COASTAL CHIROPRACTIC
**Dr. Robert LaDuca, D.C.**
**28467 DuPont Blvd. Millsboro, DE 19966**
**Phone (302) 933-0700 Fax (302) 933-0800**

## Workers' Compensation New Patient Information:

First Name: _____Last Name_____

Address: _____

City: _____ State: _____ Zip Code: _____

Cell Phone: _____ Home Phone: _____

Date of Birth: _____ Age: _____

Gender: ___Male ___Female Marital Status: ___Single ___Married ___Other: _____

How did you hear about our office? _____

Referring Doctor: _____Phone: _____

Primary Care Doctor: _____Phone: _____

## Patient Employer Data:

Employment Status:
__Employed ___Full time ___Part time ___Retired ___Unemployed ___Homemaker

Employer Name: _____Phone: _____
Job title/Position: _____

## Workers' Compensation Insurance and Claim Information: *REQUIRED

Workers' Compensation Insurance: _____
Address: _____
Phone: _____
Claim Number #: _____
Case Manager Name: _____
Phone: _____EXT:_____ EMAIL: _____

## Health Insurance Information:

Primary Health Insurance: _____
Address: _____
Phone: _____
Member/Subscriber ID#: _____
Does your insurance plan require prior authorization for specialist visits? _____

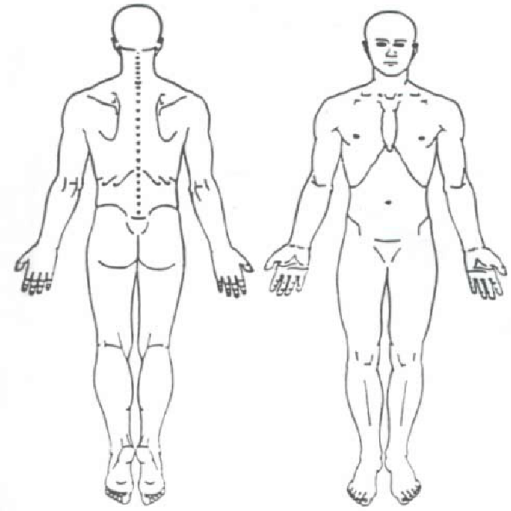
## Accident Information:

Date of Injury/Accident: _____
Describe how you were injured **(REQUIRED TO FILE WORK CLAIM)**:

_____
_____
_____
_____
_____

## Patient Symptoms:

Please mark where your pain/symptoms are:



Please grade your pain on a scale of 0-10: Circle how frequent the pain is present:

0=NO PAIN, 10=EXTREME PAIN

NECK: 0 1 2 3 4 5 6 7 8 9 10 Seldom-Intermittent-Frequent-Constant

Upper/Mid Back: 0 1 2 3 4 5 6 7 8 9 10 Seldom-Intermittent-Frequent-Constant

Lower Back: 0 1 2 3 4 5 6 7 8 9 10 Seldom-Intermittent-Frequent-Constant

When did your symptoms appear? _____
Is the condition getting progressively worse? _____

**Type of pain:**

___SHARP ___DULL ___THROBBING ___NUMBNESS ___ACHING ___SHOOTING
___BURNING ___TINGLING ___CRAMPING ___STIFNESS ___SWELLING ___OTHER_____

Does it interfere with ___SLEEP ___DAILY ROUTINE ___RECREATION?

**Activities that are painful to perform:**
___SITTING ___STANDING ___WALKING ___BENDING ___LYING DOWN ___OTHER _____

Have you ever had an X-ray, MRI or CT scan? If so, when and where?

_____

What treatments have you already received for your condition?
___ MEDICATIONS ___PHYSICAL THERAPY ___SURGERY

Name of other doctors that have treated you for your condition:
_____Phone: _____
Last Chiropractic exam/treatment: _____

**Health History:** Please check any of the following that you have or have had:

| | | | | | |
|---|---|---|---|---|---|
| ___AIDS/HIV | ___Glaucoma | ___Pacemaker | ___Alcoholism | ___Goiter | ___Parkinson's Disease |
| ___Allergy Shots | ___Lupus | ___Pinched nerve | ___Anemia | ___Gout | ___Hepatitis |
| ___Pneumonia | ___Anorexia | ___Heart Disease | ___Polio | ___Appendicitis | ___Herniated Disc |
| ___Prostate Problem | ___Arthritis | ___Hernia | ___Prosthesis | ___Asthma | ___High Blood Pressure |
| ___Psychiatric Care | ___Bleeding disorder | ___Herpes | ___Rheumatoid Arthritis | ___Breast Lump | ___Kidney Disease |
| ___Rheumatic Fever | ___Bronchitis | ___High Cholesterol | ___Scarlet Fever | ___Bulimia | ___Measles |
| ___STD | ___Cancer | ___Liver Disease | ___Stroke | ___Cataracts | ___Miscarriage |
| ___Suicide Attempt | ___Migraines | ___Thyroid Problems | ___Fibromyalgia | ___Chicken Pox | ___Multiple Sclerosis |
| ___Tonsillitis | ___Diabetes | ___Mononucleosis | ___Tuberculosis | ___Emphysema | ___Osteoporosis |
| ___Tumors, Growths | ___Epilepsy | ___Mumps | ___Typhoid Fever | ___Fractures | |
| ___Ulcers | ___Anxiety | ___Depression | ___Bipolar Disorder | ___Shingles | |

Other: _____

Are you pregnant? ___Yes ___No ____ Not Sure ____ Due Date _____

**Exercise:**
____None ____Occasionally ____Daily ____Heavy

**Work Activity**:
___ Sitting ___Standing ___Light Labor ___Heavy Labor

**Habits:**
___Smoking; Packs/Day___ _____Alcohol; Drinks/Week _____ Coffee/caffeine drinks; Cups/Day _____

**Previous Injuries:** Please include description and dates

Falls: _____
Head Injuries: _____
Broken Bones: _____
Dislocations: _____
Surgeries: _____

**Medications:**_____
_____
_____

**Family History:**
Please describe any relevant, immediate family history, e.g. cancer, diabetes, heart disease, etc.
_____
_____
_____

# COASTAL CHIROPRACTIC AUTHORIZATION FORM

**PATIENT NAME**_____

## RELEASE OF INFORMATION

I HEREBY AUTHORIZE COASTAL CHIROPRACTIC TO REALEASE MEDICAL AND FINANCIAL DATA TO MY INSURANCE CARRIERS, OTHER MEDICAL FACILITEIS AND ATTORNEY(S).

## RESPONSIBILITY OF BILL

**THE UNDERSIGNED HEREBY ACCEPTS FULL FINANCIAL RESPONSIBILITY FOR CHARGES AND SERVICES RENDERED REGARDLESS OF INSURANCE COVERAGE**.

THE UNDERSIGNED UNDERSTANDS THAT SERVICES ARE RENDERED AND CHARGED TO YOU (THE PATIENT) AND NOT TO YOUR INSURANCE COMPANY. COASTAL CHIROPRACTIC DOES NOT ACCEPT TOTAL RESPONSIBILITY FOR COLLECTING AN INSURANCE CLAIM OR NEGOTIATING A DISPUTED SETTLEMENT. IT IS THE FINANCIAL OBLIGATION OF THE UNDERSIGNED TO BE RESPONSIBLE FOR ANY CHARGES OR SERVICES NOT COVERED BY INSURANCE FOR WHICH PAYMENT IS DENIED THROUGH ANY UTILIZATION REVIEW OR PRE-CERTIFICATION PROCEDURES, OR ANY REMAINING BALANCE UPON COMPLETION OF A SETTLEMENT. THE UNDERSIGNED ALSO AGREES THAT THIS OBLIGATION SHALL EXIST REGARDLESS OF PRIVATE CONTRACTUAL AGREEMENT BETWEEN THE PATIENT AND ANY INSURANCE CARRIER, ATTORNEY OR THIRD PARTY NOT SIGNING THIS AGREEMENT.

## CONSENT FOR TREATMENT OF A MINOR CHILD

CONSENT IS HEREBY GIVEN BY THE UNDERSINGED FOR CHIROPRACTIC TREATMENT, X-RAYS AND DIAGNOSTIC STUDIES AS ORDERED BY THE DOCTORS AND THERAPIES (THERAPEUTIC MASSAGE, ELECTRICAL STIMULATION, ICE/HEAT THERAPY, HYDRO-THERAPY, THERAPEUTIC EXERCISES) PERFORMED BY THE TECHNICAL STAFF OF COASTAL CHIROPRACTIC. THE UNDERSIGNED STATES THAT HE/SHE IS THE PATIENT'S LEGAL GUARDIAN**.**

## AUTHORIZATION FOR PAYMENT OF INSURANCE BENEFITS TO PROVIDER

I HEREBY IRREVOCABLY AUTHORIZE PAYMENT OF MY MEDICAL BENEFITS OTHERWISE PAYABLE TO ME TO BE MADE PAYABLE AND MAILED DIRECTLY TO COASTAL CHIROPRACTIC FOR PROFESSIONAL SERVICES RENDERED. NO OTHER THIRD PARTY, INCLUDING MY ATTORNEY, SHOULD RECEIVE PAYMENT OF MY BILLS EXCEPT THIS OFFICE FOR THE REMAINDER OF THIS CLAIM. IT WILL BE ASSUMED AND RELIED UPON THAT THE INSURANCE CARRIER HAS AGREED TO AND ACKNOWLEDGED MEDICAL COVERAGE AND WILL SEND PAYMENT DIRECTLY TO THIS OFFICE.

_____

**PATIENT OR GUARDIAN'S SIGNATURE** **RELATIONSHIP TO PATIENT** **DATE**

COASTAL CHIROPRACTIC

28467 Dupont Boulevard
Millsboro, DE 19966
Phone 302-933-0700
Fax 302-933-0800

# Release of Medical Records

**Patient Name (please print):**_____

**Date of Birth:** _____/_____/_____

I hereby authorize _____to release all medical records, or those requested concerning the dates of treatment on or about _____ to Coastal Chiropractic, LLC.

**Please Fax the following requested information to: 302-933-0800**

- **IMAGING ONLY: X-Ray, MRI, CT Scans only (unless otherwise requested below)**
- **Other:** _____

I understand that this request for release of information stands effective for 120 days. This request may be revoked at any time but is not retroactive for requests that have been complied within good faith. This authorization may be revoked by written request to an authorized representative of Coastal Chiropractic.

**X**_____ _____/_____/_____

**Patient's Signature** **Date**

**X**_____ _____ _____/____/____

**Signature of Legal Guardian** **Relationship to Patient** **Date**

Disclosure of the specific information for release is limited to the above mentioned recipient only. Federal regulation, 42 CFR Part 2, prohibits the re-disclosure of the enclosed information unless the consent expressly permits further disclosure or the re-disclosure is otherwise permitted under regulations.

# COASTAL CHIROPRACTIC HIPAA COMPLIANCE/PATIENT CONSENT FORM

Patient Name_____

Notice of our privacy practices provides information about how we may use or disclose protected health information about you. This notice contains a patient's rights describing your rights under the law.

You have the right to restrict how your protected health information is disclosed for treatment, payment or other healthcare operations.

Authorization is voluntary and you may change or revoke this consent in writing, signed by you, however, if you do revoke the authorization, it will not have any effect on any actions taken by Coastal Chiropractic, LLC prior to the receipt of the revocation.

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## Please answer each question to the protected health information that may be used or disclosed on your behalf for treatment, payment or other healthcare operations.

May we disclose medical records to primary care physician or referring physician?
YES NO

May we disclose information about your diagnosis, treatment and services you received to your healthcare insurance for purposes of reimbursement for services rendered?
YES NO

May we phone or send a text message to confirm or update you about an appointment?
YES NO

May we leave a message on your answering machine at home or cell phone?
YES NO

May we discuss your medical condition with any member of your family?
YES NO

_____ _____

Signature of patient or representative Date