Accident Intake – Personal Patient Information

Patient's Last Name_____ First Name_____ Sex: □ M □ F

Social Security Number ____/____/_____ Driver's License #_____ Date of Birth ___/___/_____

Patient's Address_____
(Number) (Street) (City) (State) (Zip)

Home Phone_____ Cell Phone_____ Native Language_____

Email Address_____ (*If you have one, please make sure we have this, thanks!*)

Patient's Occupation_____ □ Full time □ Part time □ Retired □ Student

Patient's Employer_____ Work Phone Number_____

□ Married □ Engaged □ Single □ Divorced □ Widowed #of Children_____

Spouse/Partner's Name_____ Spouse/Partner's Occupation _____

Would you like us to send a copy of your records from our office to your primary doctor? □ Yes □ No

Name of Primary Doctor_____ Phone Number_____

Height_____ Weight _____ Blood Pressure _____/_____ Race/Ethnicity _____

*****REFERRED BY_____RELATIONSHIP_____ (VERY IMPORTANT)*****

<u>Insurance Information – If you have insurance, please provide copies of all policies/cards</u>

AUTO ACCIDENT → provide your auto insurance & your health insurance

Your Auto Insurance – please provide copy of insurance verification
Auto Insurance Company_____ Policy #_____
Claims Address _____
Claims Phone#_____ Claim # (if assigned) _____
Adjuster/Contact Person _____ Phone # _____
Do you have MedPay on your car insurance policy? □ Yes □ No □ Not Sure

Your Health Insurance – please provide copy of insurance card
Company Name_____ Policy #_____ Group #_____
Claims Address _____
Claims Phone #_____ Insured's Name _____
Insured's Date of Birth _____ Insured's Relationship to Patient _____

<u>Accident Information</u>

Date and time the accident occurred: ____ /____ /_____, ___:____ □ AM □ PM

Please explain in detail how the accident occurred.

_____

_____

_____

_____

Do you have an attorney? □ Yes □ No **If not, do you plan to retain one?** □ Yes □ No
Name of Attorney _____ Law Firm _____
Phone # _____ Address _____
Please draw below what happened in this accident:

Lien/Letter of Protection

I hereby agree that my attorney will issue payment from the proceeds of the settlement for the above-referenced incident for any amounts not paid directly by my health or automobile insurance by check to Corsello Clinic of Chiropractic of 2021 Main St, Stratford, CT 06615 for my bills for Chiropractic services rendered for injuries that were sustained.

_____

Patient's Signature

FOR AUTO ACCIDENTS ONLY (For Work-Related or Slip/Fall Accidents, continue on Page 4):

Were you wearing seat belts? □ Yes □ No Shoulder harness □ Yes □ No

What was your position in the vehicle? □ Driver □ Passenger
Name of Driver: _____
Your Relationship to Driver: _____)

If passenger, were you setting in: □ Front □ Right Rear □ Left Rear □ Other _____

Year, Make & Model of your vehicle _____Year, Make & Model of other vehicle_____

Driving conditions at time of accident: □ Day □ Night □ Dusky □ Dry □ Wet □ Damp □ Paved □ Gravel □ Other _____

Approximate speed vehicles were traveling at time of impact: Yours _____MPH Theirs _____MPH

Did airbag deploy? □ Yes □ No □ Not equipped

Were you unconscious? □ Yes □ No In a daze? □ Yes □ No

Headrests were: □ Present but not adjusted for my height □ Present but set in the middle □ Present but but set low □ Present and adjusted for my height □ There were none □ I don't recall

What was the approximate distance between your head and the headrest? _____ inches

Were you surprised by impact? □ Yes □ No, Explain _____

Were your brakes applied? □ Yes □ No. If Yes, □ Hard □ Lightly

At time of impact were you: □ Looking straight ahead □ To the right □ To the left □ Up □ Down

Were both hands on the steering wheel? □ Yes □ No, Explain _____

Was your foot on the brake? □ Yes □ No □ N/A Were you braced for impact? □ Yes □ No

Was your seat back reclined? □ Yes □ No Was your body posture: □ Straight □ Slouched

Was the vehicle that hit you? □ smaller in size than your vehicle □ larger or heavier than your vehicle □ Not sure

Did you feel pain immediately? □ Yes □ No And if so? Where? Neck □ left □ right □ middle
Lower back □ left □ right □ middle Headache □ yes □ no Other area: _____

Where in the vehicle/outside of the vehicle were you after the impact? _____

Did you strike anything in the vehicle at impact? □ Yes □ No If yes, please specify: □ Steering wheel □ Dashboard □ Windshield □ Side door □ Armrest □ Side window □ Other: _____
Please state the part of your body that hit: □ Left □ Right □ Chest □ Chin □ Knee □ Shoulder □ Hand □ Head □ Face □ Other: _____

Were you wearing glasses or a hat? □ Yes □ No □ Something else: _____
If yes, were they still on following the accident? □ Yes □ No

What was the position of your hands/arms at the time of impact? _____

What were your movements following the collision? □ Back, then forward □ Forward, then back
□ Left side to right side □ Right side to left side □ Other: _____

Approximate cost of repairs for vehicle damage: $_____ Was your vehicle totaled? □ Yes □ No

******Please email photos of (1) you positioned in your vehicle as you were at time of impact AND (2) the damage to your vehicle (if available) to us at contact@corselloclinic.com.**

FOR ALL ACCIDENTS (AUTOMOBILE, WORK-RELATED, SLIP/FALL) CONTINUE HERE!

Immediately following the accident, how did you feel? _____

Where did you go? _____

Did you go to the hospital? □ Yes □ No If yes, when? □ At time of accident □ Next day □ Other _____

How did you get to the hospital? □ Ambulance □ I drove myself □ Driven by: _____

Did the ambulance attendants place you in: □ Neck collar □ Splints □ Brace □ Other: _____

Name of the Hospital _____ Attended by Dr. _____

Were x-rays taken at the hospital? □ Yes □ No If yes, what body part(s)? _____

Were you admitted to the hospital? □ Yes □ No If yes, how long did you stay? _____

What treatment was rendered? _____

What recommendations were made? _____

Have you seen any other Doctor because of this accident? □ Yes □ No
If yes, Doctor(s) Name _____ Specialty _____
When were you first seen by the doctor above? _____
Who referred you? _____ What treatment was rendered? _____

Are you still under care there? □ Yes □ No

If yes, what are the doctor's plans? _____

If no, why did you discontinue? _____

Is your pain: □ Constant □ On and off □ Sharp □ Dull □ Other _____

Is your pain worse: □ Arising from chair □ Straining □ Coughing □ Sneezing □ When moving bowels
Do you have any numbness or tingling in your: □ Arms □ Hands □ Fingers □ Legs □ Feet □ Toes □ Other _____

What is your most comfortable position? □ Sitting □ Laying on right side □ Laying on left side
□ Laying on your back □ Laying on your stomach □ Standing □ Other _____

Is it difficult to move around in bed? □ Yes □ No

Does stretching or twisting worsen the pain? □ Yes □ No

Do any of the following relieve your pain? □ Heating pad □ Hot bath □ Shower □ Ice pack □ Medicines (specify) _____

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 leg cramps? □ Yes □ No
Arm cramps? □ 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 ____/____/_____

Are you presently able to lift:
□ Very heavy _____lbs. □ Heavy ____lbs. □ Light ____lbs. □ Sitting ____lbs.

With minimum demand of physical effort, what positions can you work in and for how long?
□ Standing (if any restriction, describe) _____
□ Walking (if any restriction, describe) _____
□ Sitting (if any restriction, describe) _____

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

Are you able to take personal care of yourself, such as dressing, bathing, etc.? □ Yes □ No If Yes, please describe: _____

Are any of your other activities of daily living affected by this accident? (Check all that apply.)
□ Walking □ Exercise □ Recreational activities □ Sleeping □ Driving □ Sexual activity □ Caring for children
□ Other, please describe: _____

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

Walking	Normal _____	Limited _____	Difficult _____	Pain _____
Standing	Normal _____	Limited _____	Difficult _____	Pain _____
Sitting	Normal _____	Limited _____	Difficult _____	Pain _____
Bending	Normal _____	Limited _____	Difficult _____	Pain _____
Stooping	Normal _____	Limited _____	Difficult _____	Pain _____
Lifting	Normal _____	Limited _____	Difficult _____	Pain _____
Pushing	Normal _____	Limited _____	Difficult _____	Pain _____

Pulling	Normal _____	Limited _____	Difficult _____	Pain _____
Climbing	Normal _____	Limited _____	Difficult _____	Pain _____
Reaching	Normal _____	Limited _____	Difficult _____	Pain _____
Gripping	Normal _____	Limited _____	Difficult _____	Pain _____
Kneeling	Normal _____	Limited _____	Difficult _____	Pain _____
Balance	Normal _____	Limited _____	Difficult _____	Pain _____
Fatigue	Normal _____	Limited _____	Difficult _____	Pain _____

Your Current Complaints/Symptoms

□ This is the first time I am experiencing these complaints.
□ I have experienced the same or similar complaints before. Please explain:

FILL OUT ONE SECTION FOR EACH SYMPTOM YOU HAVE, IF ANY, AND SKIP TO PAGE 6 WHEN YOU ARE DONE (i.e. if you are have one symptom, such as neck pain, you can skip the spaces for Symptoms 2-6 in this section and go to page 10.) Please start at the top of your body and work your way down.

Symptom 1 _____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? _____
  - Did the symptom begin suddenly or gradually? (circle one)
  - How did the symptom begin? _____
- What makes the symptom worse? (circle all that apply):
  - Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): _____
- What makes the symptom better? (circle all that apply):
  - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): _____
- Describe the quality of the symptom (circle all that apply):
  - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging Other (please describe): _____
- Does the symptom radiate to another part of your body (circle one): yes no
  - If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (circle one)
  - Morning Afternoon Evening Night Unaffected by time of day

Symptom 2 _____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

- When did the symptom begin? _____
  - Did the symptom begin suddenly or gradually? (circle one)
  - How did the symptom begin? _____
- What makes the symptom worse? (circle all that apply):
  - Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): _____
- What makes the symptom better? (circle all that apply):
  - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): _____
- Describe the quality of the symptom (circle all that apply):
  - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging Other (please describe): _____
- Does the symptom radiate to another part of your body (circle one): yes no
  - If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (circle one)
  - Morning Afternoon Evening Night Unaffected by time of day

Symptom 3 _____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? _____
  - Did the symptom begin suddenly or gradually? (circle one)
  - How did the symptom begin? _____
- What makes the symptom worse? (circle all that apply):
  - Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): _____
- What makes the symptom better? (circle all that apply):
  - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): _____
- Describe the quality of the symptom (circle all that apply):
  - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging Other (please describe): _____
- Does the symptom radiate to another part of your body (circle one): yes no
  - If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (circle one)
  - Morning Afternoon Evening Night Unaffected by time of day

Symptom 4 _____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? _____
  - Did the symptom begin suddenly or gradually? (circle one)
  - How did the symptom begin? _____
- What makes the symptom worse? (circle all that apply):
  - Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): _____
- What makes the symptom better? (circle all that apply):
  - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): _____
- Describe the quality of the symptom (circle all that apply):
  - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging Other (please describe): _____
- Does the symptom radiate to another part of your body (circle one): yes no
  - If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (circle one)
  - Morning Afternoon Evening Night Unaffected by time of day

Have you ever received Chiropractic Care? Yes No If yes, when? _____

Name of most recent Chiropractor: _____

Why are you changing Chiropractors? _____

1. **Previous interventions, treatments, medications, surgery, or care you've sought for your complaint(s):**

   _____

   _____

   _____

2. **Since the Accident, have you experienced any of the following:**
   A. Loss of Range of Motion: yes/no
      a. What body parts: _____
   B. Visual Disturbance : yes/no □ blurring l/r □ floaters l/r □ vision loss l/r □ hypersensitivity l/r
      % of time: ___ % of time: ___ % of time: ___ % of time: ___
   C. Dizziness: yes/no % of time: ____
   D. Anxiety: yes/no % of time: ____

E. Depression: yes/no % of time: ____
F. Difficulty Sleeping: yes/no

3. Past Health History:

A. Please indicate if you have a history of any of the following:
□ Anticoagulant use □ Heart problems/high blood pressure/chest pain □ Bleeding problem □ Lung problems/shortness of breath □ Cancer □ Diabetes □ Psychiatric disorder □ Bipolar disorder □ Major depression □ Schizophrenia □ Stroke/TIA's
□ Other _____ □ None of the above

B. Previous Injury or Trauma: _____

Have you ever broken any bones? Which? _____

C. Allergies:

_____

D. Medications (please continue on back of this sheet or attach medication list, if necessary):

Medication: **Reason for taking:**

_____
_____
_____
_____

E. Surgeries:

Date: **Type of Surgery:**

_____
_____
_____

F. For Females (Pregnancies and outcomes):

Pregnancies/Date of Delivery: **Outcome:**

_____
_____
_____
_____

4. Family Health History:

Do you have a family history of? (Please indicate all that apply)
□ Cancer □ Strokes/TIA's □ Headaches □ Cardiac disease □ Neurological diseases
□ Adopted/Unknown □ Cardiac disease below age 40 □ Psychiatric disease □ Diabetes
□ Other _____ □ None of the above

Deaths in immediate family: _____

Cause of parents or siblings death: Age at death:

_____

_____

_____

_____

Social and Occupational History:

A. **Job description:**

_____

B. **Work schedule:**

_____

C. **Recreational activities:**

_____

D. **Lifestyle (hobbies, level of exercise, alcohol, tobacco and drug use, diet):**

_____

Review of Systems:

Have you had any of the following **pulmonary (lung-related)** issues?
□ Asthma/difficulty breathing □ COPD □ Emphysema □ Other _____ □ None of the above

Have you had any of the following **cardiovascular (heart-related)** issues or procedures?
□ Heart surgeries □ Congestive heart failure □ Murmurs or valvular disease □ Heart attacks/MIs □ Heart disease/problems □ Hypertension (high blood pressure) □ Pacemaker □ Angina/chest pain □ Irregular heartbeat □ Other _____ □ None of the above

Have you had any of the following **neurological (nerve-related)** issues?
□ Visual changes/loss of vision □ One-sided weakness of face or body □ History of seizures □ One-sided decreased feeling in the face or body □ Headaches □ Memory loss □ Tremors □ Vertigo □ Loss of sense of smell □ Strokes/TIAs □ Other _____ □ None of the above

Have you had any of the following **endocrine (glandular/hormonal)** related issues or procedures?
□ Thyroid disease □ Hormone replacement therapy □ Injectable steroid replacements □ Diabetes □ Other _____ □ None of the above

Have you had any of the following **renal (kidney-related)** issues or procedures?
□ Renal calculi/stones □ Hematuria (blood in the urine) □ Incontinence (can't control) □ Bladder Infections □ Difficulty urinating □ Kidney disease □ Dialysis □ Other _____
□ None of the above

Have you had any of the following **gastroenterological (stomach-related)** issues?
□ Nausea □ Difficulty swallowing □ Ulcerative disease □ Frequent abdominal pain □ Hiatal hernia □ Constipation □ Pancreatic disease □ Irritable bowel/colitis □ Hepatitis or liver disease □ Bloody or black tarry stools □ Vomiting blood □ Bowel incontinence □ Gastroesophageal reflux/heartburn □ Other _____ □ None of the above

Have you had any of the following **hematological (blood-related)** issues?
□ Anemia □ Regular anti-inflammatory use (Motrin/Ibuprofen/Naproxen/Naprosyn/Aleve) □ HIV positive □ Abnormal bleeding/bruising □ Sickle-cell anemia □ Enlarged lymph nodes
□ Hemophilia □ Hypercoagulation or deep venous thrombosis/history of blood clots
□ Anticoagulant therapy □ Regular aspirin use □ Other _____ □ None of the above

Have you had any of the following **dermatological (skin-related)** issues?
□ Significant burns □ Significant rashes □ Skin grafts □ Psoriatic disorders □ Other _____
□ None of the above

Have you had any of the following **musculoskeletal (bone/muscle-related)** issues?
□ Rheumatoid arthritis □ Gout □ Osteoarthritis □ Broken bones □ Spinal fracture □ Spinal surgery □ Joint surgery □ Arthritis (unknown type) □ Scoliosis □ Metal implants
□ Other _____ □ None of the above

Have you had any of the following **psychological** issues?
□ Psychiatric diagnosis □ Depression □ Suicidal ideations □ Bipolar disorder □ Homicidal ideations □ Schizophrenia □ Psychiatric hospitalizations □ Other _____ □ None of the above

Is there anything else in your past medical history that you feel is important to your care here?
_____
_____

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of Chiropractic to provide me with chiropractic care, in accordance with this state's statutes.

****Patient's/Guardian Signature**_____ **Date:** ___/___/_____

Basic Office Policies

1. I understand and agree that health and accident insurance policies are an arrangement between my insurance carrier and me. Furthermore, I understand the Corsello Clinic of Chiropractic will prepare any necessary reports and forms to assist in making collections from the insurance company, and that any amount authorized to be paid directly to the Corsello Clinic of Chiropractic or Dr. Edward Corsello will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment.
2. I agree that I will be responsible for all attorney and legal fees if legal action becomes necessary to collect my account. I authorize Corsello Clinic of Chiropractic to obtain a credit report if deemed necessary. (In other words, I promise to pay my bill.☺)

Patient Signature _____ Date _____

Parent or Guardian Authorizing Care_____ Date _____

Emergency Contact Information:

In case of emergency, please notify _____ (First and Last Name)

Relationship to patient _____ Phone Number _____

Release and Assignment of Insurance Payments

The parties appearing below, on the date specified below, hereby agree to the following conditions, covenants, and terms regarding the benefits appearing in the policy belonging to _____ (Patient's Name, hereinafter referred to as "Patient") issued by _____ (Insurance Company Name, hereinafter referred to as "Insurance Company").

I, Patient, understand and voluntarily agree to assign all applicable medical pay provisions appearing in my insurance policy named above directly to the doctor.

The patient request, orders, and directs Insurance Company to pay the doctor directly at his office at 2021 Main Street, Stratford, CT 06615 the sums due to the doctor for all treatment received by Patient. The patient gives the doctor the exclusive right to secure the funds assigned by the patient, including the right of securing consent to represent the doctor in collecting all sums due for treatment rendered as well as any and all collections costs and fees. Patient authorizes the doctor to endorse any and all drafts on behalf of the patient and credit that amount to the patient's account.

That doctor and patient hereby enter into this agreement of benefits freely and voluntarily as evidenced by the signatures appearing below; that patient and the doctor warrant that they have read this assignment of benefits and that each understands the legal effect of the same and agree that each shall be bound by the covenants, terms and conditions appearing herein. I further authorize release of any information necessary to process my insurance claims and assign and request payment directly to Dr. Edward C. Corsello.

****Patient's/Guardian Signature**_____ **Date:** ___/___/_____

Consent for Professional Services and Release of Information

I hereby authorize and release the doctor and whomever he may designate as his assistants, to administer treatment, physical examination, x-ray studies, laboratory procedures, chiropractic care, and any clinic services that he deems necessary in my case. I further authorize him to disclose all or part of my patient's records to any person or corporation which is or may be liable under a contract to the clinic or to a family member or employer for all or part of the clinic's charges, including, but not limited to, hospital or medical services companies, insurance companies, worker's compensation carriers, welfare funds, or my employer.

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that this chiropractic office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount is to be paid directly to this chiropractic office and will be credited to my account upon receipt. Patient authorizes the doctor to endorse any and all drafts on behalf of the patient and credit that amount to the patient's account. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I terminate my care or treatment, any fees for professional services rendered to me will be immediately due and payable.

****Patient's/Guardian Signature**_____ **Date:** ___/___/_____

*******FOR WOMEN ONLY*******

Pregnancy Release:

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-rays can harm a fetus (unborn child) in the early stages.

Date of last menstrual period: ___/___/____

****Patient's/Guardian Signature_____ Date: ___/___/_____**

Consent to Evaluate and Treat A Minor Child

I _____ (parent's name), being the parent or legal guardian of _____(child's name) have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

****Parent/Guardian Signature_____ Date: ___/___/_____**

Consent to Treatment

Chiropractic procedures are considered safe and effective methods of care. Occasionally, however, complications may arise. Any procedure intended to help may have complications. While the chances of experiencing complications are small; it is the practice of this clinic to inform our patients about them. These complications may include, but are not limited to soreness, inflammation, soft tissue injury or bruising, dizziness, temporary worsening of symptoms. More serious complications are extremely rare. Additional information on side effects and complications is available upon request. It is also our policy to inform you of the procedure being performed and the risks and alternative treatments available. If your physician does not explain to your satisfaction, please ask for more information. I have read and understand the above statements regarding treatment side effects and I also understand that there is no guarantee for a specific cure or result.

****Patient's/Guardian Signature_____ Date: ___/___/_____**

X-ray Consent

Diagnostic x-rays may be advisable in my case so that a complete analysis can be made of my present musculoskeletal problem (or illness). I authorize Dr. Corsello to perform such radiographic examination necessary to diagnose and to administer whatever treatment is deemed necessary to treat my present problem (or illness).

****Patient's/Guardian Signature_____ Date: ___/___/_____**

FOR WOMEN ONLY: To the best of my knowledge I am NOT pregnant and the above named Doctor has permission to perform x-rays for diagnostic interpretation.

****Patient's/Guardian Signature_____ Date: ___/___/_____**

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy describes how we may use and disclose your protected health information (PHI) to carry our treatment, payment or health care operations (TPO) for other purposes that are permitted or required by law. "Protected Health Information" is information about you, including demographic information that may identify you and that related to your past, present, or future physical or mental health or condition and related care services.

Use and Disclosures of Protected Health Information:

Your protected health information may be used and disclosed by your physician, our staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, pay your health care bills, to support the operations of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your health care information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing, and fund raising activities, and conduction or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. Or if you consent to give a video testimony, we may show it on the office signs. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We may also communicate with you via email or text message.

We may use or disclose your protected health information in the following situations without your authorization. These situations included as required by law, public health issues, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, and organ donation. Required uses and disclosures under the law, we must make disclosures to you when required by the Secretary of the

Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES WILL BE MADE ONLY WITH YOUR CONSENT, AUTHORIZATION OR OPPORTUNITY TO OBJECT UNLESS REQUIRED BY LAW.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

****Patient's/Guardian Signature**_____ **Date:** ___/___/_____

Thank you for completing these forms, and we look forward to serving you! ☺