

## BILLING INFORMATION SHEET

ALL INFORMATION ON THIS SHEET MUST BE OBTAINED AND VERIFIED NO LATER THAN 7 BUSINESS DAYS FROM THE FIRST VISIT OF THE PATIENT TO THE CLINIC

PATIENT LAST NAME	
PATIENT FIRST NAME	
PATIENT ADDRESS, STREET NUMBER, STREET, CITY, STATE, ZIP	
PATIENT GENDER M/F	
PATIENT DOB MM/DD/YYYY	
WHAT KIND OF INJURY AUTO / WORK / OTHER	
DATE OF INJURY MM/DD/YYYY	
DATE OF FIRST TREATMENT MM/DD/YYYY	
CAR INSURANCE NAME	
CAR INSURANCE CLAIM #	
CAR INSURANCE CLAIM ADJUSTER TELEPHONE AND TEL EXTENTION	
HEALTH INSURANCE NAME IF NONE TYPE "NONE"	
HEALTH INSURANCE POLICY HOLDER IF SELF TYPE "SELF"	
HEALTH INSURANCE MEMBER ID	
IS THIS A MASS HEALTH SUBSIDIZED PLAN? Y / N	
WAS THIS COVERAGE IN FORCE ON THE DATE OF ACCIDENT Y / N	
IS THIS AN ERISA PLAN Y/N IF YES ASK FOR ERISA LETTER FROM INS	
OBTAIN HEALTH INSURANCE CARD PREFERRED TO OBTAIN Y / N	
WAS TAKEN TO THE HOSPITAL BY AMBULANCE Y / N	
OBTAIN HOSPITAL CHARGES Y / N	
OBTAIN ANY MEDICAL RECORDS RELATED TO THIS ACCIDENT Y / N	
SAW ANY OTHER MEDICAL PROVIDER? IF YES WHO/WHEN/REASON	
OBTAINED POLICE OR CRASH REPORT Y / N	
<b>NONE OF THE WORKMAN'S COMP CASES SHOULD BE SCHEDULED UNLESS THE INFORMATION BELOW IS AVAILABLE ON THIS SHEET</b>	
WC INSURANCE NAME, ADDRESS AND TELEPHONE NUMBER	
WC INSURANCE CLAIM#	
WC INSURANCE POLICY NUMBER	
EMPLOYER NAME AND TELEPHONE NUMBER	
ATTORNEY NAME	
ATTORNEY ADDRESS	
ATTORNEY TELEPHONE NUMBER	

# Vehicle Accident Report

**Patient Name:** \_\_\_\_\_

**Date of the accident:** \_\_\_\_\_ **Time of the accident:** \_\_\_\_\_ AM PM

**Patient Role:**  Driver  Front passenger  Rear passenger  Motorcycle operator  Motorcycle passenger  
 ATV operator  ATV passenger  Other \_\_\_\_\_

**Vehicle Size:**  Subcompact  Compact  Mid-size  Full-size  Other \_\_\_\_\_

**Vehicle Type:**  Car  SUV  Truck  Motorcycle  Other \_\_\_\_\_

**Travel Direction:**  North  South  East  West  Other \_\_\_\_\_ **MPH:** \_\_\_\_\_

**Road Conditions:**  Dry  Damp  Wet  Snow  Ice  Other \_\_\_\_\_

**Time of Day:**  Daylight  Dawn  Dusk  Night  Other \_\_\_\_\_

**Seat Belt:**  Used  Not used

**Shoulder Belt:**  Used  Not used

**Head Rest:**  Above head  Even with head  Below head  None

**Air Bags:**  Deployed  Did not deploy

**Driver Braking:**  Yes  No

**Accident Anticipated:**  Yes  No

**Vehicle Struck:**  Another Vehicle  By another Vehicle  A stationary object  Multiple impacts  
 Other \_\_\_\_\_

**Collision Location:**  Head On  Front  Behind  Passenger's Side  Driver's Side  
 Other \_\_\_\_\_

**Patient Struck:**  Steering wheel  Air bag  Dashboard  Rear-view mirror  Windshield  Car Interior  
 Other \_\_\_\_\_

**Moment of Impact:**  Tensed body  Neck whipped  Spine (back) twisted  Thrown over seat  Thrown side to side  
 Pinned by vehicle  Other \_\_\_\_\_

**Patient Exited Vehicle:**  Under own power  Assisted by EMS  Assisted by other  Was extricated  
 Other \_\_\_\_\_

**Patient Ejected:**  Ejected  Not ejected

**Patient Conscious:**  Lost consciousness  Did not lose consciousness

**Patient Disoriented:**  Yes  No

**Medical Attention:**  Received on scene  Not received at site

**Patient went to:**  This office  Hospital  Personal doctor  Home  Work  Resumed activities  
 Other \_\_\_\_\_

**Other Vehicle Size:**  Subcompact  Compact  Mid-size  Full-size  Other \_\_\_\_\_

**Other Vehicle Type:**  Car  SUV  Truck  Motorcycle  Other \_\_\_\_\_

**Other Travel Direction:**  North  South  East  West  Other \_\_\_\_\_ **MPH:** \_\_\_\_\_

**Other Collision Location:**  Head On  Front  Behind  Passenger's Side  Driver's Side  
 Other \_\_\_\_\_

**Injury Area(s):**  Head  Neck  Shoulders  Upper/Mid Back  Lower Back  Chest/Ribs  Arms  Elbows  
 Forearms  Wrists  Hands  Abdomen  Buttocks  Pelvis  Hips  Thighs  Legs  
 Knees  Ankles  Feet  Other \_\_\_\_\_

**Patient's/Guardian's Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

# NEW PATIENT HEALTH HISTORY QUESTIONNAIRE

Today's Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**WELCOME:** The doctor and staff welcome you and want you to provide you with the best possible care. We will conduct a thorough history and physical examination to decide if we can assist you. If we do not believe that your condition will respond to our care, we will refer you to the appropriate healthcare provider. If you are a candidate for care in this office, then a treatment plan will be recommended to fit your individual needs.

**INSTRUCTIONS:** Please complete the following information in its entirety. The information submitted on this form is strictly confidential. If you have difficulty understanding any portion of this for, please ask for assistance. If the question does not pertain to you, simply write in N/A for non-applicable.

**PERSONAL INFORMATION:**

Name: (First) \_\_\_\_\_ (Middle) \_\_\_\_\_ (Last) \_\_\_\_\_ Jr., II, III, IV  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Birth Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age: \_\_\_\_ Marital Status (Circle): Divorced Married Single Separated Widowed  
 Gender (Circle): Male / Female Home Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
 Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Email Address: \_\_\_\_\_ @ \_\_\_\_\_  
 Spouses Name: \_\_\_\_\_ Names & Ages of Children: \_\_\_\_\_  
 Is your spouse a patient in our office?  Yes  No

**Employer /Employment Status**  Employed  Unemployed  Full Time /  Part Time Student  Other

Business Name: \_\_\_\_\_ Occupation/Job Title: \_\_\_\_\_  
 Business Address: \_\_\_\_\_  
 Business Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Type of Work: \_\_\_\_\_  
 Is it ok to contact you at work?  Yes  No

**Emergency Contact Information**

Name: (First) \_\_\_\_\_ (Middle) \_\_\_\_\_ (Last) \_\_\_\_\_ Jr., II, III, IV  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Relationship: \_\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**PAYMENT/INSURANCE INFORMATION:**

Is the condition(s) that brought you here today due to an automobile accident or on the job injury?  
 Yes  No

Who besides yourself is responsible for your bill?  Self-Pay  Health Insurance  Auto Claim

Personal Health Insurance Carrier: \_\_\_\_\_ Health ID Card #: \_\_\_\_\_  
 Insured Person's Name: \_\_\_\_\_ Group #: \_\_\_\_\_  
 Insured Person's Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
 Insured Person's Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
 Auto or Workers' Comp Insurance Carrier & Claim #: \_\_\_\_\_

**PRIMARY COMPLAINT:**

When did it start? \_\_\_\_\_  
 Describe the condition: \_\_\_\_\_  
 What do you think caused the problem? \_\_\_\_\_  
 Rate the pain from 1-10: At it's worst \_\_\_\_ At the present time \_\_\_\_ At least severe \_\_\_\_  
 Does the pain travel?  Yes  No If yes, from where to where? \_\_\_\_\_  
 Is condition getting worse?  Yes  No  
 List the activities that this condition prevents you from doing? \_\_\_\_\_  
 List past treatment for this condition and if they helped \_\_\_\_\_

**SECOND COMPLAINT:**

When did it start? \_\_\_\_\_

Describe the condition: \_\_\_\_\_

What do you think caused the problem? \_\_\_\_\_

Rate the pain from 1-10: At it's worst \_\_\_\_\_ At the present time \_\_\_\_\_ At least severe \_\_\_\_\_

Does the pain travel?  Yes  No If yes, from where to where? \_\_\_\_\_

Is condition getting worse?  Yes  No

List the activities that this condition prevents you from doing? \_\_\_\_\_

List past treatment for this condition and if they helped \_\_\_\_\_

**THIRD COMPLAINT:**

When did it start? \_\_\_\_\_

Describe the condition: \_\_\_\_\_

What do you think caused the problem? \_\_\_\_\_

Rate the pain from 1-10: At it's worst \_\_\_\_\_ At the present time \_\_\_\_\_ At least severe \_\_\_\_\_

Does the pain travel?  Yes  No If yes, from where to where? \_\_\_\_\_

Is condition getting worse?  Yes  No

List the activities that this condition prevents you from doing? \_\_\_\_\_

List past treatment for this condition and if they helped \_\_\_\_\_

**LIST MEDICATIONS, VITAMINS, SUPPLEMENTS:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**LIST PAST TRAUMA, ACCIDENTS, INJURIES, HOSPITALIZATIONS, SURGERIES:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**LIST FAMILY HISTORY, SOCIAL HISTORY, EXERCISE LEVEL, SMOKING, STRESS LEVEL:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Is there any other information that you feel would be relevant to your current condition(s) that was not covered?

Please explain in the following section any information that you feel would be helpful to the doctor.

---

---

---

**AUTHORIZATION FOR RELEASE OF INFORMATION:**

I authorize the release of any medical information necessary to process my insurance claims.

**AUTHORIZATION OF ASSIGNMENT:**

I authorize payment of medical benefits to *Chawla Chiropractic, PLLC* for services rendered to me.

**REIMBURSEMENT POLICY:**

We often do not know exactly what your insurance company will pay us until we receive payment. Either way, we usually accept their payment after any deductible, co-payment and co-insurance is handled. Please understand that your insurance is an agreement between you and your insurance company and all services rendered to you are ultimately your responsibility.

**ACCEPTANCE AS A PATIENT:**

I understand and agree that this office has the right to refuse to accept me as a patient at any time before treatment begins, or terminate my care as a patient if in the course of treatment if I am not following the treatment plan for my condition, or be referred out to another health provider as the doctor deems medically necessary. I understand that the taking of a history and the conducting of a physical examination are not considered treatment, but are part of the process of information gathering so that the doctor can determine whether to accept me as a patient.

---

**PATIENT PRINTED NAME**

---

**PATIENT SIGNATURE**

---

**DATE**

**HEALTH BENEFIT AFFIDAVIT**

In accordance with Chapter 273 of the Acts of 1988, you are required to provide information regarding other health benefits (HMO, Medicare/Masshealth, etc.) available to you before processing a claim for Personal Injury Protection Benefits (P.I.P.).

Any medical expenses in excess of \$2,000.00 will not be paid under P.I.P. , if those expenses will be compensated, paid or indemnified by an outside insurance carrier (HMO, PPO, etc.). Bills submitted for payment over the \$2,000.00 limit must be accompanied by a statement from your health carrier as to their reason for non-payment. If your health insurance carrier does not cover your medical bills at 100 percent, P.I.P. may honor the partial outstanding charges.

If you have other benefits available to you, please complete SECTION ONE. In addition, if you have benefits available to you through any other policy (spouse, parent, legal guardian), please be sure to complete SECTION TWO, as well. If you do not have any other benefits available through your own policy or that of a household member, please sign SECTION THREE. For the purposes of P.I.P. benefits, coverage by Masshealth and Medicare is *not* considered health insurance.

**SECTION ONE: Benefits Information - Policy Holder**

Your Name: \_\_\_\_\_

Health Insurance Company: \_\_\_\_\_

Policy /Group Number: \_\_\_\_\_

Member Services Telephone Number: \_\_\_\_\_

Date: \_\_\_\_\_ Signature: \_\_\_\_\_

**SECTION TWO: Additional Benefits Information - Not the Policy Holder**

Health Insurance Company: \_\_\_\_\_

Policy /Group Number: \_\_\_\_\_

Policyholder: \_\_\_\_\_

Relationship: \_\_\_\_\_

Member Services Telephone Number: \_\_\_\_\_

Date: \_\_\_\_\_ Signature: \_\_\_\_\_

**SECTION THREE: No Insurance**

I certify that I do not have any accident and/or health benefits available to me through my own policy or that of a household member.

Date: \_\_\_\_\_ Signature: \_\_\_\_\_

I certify that I carry MassHealth/BMC HealthNet \_\_\_\_\_ or Medicare/Medicaid \_\_\_\_\_. I do not have any accident and/or health benefits available to me through my own policy or that of a household member.

Date: \_\_\_\_\_ Signature: \_\_\_\_\_

## APPLICATION FOR BENEFITS – PERSONAL INJURY PROTECTION

Date	Date of Accident	Claim Number	
Your Name:		Telephone Number: Home: ( ) _____ - _____ Work: ( ) _____ - _____	
Your Address:		Date of Birth:	Social Security Number
Date of Accident: / /	Time: A.M. P.M.	Place of accident(Street, City or Town, State)	
Brief description of accident:			
At Time of Accident: Were you the driver of the car?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Were you a passenger in the car?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Were you a pedestrian?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
As a result of this accident, were you injured <input type="checkbox"/> Yes			
Describe Your Injury:			
Please Describe Names and Addresses Of All Medical Providers You Have Seen And What Procedures Have Been Done To This Date:			
At the time of your accident, were you in the course of your employment? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
If you lost time:	Date disability from work began:	Date you returned to work:	
Employer and address	Occupation	From	To
Signature:		Date:	

**AUTHORIZATION FOR MEDICAL INFORMATION**

This authorization or photocopy hereof, will authorize you to furnish all information you may have regarding my condition while under your observation or treatment, including the history obtained, x-ray and physical findings, diagnosis and prognosis. You are authorized to provide this information in accordance with the Massachusetts Personal Injury Protection Benefits Law.

---

Signature

Date

**AUTHORIZATION FOR WAGE AND SALARY INFORMATION**

This authorization or photocopy hereof will authorize you to furnish all information you may have regarding my wages or salary while employed by you. You are authorized to provide this information in accordance with the Massachusetts Personal Injury Protection Benefits Law.

---

Signature

Date

**AUTHORIZATION FOR RELEASE OF COVERAGE INFORMATION BY EMPLOYER  
OR OTHER MEDICAL EXPENSE PROVIDER**

This authorization or photocopy hereof, will authorize you to furnish all information you may have regarding any policy, contract or agreement I have with or through you to provide, pay for or reimburse the cost of medical expenses. This information is required to determine the benefits available to me under the Massachusetts Personal Injury Protection Benefits Law.

---

Signature

Date

# REVIEW OF SYSTEMS

**Patient Name:** \_\_\_\_\_

**Patient File #:** \_\_\_\_\_

**Today's Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**INSTRUCTIONS:** Please fill out all of the sections. If none of the conditions apply, *circle* "None."

**Constitutional:**

- None
- Chills
- Daytime Drowsiness
- Fatigue
- Fever
- Night Sweats
- Weight Gain
- Weight Loss

**Eyes/Vision:**

- None
- Blindness
- Blurred Vision
- Cataracts
- Change in Vision
- Double Vision
- Eye Pain
- Field Cuts
- Glaucoma
- Itching (around the eyes)
- Photophobia
- Tearing
- Wears Glasses or Contacts

**Ears, Nose and Throat:**

- None
- Bleeding
- Dental Implants
- Dentures
- Difficulty Swallowing
- Discharge
- Dizziness
- Ear Drainage
- Ear Infection(s)
- Ear Pain
- Fainting
- Headaches
- Head Injury (history of)
- Hearing Loss
- Hoarseness
- Loss of Smell
- Nasal Congestion
- Nose Bleeds
- Post Nasal Drip
- Rhinorrhea (runny nose)
- Sinus Infections
- Snoring
- Sore Throats
- Tinnitus (ringing in the ears)
- TMJ Disorder

**Cardiovascular:**

- None
- Angina (chest pain or discomfort)
- Chest Pain
- Claudication (leg pain or achiness)
- Heart Murmur
- Heart Problems
- Orthopnea (difficulty breathing while lying)
- Palpitations (irregular or forceful heart beat)
- Paroxysmal Nocturnal Dyspnea (shortness of breath at night)
- Shortness of Breath
- Swelling of Leg(s)
- Ulcers
- Varicose Veins
- High Blood Pressure
- High Cholesterol

**Gastrointestinal:**

- None
- Abdominal Pain
- Belching
- Black, Tarry Stools
- Constipation
- Diarrhea
- Difficulty Swallowing
- Heartburn
- Hemorrhoids
- Indigestion
- Jaundice (yellowing of the skin)
- Nausea
- Rectal Bleeding
- Abnormal Stool Caliber (quality)
- Abnormal Stool Color
- Abnormal Stool Consistency
- Vomiting
- Vomiting Blood

**Respiration:**

- None
- Asthma
- Coughing up blood
- Shortness of Breath
- History of COVID-19
- Sputum Production
- Wheezing

**Endocrine:**

- None
- Cold Intolerance
- Diabetes
- Excessive Appetite
- Excessive Hunger
- Excessive Thirst
- Frequent Urination
- Goiter
- Hair Loss
- Heat Intolerance
- Unusual Hair Growth
- Voice Changes

**Skin:**

- None
- Changes in Nail Texture
- Changes in Skin Color
- Hair Growth
- Hair Loss
- Hives
- Itching
- Paresthesia (numbness, prickling, or tingling)
- Rash
- History of Skin Disorders
- Skin Lesions or Ulcers
- Varicosities

**Nervous System:**

- None
- Dizziness
- Facial Weakness
- Headaches
- Limb Weakness
- Loss of Consciousness
- Loss of Memory
- Numbness
- Seizures
- Sleep Disturbance
- Slurred Speech
- Stress
- Strokes
- Tremors
- Unsteadiness of Gait

**Allergy:**

- None
- Anaphylaxis (history of)
- Food Intolerance
- Itching
- Nasal Congestion
- Sneezing

**Hematology:**

- None
- Anemia
- Bleeding
- Blood Clotting
- Blood Transfusion(s)
- Bruises easily
- Fatigue
- Lymph Node Swelling

**Psychological:**

- None
- Anhedonia (inability to experience joy or enjoy life)
- Anxiety
- Appetite Changes
- Behavioral Change(s)
- Bipolar Disorder
- Confusion
- Convulsions
- Depression
- Insomnia
- Memory Loss
- Mood Change(s)

**Female:**

- None
- Birth Control Therapy
- Breast Lumps / Pain
- Burning Urination
- Cramps
- Frequent Urination
- Hormone Therapy
- Irregular Menstruation
- Urine Retention
- Vaginal Bleeding
- Vaginal Discharge

**Male:**

- None
- Burning Urination
- Erectile Dysfunction
- Frequent Urination
- Hesitancy or Dribbling
- Prostate Problems
- Urine Retention

**Patient Signature:** \_\_\_\_\_

**FOR OFFICE USE ONLY:**

I have reviewed the above ROS with the above named patient:

\_\_\_\_\_

Doctor Signature

\_\_\_\_\_

Date

## **Informed Consent for Chiropractic Treatment**

***TO THE PATIENT: You have a right to be informed about your condition, the recommended chiropractic treatment, and the potential risks involved with the recommended treatment. This information will assist you in making an informed decision whether or not to have the treatment. This information is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or refuse to give your consent to treatment.***

I request and consent to chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays. The chiropractic treatment may be performed by the licensed Doctors of Chiropractic working here. Chiropractic treatment may also be performed by a Doctor of Chiropractic who is serving as a backup for the Doctor of Chiropractic.

I have had the opportunity to discuss with the Doctor of Chiropractic, my diagnosis, the nature and purpose of my chiropractic treatment, the risks and benefits of my chiropractic treatment, alternatives to my chiropractic treatment, and the risks and benefits of alternative treatment, including no treatment at all.

I understand that there are some risks to chiropractic treatment including, but not limited to:

- ~ Broken bones / Sprains/strains
- ~ Dislocations
- ~ Burns or frostbite (physical therapy)
- ~ Worsening/aggravation of spinal conditions
- ~ Increased symptoms and pain
- ~ No improvement of symptoms or pain
- ~ Infection (acupuncture)
- ~ Punctured lung (acupuncture)

In rare cases there have been reported complications of vertebral artery dissection (stroke) when a patient receives a cervical adjustment. The complications reported can include temporary minor dizziness, nausea, paralysis, vision loss, locked in syndrome (complete paralysis of voluntary muscles in all parts of the body except for those that control eye movement), and death.

I do not expect the doctor to be able to anticipate and explain all risks and complications. I also understand that no guarantees or promises have been made to me concerning the results expected from the treatment. I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions. All of my questions have been answered to my satisfaction. By signing below, I consent to the treatment plan. I intend this consent form to cover the entire course of treatment for my current condition.

---

***To be completed by the patient:***

\_\_\_\_\_

print name

\_\_\_\_\_

signature of patient

\_\_\_\_\_

date signed

***To be completed by the patient's representative:***

\_\_\_\_\_

print name of patient

\_\_\_\_\_

print name of patient's representative

\_\_\_\_\_

signature of patient's representative

as: \_\_\_\_\_  
relationship/authority of patient's representative

\_\_\_\_\_

date signed

---

***To be completed by doctor or staff:***

\_\_\_\_\_

witness to patient's signature

\_\_\_\_\_

translated by

\_\_\_\_\_

date

\_\_\_\_\_

date

## **NOTICE OF PRIVACY PRACTICES (HIPAA NOTICE)**

This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

### **Your Rights**

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

### **Get an electronic or paper copy of your medical record:**

You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

### **Ask us to correct your medical record:**

You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. We may say “no” to your request, but we’ll tell you why in writing within 60 days.

### **Request confidential communications:**

You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will say, “yes” to all reasonable requests.

### **Ask us to limit what we use or share:**

You can ask us **not** to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say “no” if it would affect your care. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say “yes” unless a law requires us to share that information.

### **Get a list of those with whom we’ve shared information:**

You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

### **Get a copy of this privacy notice:**

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically, we will provide you with a paper copy promptly.

### **Choose someone to act for you:**

If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

### **File a complaint if you feel your rights are violated:**

You can complain if you feel we have violated your rights by contacting us. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting [www.hhs.gov/ocr/privacy/hipaa/complaints](http://www.hhs.gov/ocr/privacy/hipaa/complaints). We will not retaliate against you for filing a complaint.

## **Your Choices**

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

### **In these cases, you have both the right and choice to tell us to:**

Share information with your family, close friends, or others involved in your care. Share information in a disaster relief situation. Include your information in a hospital directory. If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

### **In these cases we never share your information unless you give us written permission:**

Marketing purposes. Sale of your information. Sharing of psychotherapy notes.

### **In the case of fundraising:**

We may contact you for fundraising efforts, but you can tell us not to contact you again.

## **Our Uses and Disclosures**

How do we typically use or share your health information? We typically use or share your health information in the following ways:

### **Treat you:**

We can use your health information and share it with other professionals who are treating you. Example: A doctor treating you for an injury asks another doctor about your overall health condition.

### **Run our organization:**

We can use and share your health information to run our practice, improve your care, and contact your when necessary. Example: We use health information about you to manage your treatment and services.

### **Bill for your services:**

We can use and share your health information to bill and get payment from health plans or other entities. Example: We give information about you to your health insurance plan so it will pay for your services.

### **How else can we use or share your health information?**

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see:

[www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html).

### **Help with public health and safety issues:**

We can share health information about you for certain situations such as preventing disease, helping with product recalls, reporting adverse reactions to medications, reporting suspected abuse, neglect, or domestic violence, preventing or reducing a serious threat to anyone's health or safety.

### **Do research:**

We can use or share your information for health research.

### **Comply with the law:**

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

**Respond to organ and tissue donation requests:**

We can share health information about you with organ procurement organizations.

**Work with a medical examiner or funeral director:**

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

**Address workers' compensation, law enforcement, and other government requests:**

We can use or share health information about you for worker's compensation claims, for law enforcement purposes or with a law enforcement official, with health oversight agencies for activities authorized by law, for special government functions such as military, national security, and presidential protective services.

**Respond to lawsuits and legal actions:**

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

**Our Responsibilities**

- We are required by law to maintain to privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.
- For more information see: [www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html)

**Changes to the Terms of This Notice:**

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request.

**OPTIONAL Additional Items:**

**1) Open Room:** We utilize an open therapy room. We make good faith attempts to keep our conversations at a low level. We offer every patient the opportunity to be treated in a private room if requested.

---

# PATIENT ACKNOWLEDGEMENT OF HIPAA NOTICE

## **Notice to Patient:**

We are required to offer you a copy of our HIPAA notice, which states how we may use and/or disclose your health information. Our HIPAA notice and office policies contain information regarding payment, health insurance, collections and other important information.

## **Patient Acknowledgement:**

I acknowledge and agree to this office's HIPAA notice. I acknowledge that I have reviewed the HIPAA notice and have the right to obtain a paper copy of the HIPAA notice. I acknowledge that I may refuse to sign this acknowledgment if I wish.

---

Patient Printed Name

---

Patient Signature or legal representative

---

If legal representative, state relationship

---

Date

## **FOR OFFICE USE ONLY:**

We have made every effort to obtain written acknowledgment of receipt of our HIPAA notice from this patient but it could not be obtained because:

- the patient refused to sign
  - we were not able to communicate with the patient
  - due to an emergency situation it was not possible to obtain a signature
  - other (please provide details):
- 

---

Name of patient

---

Name of staff member

---

Signature of staff member

---

Date

**NOTICE OF DOCTOR'S LIEN/ASSIGNMENT OF BENEFITS**

**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 also acknowledge that such doctor or his/her representative(s) may provide further consideration in exchange for this lien/assignment; including deposition testimony, trial testimony, and requested report(s).

I hereby authorize and direct you, my current and any successor attorney(s); together with any responsible insurance company, to pay directly to Chawla Chiropractic, LLC such total sums as are currently due (OPTIONAL: in the amount of \$ \_\_\_\_\_) and may become due and owing him/her in the future for all chiropractic and related services rendered me both by reason of this accident (OPTIONAL: and by reason of any other bills) that are due his office and to further withhold such total sums from any settlement, judgment, court order or verdict as may be necessary to adequately protect and fully compensate said doctor for such total sums. I hereby further give a lien or assignment of my potential benefits on my pending/prospective case to said doctor against any and all insurance benefits, referenced below, and proceeds of my settlement, judgment, court order or verdict which may be paid to you, my attorney, and/or myself as a result of the injuries or illness for which I have been or will be treated from a chiropractic scope of care perspective in connection with such accident; (OPTIONAL: including any unpaid services for chiropractic care provided prior to such accident.)

I fully understand that I am directly and fully responsible to said doctor for all chiropractic bills submitted by him for services rendered me and that this agreement is made for said doctor's additional protection and in consideration of his awaiting payment and other services provided by him, as referenced above. I further understand that such payment is not contingent on any settlement, judgment, court order or verdict by which I may eventually recover said fee and that my doctor may take appropriate and timely action to enforce payment against me for all such outstanding chiropractic bills.

I agree to promptly notify said doctor prior to any change or addition of attorney(s) used by me in connection with this accident, and I instruct my present attorney to do the same and to promptly deliver a copy of this lien to any such substituted or added attorney(s). I further acknowledge and agree that this executed lien/assignment shall be binding upon any subsequent and/or additional attorney(s) regardless of whether this written document is expressly acknowledged by such attorney.

I request that my attorney(s) and any applicable insurance company acknowledge this lien/assignment by signing below and returning to the doctor's office. The undersigned agrees that a copy of this lien may be forwarded to third parties responsible for payment to the patient and that such third parties can act directly in protecting such lien/assignment. Such insurance benefits shall include any coverages provided to the patient(s) for liability, disability, medical payments coverage, no-fault, health and accident, workers compensation and any other applicable benefits. Such insurers are directed and authorized to withhold and reimburse to my doctor such amount as necessary to satisfy the total sum owed by me for chiropractic services. (OPTIONAL: The undersigned patient further acknowledges and agrees that in the event the enforceability and/or appropriate amount subject to this lien/assignment is litigated, the prevailing party will be awarded attorney's fees and costs.)

This agreement shall be binding upon the patient's heirs, successors, personal representatives or assigns.

\_\_\_\_\_  
**Dated**

\_\_\_\_\_  
**Patient's Signature**  
(or Parent/Legal Guardian if Patient is Minor)

The undersigned, being attorney of record for the above patient (and/or insurance company representative), does hereby acknowledge receipt of this notice and hereby agrees to honor and comply with all the terms of the above agreement and agrees to protect adequately and/or otherwise withhold such sums from any settlement, judgment, court order or verdict as may be necessary to adequately protect and fully compensate said doctor above-named. Attorney and/or insurer further acknowledge that in the event the enforceability and/or appropriate amount subject to this lien/assignment is litigated, the prevailing party will be awarded attorney's fees and costs. This agreement shall be binding upon any successor, agent, representative, employee or substituted and/or added attorney(s) of the patient with the same force and effect.

\_\_\_\_\_  
**Dated**

\_\_\_\_\_  
**Attorney/Insurance Representative Signature**

Please date, sign and return one copy to doctor's office. Also keep one copy for your records.



Dr. Sudeep Chawla  
435 Newbury St. Suite 208  
Danvers, MA 01923

Office: (617) 334-5002 Fax: (978) 208-0494  
Website: www.chawlachiropractic.com  
Email: drc@chawlachiropractic.com

**Non-Covered Service Waiver Form**

**Patient's Name:** \_\_\_\_\_ **Patient's DOB:** \_\_\_\_\_

**Health Ins. Carrier:** \_\_\_\_\_ **Health Ins. ID#:** \_\_\_\_\_

**For the Member:**

I understand that I am responsible for all costs associated with the procedure(s) listed below. Chawla Chiropractic, PLLC has informed me that my health insurance carrier may not pay for this procedure(s) because it is not a covered benefit under my plan and some of these services could be bundled with other services by the insurance company.

I understand that this **non-covered service waiver** is valid for the duration of my treatment at Chawla Chiropractic, PLLC.

\_\_\_\_\_

\_\_\_\_\_

**Patient signature**

**Date**

**For the Provider:**

I certify that I have informed this patient, that their health insurance plan does not allow payment for the procedure(s) checked below because it is not a covered service under their plan.

(check all that apply)

98940 Spinal Manipulation	97124 Massage	E0730 TENS Unit
98941 Spinal Manipulation	97035 Ultrasound	A4556 Electrodes
98943 Extremity Adjustment	97110 Therapeutic Exercises	99212 Evaluation
97012 Traction. mechanical	97112 Neuromuscular Reeducation	99213 Evaluation
9920X - Initial Evaluation	97535 ADL Home	L0625 Lumbar Support
97014 Electrical Stimulation	97537 ADL Work	L3650 Shoulder Orthosis
97010 Hot/Cold Therapy	97032 Electrical Stimulation Attn	A4456 Disposable E-Stim Pads

\_\_\_\_\_

\_\_\_\_\_

Sudeep Chawla, DC

Date