Dr. Lawrence Marrich, DC

Carlisle Health and Rehabilitation Center

3401 Carlisle Blvd. NE, Albuquerque, NM 87110

Phone (505) 889-3333 Fax (505) 837-2677

Visit Related to:

Pain Symptoms Wellness Visit Auto Accident* Work Related Injury Other Injury

Patient Information: Sex: __ Female __Male

Marital Status: __Single __Married __ Partnered __Divorced __Widowed

Full Name: _____ DOB: ____/____/____ Age: _____ SS # _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____ Occupation: _____ _____

Employer: _____ Work Phone: _____

Emergency Contact: _____ Phone #: _____

Spouse / Parent / Guardian Information:

Full Name: _____ DOB: ____/____/____ Age: _____ SS # _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Employer: _____ Work Phone: _____

Email Address: _____

AUTO or Workman's Compensation ONLY

Date of Injury: _____ Time of Accident? _____ AM PM

City and State Accident Occur? _____

Location of Accident: Street / Intersection

_____

_____

Describe then Accident:

_____

_____

In this accident, were you the: __Driver __Passenger, Front __Passenger, Rear __Pedestrian

If auto collision, were you struck from: __Front __Behind __Right Side __Left side __Auto was parked

As a result of this accident were traffic citations issued to you? __Yes __ No Driver of the other vehicle? __Yes __No

Did You Hit? __Air Bag __Steering Wheel __ Side Door __Dashboard __Windshield __ other: _____

Were You Wearing Seat Belt? __Yes __No Is there a Police Report? __Yes __No

Did You See Your PCP? __Yes __No Were You Taken to Hospital? __Yes __No

BILLING PROCEDURES FOR AUTO ACCIDENT CLAIMS

First – Our office will submit claims to your Medical Coverage under Your Auto Insurance.
Second – If your Auto Insurance Coverage is exhausted, we will then submit bills to your Health Insurance.
Third – Any unpaid charges will be submitted to your attorney (if applicable)

PLEASE NOTE:

When billing HEALTH INSURANCE for injuries sustained in an Auto accident your Chiropractic Benefits may be exhausted for the entire calendar year.

Once exhausted the benefits will not restart until beginning of the Next Calendar Year.

Do you want your health insurance billed?

___ Yes, submit bills to my Health Insurance ___No, DO NOT submit bills to my Health Insurance, ONLY submit to Auto Insurance and/or Attorney.

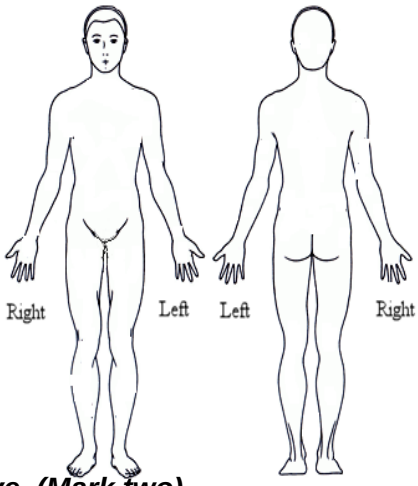
INITIAL _____

Please describe your symptoms and what brings you in for treatment:

__ Sweating
__ Depressed
__ Fever
__ Headache
__ Migraines
__ Hearing Loss L R
__ Shoulder Pain L R
__ Arm Pain L R
__ Elbow Pain L R
__ Wrist Pain L R
__ Hand Pain L R
__ Finger Pain
__ Upper Back Pain
__ Low Back Pain
__ Sleep Problem
__ Concentration
__ Neck Pain
__ Neck Stiffness
__ Hip Pain L R
__ Soreness
__ Discomfort
__ Numbness
__ Breathing Difficulties
__ Tingling
__ Dizziness
__ Fatigue
__ Weakness
__ Chest Pain
__ Rib Cage Pain
__ Memory Loss
__ Leg Pain L R
__ Sacral Pain
__ Coccyx Pain
__ Knee Pain L R
__ Ankle Pain L R
__ Foot Pain

Where specifically do you hurt? Please indicate in theist and on the Body Figure

__ Headache
__ Neck
__ Upper Back
__ Mid Back
__Lower Back
__Eyes
__Ears
__Chest
__Abdomen
__ Buttocks
__ Head
__Hip L R
__ Shoulder L R
__ Arm L R
__ Elbow L R
__ Leg L R
__ Knee L R
__ Ankle L R
__ Wrist L R
__ Hand L R
__ Jaw L R
__ Rib Cage L R



Describe on the Scale from lowest to highest of the pain you have. (Mark two)

Circle One: 0 1 2 3 4 5 6 7 8 9 10

ZERO PAIN ***UNBEARABLE PAIN***

What time of the day is the pain?

__ None __Morning __ Midday __ After Work __ Evening __ Nighttime __ All Day Long

Severity: __ Mild __ Moderate __ Severe

Frequency: __Once __ Intermittent __ Occasional __ Frequent __ Constant

Quality: __ Dull __ Aching __ Sharp __ Stabbing __ Burning __Sore

Have you Been Treated by another Facility for this injury/ Symptoms? ____ Yes ____ No
If, Yes, When and Where? _____
_____

What Activities of Daily Living are you having difficulty performing?

__Sleeping
__Walking
__Standing
__ Sitting
__ Bending
__Dressing
__Shoes
__Toileting
__ Cleaning
__ Self-Care
__ Family Care
__ Child Care
__Driving
__ Gardening
__ Working
__ Lifting
__ Desk Work
__ Traveling
__School
__ Concentrate

Describe how the pain affects these Activities of Daily Living:

_____
_____

***Circle the number that describes the pain and Activities of Daily Living (ADL)*:**

1 – No Pain
2 – Slight Discomfort
3 – Pain with No Effect on ADL's
4 – Pain with a Little Effect on ADL's
5 – Pain Prevents Any ADL's
6 – Pain Limits Work and Prevents Any ADL's
7 – Pain Prevents Both Work and ADL's
8 – Pain Prevents Working, ADL's and Activity
9 – Pain Keeps Me in Bed or Sitting at All Time
10 - Pain Everywhere, All the time

***What other conditions have you been treated for? (Explain in detail*)**

_____

What Surgeries or Procedures have you had? (Explain in detail)

_____

_____

Medical History – (Check all that apply)

__Diabetes
__Arthritis
__AIDS
__ Sciatica
__Bursitis
__ Osteoporosis
__Alzheimer
__Kidney Disease
__Gout
__ Amputation
__ Ulcers
__High Blood Pressure
__Cancer
__ Heart Attack
__Stroke
__ COPD
__Scoliosis
__Low Blood Pressure
__ Ulcers
__Deafness
__ Blindness
__Migraines
__Disc Disorder
__Neuralgia
__Constipation
__ Diarrhea
__Nausea
__Vomiting
__Varicose Vein
__Convulsions
__ Fainting
__ Sweats
__Chills
__Nervousness
__Eczema
__ Prostrate Trouble
__Bleeding
__Tonsillitis
__Earache
__ Hemorrhoids
__ Pregnancy
__ Neuro-Muscular Disease

OTHER MEDICAL INFORMATION:

List any Current Allergies: (Be specific)

_____
_____
_____

Current Medications You are Taking: (Be specific)

_____
_____
_____

I CERTIFY THAT THE ABOVE INFORMATION I HAVE GIVEN IS TRUE. I DECALRE THAT I HAVE LISTED ALL THE MEDICAL/HEALTH INSURANCE PLANS FROM WHICH I MAY RECEIVE BENEFITS.

_____

Patients Signature **Date** **Patients Name (Please Print)**

INSURANCE INFORMATION

Insurance and Primary Care Physician (PCP) Information:

INS: _____Member/Acct#: _____ Group #_____

_____

Employer: _____ Phone #: _____

Policyholder's Name: _____ Self Spouse Child Other:

PCP Name: _____ Phone #: _____

Auto Accident / Workman's Comp

1: Ins. Company: _____ Claim #: _____

Adjuster:_____

_

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

2: Ins. Company: _____ Claim #: _____

Adjuster:_____

_

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Attorney

1: Attorney Office: _____ Contact Person:

_____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Attorney

2: Attorney Office: _____ Contact Person:

_____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

PATIENT'S STATEMENT OF PRIVACY RIGHTS – HIPAA

As a patient of this practice, you have the right to privacy of your Personal Health Information and know that such information shall be properly and securely maintained by this practice, in accordance with our own policy and in compliance with the Health Information Portability and Accountability Act of 1996 (HIPAA). HIPAA was enacted to give you, the patient of a health care provider and covered under a health insurance claim, more control over your health information, to set boundaries on the health care providers and others must achieve to protect the privacy of Personal Health Information, and to hold violators accountable, with appropriate penalties for violations of a patient's right to privacy.

I hereby acknowledge receipt of this offices statement of Privacy Rights provided on my behalf and in accordance with law and have read and understand my rights to privacy and security of Personal Health Information, as a patient of this practice.

INITIAL _____

OFFICE FINANCIAL POLICY

In as much as I have consented to be treated by Dr. Lawrence Marrich, I do so with the understanding that I am directly and personally responsible to pay in full all fees for the service(s) I received. I agree unless I otherwise notify the office of Dr. Marrich within 24 hours prior to my scheduled appointment, that there will be a non-cancellation fee charged.
Health/Auto Insurance At my request, and as a courtesy to me, after providing Dr. Marrich with a copy of my insurance identification card, this office agrees to assist me financially by billing my insurance company and awaiting their direct payment of those amounts allowable under the terms of my policy. I hereby request and authorize that payment of insurance benefits for service(s) provided to me by Dr. Marrich to be made directly to Dr. Marrich. I understand that I am financially responsible for any co-payments, deductibles, and non-covered services. Dr. Marrich accepts assignment on all covered service(s) unless otherwise notified. I also direct any third-party insurer and/or my attorney to pay any outstanding charges directly to Dr. Marrich from any settlement I may receive.

I have been informed that in the event my insurance benefits are terminated or exhausted, I agree to pay all charges in full at the time services are rendered. In the event my account is turned over for collection, I agree to pay all costs of collection, including attorney's fees."

I agree to satisfy my deductible, co-payments and pay any amount not covered by my insurance company.

I also acknowledge and understand that payment for services is not contingent on any settlement, verdict, arbitration award or mediated settlement. I agree to pay for your services regardless of the outcome of any legal proceeding involving any accident in which I was involved or the injuries I suffered.

I also have been informed that the following service(s) may not be covered by my insurance company and I will pay an additional amount for the service(s). Example of service(s) not covered: Homeopathic remedies, vitamins, supplements, durable medical equipment, and modalities (Heat and electrical stimulation).

INITIAL_____

CONSENT TO TREATMENT (MINOR)

I hereby request and authorize *Dr. Lawrence Marrich,* to perform diagnosis tests and render chiropractic adjustments and other treatment to my minor son/daughter _____. This authorization also extends to all other doctors and office staff members and is intended radiographic examination at the doctor's discretion.

As of this date, I have the legal right to select and authorize health care services for the minor child named above. (If applicable) Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse or other parent is not required. If my authority to so select and authorize this care should be revoked or modified in any way, I will immediately notify the office.

INFORMED CONSENT TO TREATMENT

PATIENT NAME: _____

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The nature of the chiropractic adjustment:
The primary treatment used by Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click,' much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Examination and Treatment
As part of the examination and treatment, you are consenting to the following procedures:
___ spinal Manipulation ___ palpation ___ vital signs ___ range of motion ___ orthopedic testing
___ basic neurologic testing ___ electrotherapeutic stimulation ___ hot packs/ red light

The risk inherent in chiropractic adjustment
As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. The Doctor will male every reasonable effort during examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to the Doctor's attention it is your responsibility to inform the Doctor.

The probability of those risks occurring
Fractures are rare occurrences and generally result from some underlining weakness of the bone which we check for during the taking of your history and during examination and X-ray. Stroke and/or arterial dissection cause by chiropractic manipulation of the neck has been the subject of ongoing medical research and debate. The most current research on the topic is inconclusive as to a specific incident of this complication occurring. If there is a casual relationship at all it is extremely rare and remote. Unfortunately, there is not recognized screening procedure to identify patients with neck pain who are at risk of arterial stroke.

The availability and nature of other treatment options
Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and painkillers
- Hospitalization
- Surgery

If you chose to use of the above "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated
Remaining untreated may allow the formation of adhesions and reduce mobility which nay set up a pain reaction further reducing mobility. Over time this process may complicates treatment making it more difficult and less effective the longer it is postponed.

Patients Signature	**Date**	**Patients Name (Please Print)**
Parent/Guardian Signature	**Parent/Guardian Name (Please Print)**	
Witness (Office staff)	**Date**	