Gary Seghi, D.C. 1613 W. 6th Street, Austin, TX 78703

Referred by: ___________________________

Office Use Only:

Patient Account Number ____________________

Today's Date ___________________________
Full Name ___________________________
Address ___________________________
City ___________________________
State ___________________________
Zip Code ___________________________
Telephone ___________________________

Age ___________________________
Birth Date ___________________________
SS# ___________________________
Race ___________________________
Sex ___________________________
Marital Status ___________________________
Age of Children ___________________________

Occupation ___________________________
Employer ___________________________
Address ___________________________
City ___________________________
State ___________________________
Zip Code ___________________________
Telephone ___________________________

Emergency Contact ____________________
Relationship___________________________
Telephone ___________________________

Insurance Information – Your automobile Personal Injury Protection Insurance Company

Company ___________________________
Address ___________________________
City ___________________________
State ___________________________
Zip Code ___________________________

Adjuster's Name___________________________
Telephone ___________________________
Policy # ___________________________
Claim # ___________________________
Insured's Name___________________________

Motor Vehicle Accident Information

Date of Accident ___________________________
Location of Accident___________________________
How did the accident occur?___________________________

Were you the	Driver	Passenger		
Was your vehicle hit from	Behind	Front	Left Side	Right Side

YES NO Were you wearing a safety belt?
YES NO Was your neck or body rotated in the car seat upon impact?
YES NO Did you anticipate and/or were you bracing yourself for the collision?
YES NO Did you strike your head or body against any part of the vehicle? If yes, what parts?
____
YES NO Did you feel stunned?
YES NO Did you lose consciousness?
YES NO Were you able to get out of the vehicle and walk?
YES NO Could you move all parts of your body after the collision? If not, explain.
____
YES NO Was the accident reported to the police?
YES NO Were there any citations issued? If yes, to whom?___________________________
YES NO Have you lost any time off of work? If yes, From____________________ TO____________________

Account#____________________

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Patient Name ______________________________

Instructions for completing pages 2 – 4:
1. Answer questions as completely as possible.
2. Circle the **CONDITIONS** that ***APPLY*** to you.
3. Circle the **YES/NO** options.

1. Your chief complaint is: ______________________________
2. Date the condition began: ______________________________
3. What were you doing? ______________________________
4. How often does it bother you? **CONSTANT DAILY WEEKLY MONTHLY YEARLY**
5. How long does the discomfort last? **CONSTANT MINUTE(S) HOUR(S) DAY(S) WEEK(S)**
6. What does it prevent you from doing? ______________________________
7. Have you had this or a similar condition before? **YES NO If yes, when:** ____________
8. What have you done yourself to ease the problem? ______________________________
____
9. What do you think is wrong with your body? ______________________________
10. How has your complaint altered your lifestyle? ______________________________
____
11. Did you receive emergency room care? **YES NO If yes, when?** ____________
12. Did your complaint require hospitalization? **YES NO If yes, when?** ____________
13. List healthcare providers seen for this condition:

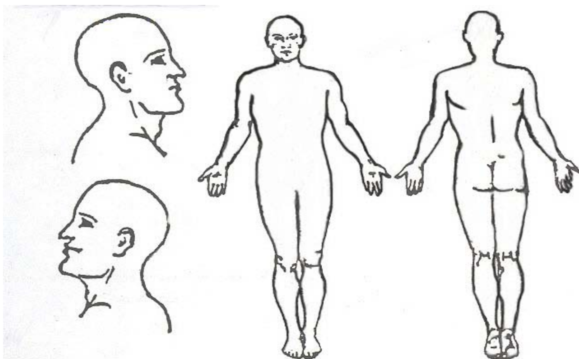
	Name	**Date**	**Diagnosis**
Chiropractor			
MD			
Osteopath			
Acupuncturist			
Physical Therapist			
Rehabilitation Center			
Massage Therapist			
Other			

14. For Women Only: Is there any chance you may be pregnant? **YES NO**
15. List any medications which you are currently taking ______________________________
16. Give the date of any of the following tests or procedures that have been performed on you:

	Date		**Date**
X-Rays		Urinalysis	
CT		Blood Work	
MRI		"Med. Dose Pack"	
EMG		Cortico-steroid Injection	
EEG		Discectomy	
Mylogram		Laminectomy	
Bone Scan		Spinal Fusion	

On the diagrams below:

17. Place a **CIRCLE** where you hurt
18. Draw an **ARROW** from the circle if the pain radiates or travels to other parts of the body
19. Place **X's** at the areas of numbness or tingling



20. If you have more than one complaint, please list them in the order of severity with 1 being the most severe.

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________

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Patient Name ____________________________

Instructions:
Place a check mark next to the descriptions that apply to your present condition provide detailed descriptions where possible.

21. For your chief complaint, indicate if it is:
_____ constant pain
_____ intermittent pain (fluctuates)

It is:
_____ getting worse
_____ getting better
_____ staying the same

It feels:
_____ like a dull ache
_____ primarily dull but sharp at times
_____ sharp or stabbing
_____ like a "catch"
_____ electrical
_____ throbbing
_____ burning
_____ deep
_____ muscular tightness (ache)

How else would you describe your pain?

____

It is most severe:
_____ with activity
_____ in certain positions
_____ in early morning
_____ toward evening
_____ when sleeping

What else will make the pain worse?

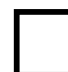
____

22. Indicate whether the following activities **HELP** or **HURT** your condition:

HELPS	**HURTS**	
______	______	rest
______	______	lifting
______	______	sitting
______	______	driving
______	______	walking
______	______	standing
______	______	sneezing
______	______	coughing
______	______	stairways
______	______	turning head
______	______	carrying things
______	______	general activity
______	______	bending forward
______	______	bending backward
______	______	laying on stomach
______	______	laying on back
______	______	prolonged sitting or standing
______	______	moving from sitting to standing

23. Indicate if you have noticed any of the following conditions since your complaint began:
_____ fatigue
_____ chest pain
_____ depression
_____ loss of memory
_____ anxiety about the future
_____ shortened attention span
_____ harder to concentrate or focus
_____ stressed out more easily
_____ frustrated more easily
_____ sleeping problems
_____ more irritable
_____ less patient
_____ tension
_____ diarrhea
_____ constipation
_____ loss of taste
_____ loss of smell
_____ loss of balance
_____ buzzing in ears
_____ fainting
_____ dizziness
_____ cold sweats
_____ face flushed
_____ nervousness
_____ stomach upset
_____ shortness of breath
_____ headache
_____ migraines
_____ light bothers eyes
_____ numbness in legs
_____ numbness in feet
_____ numbness in toes
_____ numbness in arms
_____ numbness in fingers
_____ stiff neck
_____ ache in back
_____ tight muscles
_____ pins and needles in legs
_____ pins and needles in arms
_____ muscle twitching in arms or legs
_____ loss of strength in handgrip or in arms
_____ loss of strength in legs

24. If you need to expand your responses to this questionnaire, or have any other matter you wish to have Dr. Seghi address, please check the box below and continue your comments on the reverse side of this page.



Patient Name ______________________________

Instructions
Answer questions as completely as possible and circle the **YES/NO** options as they apply.

25. Have you been treated for or had the following conditions at **ANY** time in your life. Circle YES or NO and provide a brief description and date of occurrence.

If **YES** – Date/Brief Descr.

YES **NO** Any physical deformity or defect?……………………………………………________________________
YES **NO** Any surgical procedures or implants? ………………………………………________________________
YES **NO** Cyst, tumor, cancer, or blood disorder?……………………………………________________________
YES **NO** Any disorder of your eyes, ears, nose, or throat?…………………………________________________
YES **NO** Any diabetes, thyroid, or other glandular disorder?………………………. ________________________
YES **NO** Any disorder of your skin, lymph nodes, or breasts?………………………________________________
YES **NO** Any disorder of your lungs or respiratory system?…………………………________________________
YES **NO** Any arthritis, bursitis, sciatica, gout, or recurrent back pain?………………..________________________
YES **NO** Any disorder of your back, spine, muscles, bones, or joints?……………….________________________
YES **NO** Any asthma, emphysema, shortness of breath, or chronic cough?………...________________________
YES **NO** Any disease of your stomach, intestines, gallbladder, or liver?……………..________________________
YES **NO** Any recurrent abdominal pain, indigestion, ulcers, diarrhea, or colitis?……________________________
YES **NO** High blood pressure, chest pain or angina, heart murmur, or any disorder of your heart or blood vessels?………………………………………________________________
YES **NO** Seizure disorder, fainting spells, paralysis, nervous or mental disorder, dizziness, or any disease or abnormality of your brain or nervous system?. ________________________
YES **NO** Any sugar, protein, or blood in your urine, kidney stone or disorder of your kidneys, bladder, prostate, ovaries, uterus, or complications of pregnancy? ________________________
YES **NO** Any history of cancer, heart disease, stroke, hepatitis or osteoporosis?……________________________
YES **NO** Any chemical dependency?…………………………………………………...________________________

26. During the past **FIVE** years, have you: If **YES** - Date/ Descr.

YES **NO** Had a physical, blood work-up, or urinalysis? …………………………………________________________
YES **NO** Had a check-up, consultation, illness, or surgery?……………………………________________________
YES **NO** Had an electrocariogram, Xray, MRI, CT Scan, EMG, bonescan, or any other diagnostic test?……………………………………………………….. ________________________
YES **NO** Been advised to have any test or surgery which wasn't done? …………… ________________________
YES **NO** Been treated or evaluated at a hospital, clinic or health facility? …………… ________________________

27. Name and address of your primary care physician with dates and reasons for visits in the past 5 years:

28. During the past **TWELVE** months, have you:
YES **NO** Gained more than 15 pounds of weight?
YES **NO** Lost more than 15 pounds of weight?

29. Your present lifestyle habits
Coffee _____________ cups per day
Tea _____________ cups per day
Smoke _____________ packs per day/week
Alcohol _____________ glasses per week of wine, beer or hard liquor
Exercise _____________ hours per week
Your type of exercise: **Walking** **Running** **Biking** **Swimming** **Stretching** **Yoga** **Pilates** **Gym/Weights** **Tennis** **Other**_____________

30. Now, please tell me what is going well in your life, what is positive?
____

I, ___________________________________, certify by my signature that the answers to questions #1-30 are true and accurate to the best of my knowledge.

________________________________ _______________
Your Signature ***Date***

Gary Seghi, D.C.   1613 West 6th Street, Austin, TX   78703   (512) 478–1613

ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO DOCTOR
ACCIDENT AND HEALTH INSURANCE

PATIENT: ____________________________________

CLAIM/GROUP#: ______________________________

SOCIAL SECURITY/I.D.# _________________________

I hereby instruct and direct ___________________________ Insurance Company to pay for services rendered by check made out to:

Gary Seghi, D.C.,

Mailed directly to:

Gary Seghi, D.C., 1613 W. 6th Street, Austin, TX 78703

The professional and/or medical/chiropractic expense benefits allowable and otherwise payable for me under my current insurance policy will be used as payment toward the total charges for professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS, TITLE, AND INTEREST 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.

DEMAND FOR PAYMENT: To any insurance company providing benefits of any kind to myself for treatment rendered by Dr. Gary Seghi, you are hereby tendered to pay in full the bill for services rendered within 60 days following your receipt of such bills for services to the extent such bills are payable under the terms of my policy for benefits, less any amount which I personally owe which is not payable under the terms of the policy. This demand specifically conforms with Article 21.55 of the Texas Insurance Code, providing for attorney fees, 18% penalty, court costs, and interest from Judgment, upon violation.

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

Dated this ____ day of ______________, 20___

____
Signature of Policyholder

____
Signature of Claimant, if other than policyholder

Gary Seghi, D.C., 1613 West 6th Street, Austin, TX 78703 (512) 478–1613

OFFICE POLICIES AND ASSIGNMENT OF BENEFITS

Payment Policy: Unless other arrangements are made in advance, payment is expected at the time services are provided. If Dr. Seghi is a member of your insurance plan that requires a co-payment or percentage payment, that payment is required at the time services are provided.

Insurance Payment Policy: You are personally responsible for the payment of all fees that incur during your course of treatment with Dr. Seghi. At the time of treatment, if not before, our staff will attempt to contact your insurance carrier to obtain benefit information. However, this is only an estimate, your insurance policy may not guarantee coverage or payment. In the event that your insurance company denies payment of a claim submitted by our office on your behalf, you will be responsible for payment in full. Any negotiation with an insurance company is your responsibility, however, our staff will make every attempt to offer you assistance on your behalf.

Irrevocable Assignment of Benefits: Dr. Gary Seghi is assigned the exclusive, irrevocable right to any cause of action that exists in my favor against any insurance company for the terms of policy, including the exclusive, irrevocable right to receive payment for such services, make demand in my name for payment, and prosecute and receive payment for such services; make demands in my name for payment and prosecute and receive penalties, interest, court costs, or other legally compensable amounts owed by an insurance company, in accordance with Article 21.55 of the Texas Insurance Code or other applicable insurance of state statute. I, as the patient and/or responsible party, further agree to cooperate, provide information as needed, and appear as needed, wherever to assist in the prosecution of such claims for insurance benefits upon request.

Referrals from Primary Care Physicians: Some insurance policies require patients to obtain referrals from a primary care physician before receiving evaluation and treatment at this clinic. ***It is your responsibility to obtain your initial referral from your primary care physician*****.** It is important to note that referrals authorized by primary care physicians usually have an expiration date; it is your responsibility to be aware of this date and inform our staff if you would like assistance getting additional referrals. If you do not inform our staff of your need for a new referral and you do not get the additional referral yourself, you will be responsible for any charges not covered by your insurance company. At your request, our staff will attempt to offer assistance with additional referrals, but we cannot obtain your initial referral to Dr. Seghi on your behalf.

Any change in your insurance policy can alter payments and/or referrals. It is the patient's responsibility to inform our staff of any policy changes.

Termination of Care Waiver: I hereby acknowledge that if I do not keep appointments as recommended to me, at this clinic, Dr. Gary Seghi has the full and complete right to terminate responsibility for my care and relinquish any disability granted by me within a reasonable period of time. If during the course of my care, my insurance company requires me to take an examination from any other doctor, I will notify Dr. Gary Seghi immediately.

My signature below indicates that I have read the above information and understand the payment and referral policies, and procedures described above.

____
Name of Patient (Print)

______________________________ ____________
Signature of Patient Date

Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of your Protected Health Information

Your Protected Health Information will be used by the Office of Dr. Gary Seghi, D.C. or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office. We may also send you thank you cards for referrals.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. You may review the Notice prior to signing this consent. You may request a copy of the Notice at the Front Desk.

Requesting a Restriction on the Use or Disclosure of Your Information

You may request a restriction on the use or disclosure of your Protected Health Information.

This office may or may not agree to restrict the use or disclosure of your Protected Health Information.

If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

Reservation of Right to Change privacy practice

This office reserves the right to modify the privacy practices outlined in the Notice.

Signature

I have reviewed this consent form and give my permission to this office to use and disclose my health information in accordance with it.

____

Name of Patient (Print)

____

Signature of Patient **Date**

____

Signature of Patient Representative

____

Relationship of Patient Representative to Patient

____

Office Representative **Date**