

WORK / COMP HISTORY

Patient _____ Phone () _____

Address _____ City _____ State _____ Zip _____

Age _____ Birthdate _____ Sex _____ S/S# _____

Name of Compensation Carrier: _____ Phone () _____

Address of Carrier: _____ City _____ State _____ Zip _____

Employer's Name: _____ Phone () _____

Employer's Address: _____ City _____ State _____ Zip _____

1. Type of Business _____ Your Occupation _____

2. Date Injured _____ Hour _____ AM / PM Last Date Worked _____ Are you off work? () Yes () No

3. Previous Workers' Compensation Injury? () Yes () No

4. Accident reported to employer? () Yes () No Name of person reported accident to _____

5. Injured at: _____ City _____ State _____ Zip _____

6. Length of time worked there prior to accident: _____

7. Type of work being done at time of injury: _____

8. In your own words, please describe accident: _____

9. Have you been treated by another doctor for this accident? () Yes () No

If yes, please list doctor's name and address: _____

What type of treatment did you receive? _____

How long were you treated by this doctor? _____

10. Are you: () improved () unchanged () getting worse

11. What types of medicines are you taking? _____

Do these medicines help? () Yes () No () Don't know

12. Have you had physical therapy? () Yes () No If yes, how often?

() Daily () Every other day () Several times a week () Weekly () Every other week

() Monthly () Other _____

Does the physical therapy help? () Yes () No () Don't know

13. Prior to this accident, have you ever had any of the physical complaints similar to what you have now?

() Yes () No () Don't know

If yes, describe: _____

Were these similar complaints the results of a previous accident(s)? () Yes () No

Please provide details of accident(s): _____

14. Have you had any other serious accidents which required medical care? () Yes () No

Describe: _____

15. Have you had any serious illnesses that required hospitalization? () Yes () No

Describe: _____

16. Have you had any surgeries? () Yes () No

If yes, list type of surgery and date: _____

17. Have you had any nervous or mental illnesses? () Yes () No

Have you had psychiatric care? () Yes () No

18. Have you received a medical discharge from the Armed Forces? () Yes () No

19. Have you returned to work since this accident? () Yes () No

If you have returned to work since your accident, please fill out the information below:

DATE	EMPLOYER	OCCUPATION	LIGHT DUTY REG. DUTY	FULL-TIME PART-TIME

CURRENT MEDICAL COMPLAINTS

BACK PAIN:

1. Currently, I have pain in my: () low back () mid back () upper back
2. My pain began: () gradually () suddenly
3. I have pain: () sometimes () all of the time
4. My pain goes into my: () right leg () left leg () both
5. I have tingling and/or numbness in my: () right leg () left leg () both
6. My pain is worse when I:
 - cough or sneeze () Yes () No
 - sit () Yes () No
 - bend () Yes () No
 - walk () Yes () No
 - lift () Yes () No
 - push () Yes () No
 - pull () Yes () No
7. My back is worse with sexual activity () Yes () No
8. My pain wakes me up during the night () Yes () No
9. Changes in the weather affect my pain () Yes () No

NECK PAIN:

- 1. My neck pain began: () gradually () suddenly
- 2. I have pain: () sometimes () all of the time
- 3. My pain goes into my: () right arm () left arm () both
- 4. I have tingling and/or numbness in my: () right arm () left arm () both
- 5. My pain is worse when I:
 - cough or sneeze () Yes () No
 - bend forward () Yes () No
 - lift () Yes () No
 - push () Yes () No
 - pull () Yes () No
 - turn my head () Yes () No
- 6. My pain wakes me up during the night () Yes () No
- 7. Changes in the weather affect my pain () Yes () No
- 8. I have neck stiffness () Yes () No
- 9. I have headaches () Yes () No
- 10. If I do get headaches, they occur: () sometimes () all of the time

OTHER PAIN:

Please describe any current medical complaints which you are experiencing and were not previously covered on this questionnaire, or list any additional comments you wish to make regarding your condition:

JOB DESCRIPTION:

(In terms of an 8-hour workday, "occasionally" means 33%, "frequently" means 34% to 66%, and "continuously" means 67% to 100% of the day).

1. In a typical 8-hour workday, I: (Circle # of hours / activity)

Sit:	1	2	3	4	5	6	7	8	hours
Stand:	1	2	3	4	5	6	7	8	hours
Walk:	1	2	3	4	5	6	7	8	hours

2. On the job, I perform the following activities:

	NOT AT ALL	OCCASIONALLY	FREQUENTLY	CONTINUOUSLY
Bend / stoop	()	()	()	()
Squat	()	()	()	()
Crawl	()	()	()	()
Climb	()	()	()	()
Reach above shoulder level	()	()	()	()
Crouch	()	()	()	()
Kneel	()	()	()	()
Balancing	()	()	()	()
Pushing / Pulling	()	()	()	()

3. On the job, I lift:	NOT AT ALL	OCCASIONALLY	FREQUENTLY	CONTINUOUSLY
Up to 10 pounds	()	()	()	()
11 to 24 pounds	()	()	()	()
25 to 34 pounds	()	()	()	()
35 to 50 pounds	()	()	()	()
51 to 74 pounds	()	()	()	()
75 to 100 pounds	()	()	()	()

4. Do you have to bend over while doing any lifting? () Yes () No

5. Are your feet used for repetitive movements, such as in operating foot controls? () Yes () No

6. Do you use your hands for repetitive actions, such as:

	SIMPLE GRASPING		FIRM GRASPING		FINE MANIPULATING	
Right hand	() Yes	() No	() Yes	() No	() Yes	() No
Left hand	() Yes	() No	() Yes	() No	() Yes	() No

7. Are you required to work on unprotected heights? () Yes () No

Describe: _____

8. Are you required to be around moving machinery? () Yes () No

Describe: _____

9. Are you exposed to marked changes in temperature and humidity? () Yes () No

Describe: _____

10. Are you required to drive automotive equipment? () Yes () No

Describe: _____

11. Are you exposed to dust, fumes and/or gases? () Yes () No

Describe: _____

12. Please list any additional comments: _____

Signature: _____ Date: _____



NORTH SCOTTSDALE FAMILY
CHIROPRACTIC

8080 E. Gelding Drive Suite D101 Scottsdale, AZ 85260
Office: (480) 588-5111 Fax: (480) 588-8805

OFFICE POLICIES

If you need to reschedule or cancel an appointment please call our office 24 hours in advance to do so. You will be charged \$25 for missed appointments or cancellations with less than 24 hours notice.

Please refrain from wearing strong colognes/perfumes to our office as many of our patients have highly sensitive allergies and/or respiratory problems.

Please notify the doctor of any changes in health status, regardless of the significance.

Please notify the staff of any changes in your insurance coverage.

A balance is not to exceed \$100.

FINANCIAL POLICIES

PATIENTS WITHOUT INSURANCE

We request that 100% of the first visit be paid at the time of the visit. On other visits, payment may be made at the end of the week if you sign a credit guarantee form. We are happy to accept your cash, checks and credit cards.

GROUP OR INDIVIDUAL INSURANCE

When possible, we will call to verify benefits on your insurance. However, the benefits quoted to us by your insurance company are not a guarantee of payment. Payment will be due by you at the time of service for any non-covered services, deductibles or co-pays.

"ON THE JOB" INJURY (Worker's Compensation)

If you are injured on the job, your care should be paid for under your employer's Worker's Compensation insurance. You will need to inform your employer of the accident and obtain the name and address of the carrier of their insurance. If your employer does not provide us with this information, if a settlement has not been made within 3 months, or if you suspend or terminate care, any fees and services are due immediately.

PERSONAL INJURY OR AUTOMOBILE ACCIDENTS

Please notify your auto insurance carrier of your visit to our office immediately. Notify our insurance department immediately if an attorney is representing you. Although you are ultimately responsible for your bill, we will wait for settlement of your claim for up to six months after your care is completed. Once the claim is settled or if you suspend or terminate care, any fees for services are due immediately.



NORTH SCOTTSDALE FAMILY
CHIROPRACTIC

MEDICARE

We do accept assignment from Medicare. The check is usually sent directly to our office in payment of the services that Medicare will cover which for Chiropractors is ONLY manual manipulation of the spine. Medicare pays 80% of the allowable fee once the deductible has been met. You are required to pay the deductible and the remaining 20% as well as any non-covered services. Our office completes and files the forms for Medicare at no charge.

SECONDARY INSURANCE

Please inform us of any secondary insurance you may have. We will assist you if you need help in filing.

I have read and understand the payment policy of North Scottsdale Family Chiropractic. I understand that my insurance is an arrangement between myself and my insurance company, NOT between North Scottsdale Family Chiropractic and my insurance company. I request that North Scottsdale Family Chiropractic prepare the customary forms at no charge so that I may obtain insurance benefits. If the insurance company does not pay their portion within 45 days we expect you to contact them to insure that the claim gets paid. If the insurance company sends a check directly to you, it should be brought to our office as soon as possible. You may also be sent a monthly statement with your account balance. Please call us with any financial concerns or challenges. I also understand that if my insurance does not respond within 60 days, or if I suspend or terminate my schedule of care as prescribed by the doctors at North Scottsdale Family Chiropractic that fees will be due and payable immediately. Any additional collection fees will be the patient's responsibility.

Patient's signature (or guardian if patient is a minor)

Date

Witness



NORTH SCOTTSDALE FAMILY
CHIROPRACTIC

8080 E. Gelding Drive Suite D101 Scottsdale, AZ 85260
Office: (480) 588-5111 Fax: (480) 588-8805

Date: _____

**ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO DOCTOR
PRIVATE AND GROUP ACCIDENT AND HEALTH INSURANCE**

Patient: _____ SS#/ID#: _____

Employer: _____ Claim/Group#: _____

I hereby instruct and direct payment of all professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy to:

**North Scottsdale Family Chiropractic
8080 E. Gelding Drive
Suite# D101
Scottsdale, AZ 85260**

as payment for professional services rendered. THIS IS A DIRECT-ASSIGNMENT OF MY RIGHTS AND BENEFITS 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.

If my current policy prohibits direct payment to the doctor, I hereby instruct and direct you to make out the check to me and mail it as follows:

**North Scottsdale Family Chiropractic
8080 E. Gelding Drive
Suite# D101
Scottsdale, AZ 85260**

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

I also authorized the release of any information pertinent to any insurance company, attorney, or adjuster involved in this case.

I authorize the doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

Date at _____: _____ this _____ day of _____, 20_____

Insured

Witness



NORTH SCOTTSDALE FAMILY
CHIROPRACTIC

Dr. Thomas V. Tuzzolino, D.C., F.I.A.M.A.

Terms of Acceptance

When a patient seeks chiropractic healthcare and we accept a patient for such care, it is essential for both to be working toward the same objective.

It is important that each patient understand both the objective and the method that will be used to attain improved spinal health. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxations. Our chiropractic method of correction is by specific, gentle, manual adjustments of the spine. In some cases an adjusting instrument (an activator) will be used at the discretion of the doctor.

Health: A state of optimal physical, mental, and social well-being, not merely the absence of symptoms.

Vertebral Subluxation: A misalignment of one or more of the twenty-four vertebra in the spinal column which can cause alteration of nerve function and transmission of nerve impulses resulting in a lessening of the body's ability to perform at its optimal potential.

We only offer to diagnose either vertebral subluxations or neural-musculoskeletal conditions of the body, however, if during the course of the chiropractic spinal examination we encounter non-chiropractic or unusual findings, we will advise you. We have a list of other professional health care providers for referral purposes if indicated.

I, _____ have read and fully understand the above statements. All questions regarding the doctors' objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis, and understand that all charges incurred are my responsibility.

(patient signature)

(date)

****Consent to evaluate and adjust a minor child:**

I, _____ being the parent/legal guardian of _____ have fully read and understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care from Dr. Thomas V. Tuzzolino, D.C., F.I.A.M.A.

(authorized signature)

(date)

****Pregnancy Release:**

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his associates have my permission to perform, if needed, an x-ray evaluation. I have been advised that x-rays can be hazardous to an unborn child. *Date of last menstrual period:* _____

(patient signature)

(date)



NORTH SCOTTSDALE FAMILY
CHIROPRACTIC

INFORMED CONSENT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future work at the clinic or office listed below or any other office or clinic.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient Signature _____ Date _____

Witness Signature _____ Date _____

PROTOCOL FOR PRESERVATION OF PATIENT RECORDS

Pursuant to ARS 32-3211 and the requirements for the State of Arizona for the preservation of patient records, this document is intended to inform all patients of North Scottsdale Family Chiropractic of their rights and obligations.

Patients or their representatives may request copies of their records, in writing. North Scottsdale Family Chiropractic agrees to comply with Arizona law for the production of these records and will timely respond to any reasonable requests.

North Scottsdale Family Chiropractic will maintain your records for a period of seven (7) years following your last date of service. After 7 years from the last date of service, North Scottsdale Family Chiropractic reserves the right to destroy your records. Should North Scottsdale Family Chiropractic exercise that right, North Scottsdale Family Chiropractic will first attempt to contact you and inform you of your right to obtain a copy of these records. North Scottsdale Family Chiropractic will attempt to contact you by regular mail, at your last known address, and will give you thirty (30) days to request that your records not be destroyed. If you do not respond to this notice, you will be waiving your rights to have your records preserved.

Should North Scottsdale Family Chiropractic retire, cease to practice, or sell the practice to another health care professional, North Scottsdale Family Chiropractic will notify all eligible patients, by regular mail, concerning the location of their records and how they may request copies of those records. The required notice will be sent to each eligible patient's last known address.

Patient Signature

I acknowledge receipt of this document

MEDICAL RELEASE AUTHORIZATION

TO WHOM IT MAY CONCERN:

I _____ DO HEREBY AUTHORIZE NORTH SCOTTSDALE FAMILY CHIROPRACTIC, INC. TO RELEASE MEDICAL RECORDS, TOGETHER WITH ANY ADDITIONAL INFORMATION RELATIVE TO THE DIAGNOSIS, TREATMENT AND PROGNOSIS OF MY CONDITION. ALSO ADVISE THE AMOUNT OF MY BILLS TO DATE AS WELL AS THE PROBABLE AMOUNT OF THE FINAL BILL FOR SERVICES RENDERED TO AND FOR ME TO: _____ A PHOTOCOPY OF THIS AUTHORIZATION SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL.

DATE _____

SIGNATURE _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____