

Office Use Only:

Patient Account Number _____

Referred by: _____

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 Employer's Worker's Compensation Company

Company _____
Address _____
City _____
State _____
Zip Code _____

Adjuster's Name _____
Telephone _____
Policy # _____
Claim # _____
TWCC# _____

Accident Information

Date of Accident _____ Location of Accident _____

How did the accident occur? _____

YES NO Has a report of injury been filed with the Texas Worker's Compensation Commission?
If yes, the **When?** _____

YES NO Have you told your employer about the accident?

YES NO Have you had a similar injury before? If yes, **WHEN?** _____

YES NO Did anyone witness the accident? If yes, what is **THEIR NAME?** _____

YES NO Have you lost time from work? IF yes, **FROM** _____ **TO** _____

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.

Patient Name _____

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:

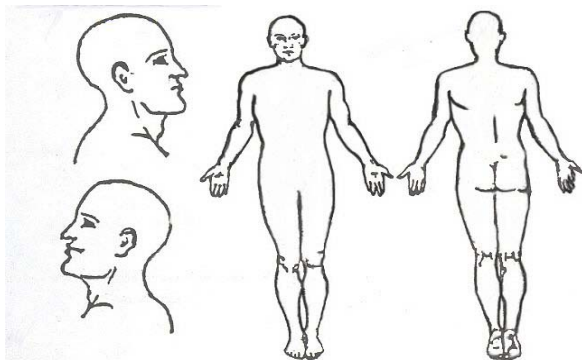
	Name	Date	Diagnosis
Chiropractor	_____	_____	_____
MD	_____	_____	_____
Osteopath	_____	_____	_____
Acupuncturist	_____	_____	_____
Physical Therapist	_____	_____	_____
Rehabilitation Center	_____	_____	_____
Massage Therapist	_____	_____	_____
Other	_____	_____	_____

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. _____

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
<input type="checkbox"/>	<input type="checkbox"/> rest
<input type="checkbox"/>	<input type="checkbox"/> lifting
<input type="checkbox"/>	<input type="checkbox"/> sitting
<input type="checkbox"/>	<input type="checkbox"/> driving
<input type="checkbox"/>	<input type="checkbox"/> walking
<input type="checkbox"/>	<input type="checkbox"/> standing
<input type="checkbox"/>	<input type="checkbox"/> sneezing
<input type="checkbox"/>	<input type="checkbox"/> coughing
<input type="checkbox"/>	<input type="checkbox"/> stairways
<input type="checkbox"/>	<input type="checkbox"/> turning head
<input type="checkbox"/>	<input type="checkbox"/> carrying things
<input type="checkbox"/>	<input type="checkbox"/> general activity
<input type="checkbox"/>	<input type="checkbox"/> bending forward
<input type="checkbox"/>	<input type="checkbox"/> bending backward
<input type="checkbox"/>	<input type="checkbox"/> laying on stomach
<input type="checkbox"/>	<input type="checkbox"/> laying on back
<input type="checkbox"/>	<input type="checkbox"/> prolonged sitting or standing
<input type="checkbox"/>	<input type="checkbox"/> 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