, THERAPY AND/OR OTHER MEDICAL SERVICES

This agreement is entered into for and in consideration of services rendered by NEUROMUSCULOSKELTAL CHIROPRACTIC & REHABILITATION ASSOCIATES and in consideration of their agreement to provide Chiropractic, therapy and/or other medical services to_____ in connection with

_____.

I_____ hereby, authorize and direct my Attorney, _____Esquire, to pay directly to NEUROMUSCULOSKELETAL CHIROPRACTIC & REHABILITATION ASSOCIATES any outstanding balance due and owing for such chiropractic, therapy and/or other medical services rendered to me for my accident and to withhold such sums from any settlement, judgment or verdict recovered in my favor as may be necessary to adequately pay said medical bills. I direct my attorney to contact NEUROMUSCULOSKELETAL CHIROPRACTIC & REHABILITATIN ASSOCIATES at the time of settlement of my claim to notify them of the recovery and to obtain a statement of my accounts. In addition, I agree that no distribution of monies will be made to me until such time as my undisputed medical bills and costs have been paid.

In the event another Attorney or law firm is substituted in the prosecution of my claim, the new Attorney must honor this agreement.

I fully understand that I am directly and fully responsible to NEUROMUSCULOSKELETAL CHIROPRACTIC & REHABILITATION ASSOCIATES for all outstanding bills for chiropractic, therapy and/or other medical services rendered to me in connection with the above mentioned matter. I further understand that such payment obligation is not contingent on the successful settlement, judgment or verdict by which I may eventually recover monies and it continues to be my separate obligation to pay in full if no monies are recovered in connection with my accident case.

Patient Signature:_____ Date:_____

The undersigned being of record for the above named client in connection with the said accident case, does hereby agree to observe all the above terms and agrees to withhold such sums from any settlement, judgment, ot verdict as may be necessary to adequately protect and pay in full the outstanding balance due to NEUROMUSCULOSKELETAL CHIROPRACTIC & REHABILITATION ASSOCIATES arising from the above mentioned accident.

Attorney's Signature_____ Date:_____