# Feeney Chiropractic Care Centre, LLC

John P. Feeney, D.C.

File #

Name:_____ Date:_____
Address:_____ City:_____ State:_____ Zip:_____
DOB:_____ Age _____ Social Security #_____
Home #:_____ Work #:_____ Cell #:_____ E-mail:_____
Handedness Right / Left

Primary Care Physician:_____
Referred to Feeney Chiropractic Care Centre:_____

Date of Injury:_____ Time: _____
or
Period of time over which your injury occurred:_____

Name of Insurance Company Responsible for the Payment of Your Injuries:_____
Address: _____ City:_____ State:_____Zip:_____
Claim#:_____ Claim Agent: _____ Ph#_____

Very Important (for your protection)
❑ Yes ❑ No
I have completed and turned in all of the paperwork, forms, etc. required by the Insurance Company in order to initiate payment on my medical bills. You should be fully aware that it is your responsibility to complete the necessary paperwork as mandated by the Insurance Carrier that is responsible for the payment of all medical expenses that you may have already accrued from other treatment(s) or shall accrue from this or any subsequent treatment(s).
If this paperwork is not completed (in a timely manner) the Insurance Company will not initiate the payment of your benefits and may choose to deny payment on your entire claim, regardless of the party at fault.
We are here to help you simplify this process by answering any questions to the best of our ability. Please do not hesitate to ask for assistance.

❑ Yes ❑ No Do you have any Private Health Insurance (this is for your protection in case of the denial of your claim)?

Name of Private Insurance:_____
ID#: _____
* Please Note, this information is for your protection in case there is an emergency
* Please provide a copy of your private insurance card

❑ Yes ❑ No Do you have an attorney to assist you?
If yes, Name of Law Firm:_____
Name of Attorney:_____
Address: _____City:_____
State:_____ Zip:_____

Employer:_____ Phone:_____
Occupation:_____ Job: Position_____
Employer Address:_____City:_____State:_____Zip:_____
How long have you been employed by your present employer?_____

❒ **Yes** ❒ **No** Did your injuries occur from a single incident.
If yes, what date?_____ Approx Time?(if known)_____

❒ **Yes** ❒ **No** Did your injuries occur over a period of time?
If yes, approximately what was the time phrase of occurrence? _____

❒ **Yes** ❒ **No** Were you performing your normal job duties when injured?

❒ **Yes** ❒ **No** Did your injuries occur on your jobsite?
If no to above question, where did your injury occur? _____
_____

## Injury Details

Briefly describe how you injured yourself:_____
_____
_____
What were your immediate symptoms?_____
_____
_____

❒ **Yes** ❒ **No** Did anyone witness your injuries?
❒ **Yes** ❒ **No** Did you report your injuries to your supervisor?
❒ **Yes** ❒ **No** Did you report your injuries to someone other that your supervisor?
Name of the person you reported your injuries to:_____
Name of the contact person (if needed) to discuss your condition:_____
Telephone #:_____

❒ **Yes** ❒ **No** Were you given any specific recommendations after reporting your injuries?
If yes, please briefly describe_____
_____
_____

❒ **Yes** ❒ **No** ❒ **Don't Recall** After your injury, did you lose consciousness?
If yes, please describe_____
❒ **Yes** ❒ **No** Did you sustain any cuts, lacerations or bruises?
If yes, please describe_____
❒ **Yes** ❒ **No** Have your symptoms changed since you originally got injured?
If yes, please describe_____
❒ **Yes** ❒ **No** ❒ **Don't Recall** Did your feet/ankles get twisted or jammed into the floorboard?

❒ **Yes** ❒ **No** Did your body strike anything else within the vehicle? If yes, please describe_____
_____

❒ Yes ❒ No Did you go to your company's employee health center?
If yes, what treatment was conducted?_____
_____

❒ Yes ❒ No Were you given any specific recommendations or placed on any restrictions from employee health? _____
If yes, what were they?_____

❒ Yes ❒ No Did you see a company physician?

❒ Yes ❒ No If yes, was any treatment conducted?
If treatment was rendered at employee health, please briefly describe_____
_____
_____

❒ Yes ❒ No Were you taken to the Emergency Room immediately after the accident? (If yes, how were you transported) ❒ Ambulance ❒Drove Self ❒ Driven by another ❒ Medi-Vac

❒ Yes ❒ No Did you go to the Emergency Room later in the day or at all? If you went to the Emergency Room, which one? _____

If you went to the Emergency Room, did you (check all that apply)
❒ get examined ❒ have x-rays ❒ have a Cat Scan ❒ have an EKG
❒ get stitches ❒ get casted ❒ get admitted to the hospital
❒ other:_____

❒ Yes ❒ No Were you prescribed any medications? If yes, which ones?_____
_____

## Follow-up Treatment

❒ Yes ❒ No Have you seen your family physician? If yes, what medications/treatments were prescribed?_____

❒ Yes ❒ No Was physical therapy prescribed?
If yes, where?_____
For how long?_____
Approximate times per week?_____

❒ Yes ❒ No Have you been referred to any specialist (i.e. Neurosurgeon, Neurologist, Orthopedic Surgeon, Physiatrist, etc.)
If yes, please list:
1. _____
2. _____
3. _____
4. _____
5. _____

❒ Yes ❒ No Due to your injuries, have you had any of the following tests?

LOCATION

❒ X-Rays_____
❒ MRI_____
❒ Cat Scan_____
❒ EMG_____
❒ Other_____
_____

**AUTHORIZATION AND RELEASE:** I authorize payment of insurance benefits directly to the Feeney Chiropractic Care Centre. I authorize physician to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. In the unanticipated event that the expenses for my treatment are not covered by my Insurance Carrier (or Private Insurance) I am responsible for payment of professional services.

I understand and agree to allow Feeney Chiropractic Care Centre to use my Patient Health Information for the purposes of treatment, payment, healthcare operations, and coordination of care. I understand that my medical records are privileged and confidential information and that my records will be utilized by this office strictly within the parameters of my legal rights concerning said records.

I am aware that there is a more detailed account of all policies and procedures concerning the privacy of my Patient Health Information. We encourage you to read the HIPAA NOTICE that is available to you desk for you to read in its entirety at the front, before signing this notice. If there is anyone you do not want to receive your medical records, please inform our office.

_____ _____

Patient Signature Date

_____ _____

Guardian's Signature Authorizing Care Date

## Present complaints due to accident:

| | | | | | |
|---|---|---|---|---|---|
| ❒ Yes | ❒ No | Headaches | ❒ Yes | ❒ No | Cramp of muscles in left leg |
| ❒ Yes | ❒ No | Dizziness | ❒ Yes | ❒ No | Cramping of muscles in right leg |
| ❒ Yes | ❒ No | Light sensitivity | ❒ Yes | ❒ No | Left knee pain |
| ❒ Yes | ❒ No | Nausea with headaches | ❒ Yes | ❒ No | Right knee pain |
| ❒ Yes | ❒ No | Jaw pain | ❒ Yes | ❒ No | Left foot and/or ankle pain |
| ❒ Yes | ❒ No | Facial pain | ❒ Yes | ❒ No | Right foot and/or ankle pain |
| ❒ Yes | ❒ No | Heaviness of head | ❒ Yes | ❒ No | Anxiety |
| ❒ Yes | ❒ No | Neck pain and/or stiffness | ❒ Yes | ❒ No | Tension |
| ❒ Yes | ❒ No | Numb, tingling and/or weak down left arm | ❒ Yes | ❒ No | Insomnia |
| ❒ Yes | ❒ No | Numb, tingling and/or weak down right arm | ❒ Yes | ❒ No | Depression |
| ❒ Yes | ❒ No | Left shoulder pain | ❒ Yes | ❒ No | Difficulty with concentration |
| ❒ Yes | ❒ No | Right shoulder pain | ❒ Yes | ❒ No | Irritability |
| ❒ Yes | ❒ No | Cramping of muscles in left arm | ❒ Yes | ❒ No | Loss of taste |
| ❒ Yes | ❒ No | Cramping of muscles of right arm | ❒ Yes | ❒ No | Loss of smell |
| ❒ Yes | ❒ No | Mid back pain and/or stiffness | ❒ Yes | ❒ No | Vision change |
| ❒ Yes | ❒ No | Pain into rib cage | ❒ Yes | ❒ No | Memory loss |
| ❒ Yes | ❒ No | Sternal pain | ❒ Yes | ❒ No | Fatigue |
| ❒ Yes | ❒ No | Low back pain and/or stiffness | ❒ Yes | ❒ No | Mental dullness |
| ❒ Yes | ❒ No | Numb, tingling and/or weak down left leg | ❒ Yes | ❒ No | Ringing or buzzing in ears |
| ❒ Yes | ❒ No | Numb, tingling and/or weak down right leg | | | |

**Notes:**

## Present Medications

| Injury Related | Prior to Injury |
|---|---|
| | |

**As a result of your injuries, are any of the following conditions difficult or impossible to perform? Check all that apply.**

| | | | |
|---|---|---|---|
| ☐ Yes | ☐ No | ☐ Not Applicable | Heavy lifting (50 lbs. and above from ground level) |
| ☐ Yes | ☐ No | ☐ Not Applicable | Moderate lifting (25 lbs. to 49 lbs. from ground level) |
| ☐ Yes | ☐ No | ☐ Not Applicable | Light lifting (Less than 25 lbs. from ground level) |
| ☐ Yes | ☐ No | ☐ Not Applicable | Bending |
| ☐ Yes | ☐ No | ☐ Not Applicable | Twisting |
| ☐ Yes | ☐ No | ☐ Not Applicable | Standing |
| ☐ Yes | ☐ No | ☐ Not Applicable | Sitting |
| ☐ Yes | ☐ No | ☐ Not Applicable | Sleeping |
| ☐ Yes | ☐ No | ☐ Not Applicable | Gripping |
| ☐ Yes | ☐ No | ☐ Not Applicable | Pushing |
| ☐ Yes | ☐ No | ☐ Not Applicable | Pulling |
| ☐ Yes | ☐ No | ☐ Not Applicable | Reaching |
| ☐ Yes | ☐ No | ☐ Not Applicable | Housework |
| ☐ Yes | ☐ No | ☐ Not Applicable | Dressing self (i.e. putting shoes on) |
| ☐ Yes | ☐ No | ☐ Not Applicable | Bathing/ Showering |
| ☐ Yes | ☐ No | ☐ Not Applicable | Brush teeth in morning |
| ☐ Yes | ☐ No | ☐ Not Applicable | Shaving |
| ☐ Yes | ☐ No | ☐ Not Applicable | Caring for children |
| ☐ Yes | ☐ No | ☐ Not Applicable | Sexual Activities |

☐ Yes ☐ No Is there anything that makes you feel better? (i.e.: medication, exercise, heat/ice, rest)
(if yes , please explain) _____
_____

## Past Medical History

☐ Yes ☐ No 1. Did you have any of your current complaints prior to the accident?
(if yes, please explain)_____
_____
_____

☐ Yes ☐ No 2. Have you ever had an auto and/or work comp claim(s) in the past? (if yes, please list them and approx. dates): _____
_____
_____

☐ Yes ☐ No 3. Have you ever been given an impairment rating or been listed with permanent injuries?_____

☐ Yes ☐ No 4. Have you had any other major injuries in the past? (i.e., Auto accidents, falls, traumas etc. If yes, please explain) _____
_____

**(Do you have any of the following disorders?)**

- ❒ **Yes** ❒ **No** Allergies
- ❒ **Yes** ❒ **No** Anemia
- ❒ **Yes** ❒ **No** Asthma
- ❒ **Yes** ❒ **No** Cancer
- ❒ **Yes** ❒ **No** Chronic Obstructive Pulmonary Disease
- ❒ **Yes** ❒ **No** Diabetes
- ❒ **Yes** ❒ **No** Depression/Anxiety
- ❒ **Yes** ❒ **No** Emphysema
- ❒ **Yes** ❒ **No** Gastrointestinal problems (i.e. Colitis, Chron's Disease)
- ❒ **Yes** ❒ **No** Heart Disease
- ❒ **Yes** ❒ **No** Hepatitis / Cirrhosis
- ❒ **Yes** ❒ **No** High Blood Pressure
- ❒ **Yes** ❒ **No** High Cholesterol
- ❒ **Yes** ❒ **No** HIV / AID's
- ❒ **Yes** ❒ **No** Stroke
- ❒ **Yes** ❒ **No** Thyroid Disease
- ❒ **Yes** ❒ **No** Ulcers (peptic or gastric)
- ❒ **Yes** ❒ **No** Other Medical Conditions (if yes, please describe): _____

_____

**<u>Surgical History:</u> (List surgeries (other than surgeries due to this accident) and approximate dates)**

1. _____
2. _____
3. _____
4. _____
5. _____

## Social History

1. Martial Status: _____ Number of Children:_____

2. Education Status (check all that apply):
   - ❒ Grade School
   - ❒ High School
   - ❒ GED
   - ❒ Some College
   - ❒ Associates Degree
   - ❒ Specialty Degree (PTA, Dental Hygienist, Chiropractic Tech, MRI Tech)
   - ❒ 4 Year Degree
   - ❒ Graduate Degree
   - ❒ Doctorate (PhD, EdD, etc)
   - ❒ Professional Degree (MD, DO, DC, DDS, DVM, DPMETC)
   - ❒ Professional Health Care Degree (RN, PT, ATC, PA, CNP, etc.)

## Job Description and Work History

**Employer:** _____
**Job Title:** _____
❒ **Yes** ❒ **No** Does your job require lifting? If yes, what is the maximum amount you are required to lift? _____

Place a ✓ next to all that apply to your job requirements:

- ❒ Lifting (max weight)
- ❒ Bending
- ❒ Twisting
- ❒ Gripping
- ❒ Repetitive Use of arms
- ❒ Pushing
- ❒ Pulling
- ❒ Reaching
- ❒ Overhead Activity
- ❒ Repetitive use of legs

Others: _____

What is the average number of hours you are required to sit per day? _____
What is the average number of hours you are required to stand per day? _____
What is the average number of hours you are required to work per week? _____

❒ **Yes** ❒ **No** Do you smoke tobacco? (if yes how much do you smoke) _____ packs per week.
❒ **Yes** ❒ **No** Do you chew tobacco? (if yes, On Rare Occasions _____ Moderate _____ Heavy _____ ).

❒ **Yes** ❒ **No** Do you consume alcohol?

a. Never _____
b. Very Rarely _____
c. Lightly_____ (average 1 drink or less per day)
d. Moderately _____ (average 2-3 drinks per day)
e. Heavily _____ (average 4 or more drinks per day)

**Scale: 1 Drink = 12 oz. of Beer**
**5 oz. of Wine**
**1 oz. of Hard Liquor**

❒ **Yes** ❒ **No** Have you ever been addicted to alcohol, prescription drugs, or street drugs?

## Recreational Activities

List some of the hobbies or recreational activities you enjoyed prior to your injury. Place an **X** by those activities you can no longer perform/enjoy because of your injury (i.e., hiking, dancing, playing with and/or lifting children, jogging, aerobics, working out, going out with friends, etc.).

1._____ 4._____

2._____ 5. _____

3._____ 6._____

## Disability and/or Job Restrictions:

❒ **Yes** ❒ **No** Are you currently on disability due to your injuries (i.e. not working at all)?
If yes, what is the name of the Doctor who placed you on disability?

_____

If yes, dates of disability: _____

❒ **Yes** ❒ **No** Where you previously disabled do to your injuries?
If yes, what is the name of the Doctor who placed you on disability?

_____

If yes, dates of disability: _____

❒ **Yes** ❒ **No** Do you currently have any job restrictions?
If yes, what is the name of the Doctor who gave you restrictions?

_____

Please describe your restrictions:_____

_____

_____

## Patient request for Patient Records

**Date:** _____

**To:** _____

**Patient Name:** _____

**I hereby authorize the release of my Medical Records and request that they be transferred to:**

***Feeney Chiropractic Care Centre***
***835 Pulaski Highway***
***Bear, DE 19701***

**Patient Signature:**_____

**Social Security :**_____

# Feeney Chiropractic Care Centre, LLC

John P. Feeney, D.C.

## Worker's Compensation

**Patient Payment:** Patient's covered by worker's compensation need only pay for food supplements and orthopedic supports. All other services are covered 100% by your insurance. If there are any exceptions, you will be advised of them immediately.

**Explanation of Benefits:** Worker's compensation covers all examinations, treatment, and x-ray costs once treatment has been authorized. Your employer has the sole right whether to grant authorization for treatment or not. Your supervisor on the job can also grant authorization. If authorization is refused, the patient may undergo treatment using coverage provided by your major medical or group health plan.

**Office Policy:** Patients involved in a worker's compensation case must bring in a signed authorization for treatment to our office. If signed authorization is not brought to our office within one week of the date of your first visit, the balance will be transferred to your account. You will be responsible for all charges until authorization is received from your employer.

**PLEASE NOTIFY OUR OFFICE OF THE NAME OF YOUR ATTORNEY OR ASK US FOR THE NAME OF SEVERAL IN YOUR AREA.**

### AUTHORIZATION TO PAY PHYSICAN AND RELEASE INFORMATION

I authorize payment of medical benefits directly to Feeney Chiropractic Care Centre, LLC. for professional services rendered in this office. I also authorize the release of any medical information and medical records necessary to process my claims. I have received a copy of this financial statement for my records.

_____ / ____ / _____
DATE

_____
PATIENT SIGNATURE

835 PULASKI HIGHWAY (ROUTE 40) – BEAR, DELAWARE 19701 – (302) 328.0200 – FAX: (302) 328.3289

**Feeney Chiropractic Care Centre, LLC**

**John P. Feeney, D.C.**

# Notice of Doctor's Lien

Patient: _____

Date of Accident: _____

I do hereby authorize _____ to furnish you, my attorney, with a full report of his examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I was recently involved.

I hereby authorized and direct you, my attorney, to pay directly to said doctor such sums as may be due and owing him for medical service rendered me both by reason of this accident and by reason of any other bills that are due to his office and to withhold such sums for any settlement, judgment or verdict as may be necessary to adequately protect and fully compensate said doctor. And I hereby further give a Lien on my case to said doctor against any and all proceeds of my settlement, judgment or verdict which may be paid to you, my attorney, or myself, as the result of the injuries for which I have been treated were injuries in connection therewith.

I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by him for service rendered me and that this agreement is made solely for said doctors additional protection and in consideration of his awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

I agree to promptly notify said doctor of any change or edition of attorney(s) used by me in connection with this accident, and I instruct my attorney to do the same and promptly deliver a copy of this lien to any such substituted or added attorney(s).

Please acknowledge this letter by signing below and returning to the doctor's office. I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment but may declare the entire balance due and payable.

Dated: _____ Patient's Signature: _____

The undersigned being attorney of record for the above patient does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment, or verdict, as may be necessary to adequately protect and fully compensate said doctor above-named. Attorney further agrees that in the event this lien is litigated that the prevailing party will be awarded attorney fees and costs.

Dated: _____ Attorney's Signature: _____

835 PULASKI HIGHWAY (ROUTE 40) – BEAR, DELAWARE 19701 – (302) 328.0200 – FAX: (302) 328.3289

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John P. Feeney, D.C.

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Dated: _____ Attorney's Signature: _____

Feeney
Chiropractic
Care
Centre, LLC

John P. Feeney, D.C.

## LIMITED POWER OF ATTORNEY TO ENDORSE CHECKS

**KNOW ALL MEN BY THESE PRESENTS: That the undersigned has made, constituted, and appointed**

## FEENEY CHIROPRACTIC CARE CENTRE

**And any of its duly authorized agents and employees as and to be the undersigned's true and lawful Attorney for and in the undersigned's name, place, and stead to endorse any and all checks, drafts, or money orders which are made payable to the undersigned. Said checks, drafts, or money orders are to pay for chiropractic services or the like, which have been or are to be performed at the request or with the knowledge and approval of the undersigned and/or the maker of the check, draft, or money order.**

**The undersigned by these presents does thus give and grant this limited power of attorney to the above named office or doctor, including the full power and authority to do and perform as the undersigned might or could do if personally present as far as the endorsing and cashing of said checks are concerned.**

**The undersigned does hereby ratify and confirm any and all actions taken by the said office or doctor in accordance with this special power of attorney and which the said office or doctor shall do or cause to be done by virtue of these presents.**

**IN WITNESS THEREOF the undersigned have set their hands, this _____ day of _____, 20_____.**

**Patient's full name:**_____

**Signature of patient:**_____

**Witness to patient's signature:**_____

# Feeney Chiropractic Care Centre, LLC

John P. Feeney, D.C.

**PATIENT:** _____

**ID#:** _____

**GROUP#:** _____

I hereby instruct and direct that _____ Insurance Company to pay by check made out and mailed to:

**Feeney Chiropractic Care Centre, L.L.C.**
**835 Pulaski Hwy.**
**Bear, DE 19701**
**Employer ID#: 46-1703135**

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

**C/O Feeney Chiropractic Care Centre, L.L.C.**
**835 Pulaski Hwy.**
**Bear, DE 19701**

The professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the 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, nay balance of said professional service charges over and above this insurance payment.

A photocopy of this assignment shall be considered as effective and valued as the original.

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

_____ _____/_____/_____
Signature of Patient Date

_____ _____
Signature of Policyholder Witness

**I hereby authorize Feeney Chiropractic Care Centre, L.L.C. to file a formal written complaint with the Insurance Commissioner when necessary.**

_____
Signature of Patient