Lendino Sports & Family Chiropractic
120 W. Old Country Road
Hicksville, NY 11801

WORKER'S COMPENSATION HISTORY

Patient Name _____ *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* _____

Type of Business _____ *Your Occupation* _____
Date Injured _____ *Hour* _____ *AM/PM Last Date Worked* _____
Previous Worker's Compensation Injury? ( ) *Yes* ( ) *No*
Was Accident Reported to Employer? ( ) *Yes* ( ) *No*
Name and Title of Person Accident was Reported to _____
Injured at: _____ *City* _____ *State* _____ *Zip* _____
Length of Time Worked there Prior to Accident _____
Type of Work Done Prior to Injury _____
In Your Own Words, Please Describe the Accident: _____
_____
_____
_____

Have You Been Treated by any Doctors for this Accident ( ) *Yes* ( ) *No*
If so, Names, Forms of Treatment and Duration _____
_____
_____

Are you: ( ) *Improved* ( ) *Unchanged* ( ) *Getting Worse*
What Types of Medications are You Taking _____
_____

Do These Medications Help? ( ) *Yes* ( ) *No*

_____

Prior to this Accident, Have You Ever Had any of the Physical Complaints Similar to What You Have Now? ( ) *Yes* ( ) *No*

If Yes, Describe _____

_____

_____

_____

Have You Had Any Other Accidents which Required Medical Care? ( ) *Yes* ( ) *No*

If Yes, Describe _____

Have You had any Surgeries ( ) *Yes* ( ) *No*

If Yes, List Types and Dates _____

_____

Have You Had Any Nervous or Mental Illness? ( ) *Yes* ( ) *No*

Have You Had any Psychiatric Care? ( ) *Yes* ( ) *No*

Have You Received a Medical Discharge from the Armed Forces? ( ) *Yes* ( ) *No*

Have You Returned to Work Since the Accident? ( ) *Yes* ( ) *No*

If Yes, When? _____

CURRENT MEDICAL COMPLAINTS

NECK PAIN:

My neck pain began: ( ) *gradually* ( ) *suddenly*

I have pain: ( ) *sometimes* ( ) *all the time*

My pain goes into my: ( ) *right arm* ( ) *left arm* ( ) *both*

I have tingling and numbness in my: ( ) *right arm* ( ) *left arm* ( ) *both*

My pain is worse when I:

Please circle:

Cough or sneeze	*Lift*	*Turn head right*	*Tilt head left*
Bend head forward	*Push*	*Turn head left*	*Sleep*
Bend head backwards	*Pull*	*Tilt head right*	*Sit too long*

The pain wakes me up at night: ( ) *Yes* ( ) *No*

Changes in the weather affect my pain: ( ) *Yes* ( ) *No*

I have neck stiffness: ( ) *Yes* ( ) *No*

I have headaches: ( ) *Yes* ( ) *No*

If I do get headaches, they occur: ( ) *Sometimes* ( ) *All the time*

BACK PAIN:

Currently, I have pain in my: ( ) *upper back* ( ) *mid back* ( ) *lower back*
My pain began: ( ) *gradually* ( ) *suddenly*
I have pain: ( ) *sometimes* ( ) *all of the time*
My pain goes into my: ( ) *right leg* ( ) *left leg* ( ) *both*
I have tingling and numbness in my: ( ) *right leg* ( ) *left leg* ( ) *both*
My pain is worse when I:
Please circle:

cough or sneeze	*walk*	*sleep*
sit	*lift*	*stand*
bend	*push*	

My pain is worse with sexual activity: ( ) *Yes* ( ) *No*
My pain wakes me up during the night: ( ) *Yes* ( ) *No*
Changes in the weather affect my pain: ( ) *Yes* ( ) *No*

OTHER PAIN:

Please describe any current medical complaints that 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).

In a typical 8-hour workday, I: (Circle # of hours of 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*

On the job, I perform the following activities:

	NOT AT ALL	***OCASSIONALLY***	***FREQUENTLY***	***CONTINUOUSLY***
Bend/stoop	☐	☐	☐	☐
Squat	☐	☐	☐	☐
Crawl	☐	☐	☐	☐
Climb	☐	☐	☐	☐
Reach above the shoulders	☐	☐	☐	☐
Crouch	☐	☐	☐	☐
Kneel	☐	☐	☐	☐
Balancing	☐	☐	☐	☐
Pushing/pulling	☐	☐	☐	☐

REPORT OF ON THE JOB INJURY

NAME _____ S.S. #: _____
EMPLOYER AT THE TIME OF INJURY _____
EMPLOYER'S ADDRESS _____
NAME OF PERSON TO WHOM YOU REPORTED INJURY _____
EMPLOYER TELEPHONE NUMBER _____
WHERE WERE YOU INJURED (TOWN) _____
DATE OF INJURY _____ TIME _____ A.M. ☐ P.M. ☐
BRIEF DESCRIPTION OF ACCIDENT/INJURY _____

_____
WHAT AREA DID YOU INJURE? _____
DID YOU GO TO THE HOSPITAL? _____ NAME OF HOSPITAL _____
WERE X-RAYS TAKEN? _____ WHERE? _____
HAVE YOU BEEN TREATED BY ANOTHER PHYSICIAN FOR THIS INJURY? _____
IF YES, NAME AND TYPE OF PHYSICIAN _____
HAS A COMPENSATION NUMBER BEEN ASSIGNED TO THIS CASE? _____
IF YES, WHAT IS THE NUMBER? _____
INSURANCE COMPANY NAME AND ADDRESS FOR THIS CASE _____

_____
PLEASE CHECK ONE: ☐ I AM WORKING ☐ I AM NOT WORKING
☐ I AM CURRENTLY NOT WORKING AT ANY JOB OF ANY KIND AT THIS TIME

I UNDERSTAND THAT I AM PERSONALLY REPONSIBLE FOR THE NORMAL OFFICE FEE IF COMPENSATION CARRIER DOES NOT HONOR MY CLAIM

SIGNATURE _____

TERMS OF ACCEPTANCE

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

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease. We only offer to diagnose either vertebral subluxations or neuromusculoskeletal conditions. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of another health care provider.

Patient's 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 Doctor of Chiropractic named below and/or other licensed Doctors of Chiropractic working at this clinic or office. Chiropractic treatment may also be performed by a Doctor of Chiropractic who is serving as a backup for the Doctor of Chiropractic named below.

I have had the opportunity to discuss with the Doctor of Chiropractic named below, 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 -Burns or frostbite (physical therapy) -No improvement of symptoms or pain
-Dislocations -Worsening/aggravation of spinal conditions -Infection (Acupuncture)
Sprains/strains - Increased symptoms and pain -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.

TREATMENT PLAN: _____
_____

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

_____ _____
Print name *Print name of patient*

_____*Date:*_____ _____
Signature of patient *Sign name of patient's representative and relationship*

To be completed by doctor or staff:
Witness to patient's signature: _____Sign:_____ Date:_____

Richard G. Lendino, D.C.
120 W. Old Country Road
Hicksville, NY 11801

HIPPA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. <u>PLEASE REVIEW IT CAREFULLY.</u>

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carryout treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law. Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.
Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission. Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment, employee review, training of medical students, licensing, fundraising, and conducting or arranging for other business activities. For example, we may disclose your protected health

information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by your name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you. We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

Other Permitted and Required Uses and Disclosures *will be made only with your consent, authorization or opportunity to object unless required by law. You may revoke the authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.*

YOUR RIGHTS

The following are statements of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information (fees may apply)

Under federal law, however, you may not inspect or copy the following records. Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality. You have the right to request a restriction of your protected health information – This means you may ask us not to use or disclose any part of your protected health information and by law we must comply when the protected health information pertains solely to a health care item or service for which the health care provider involved has been paid out of pocket in full. You may also request that any part of your protected health information not be disclosed to family

members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. By law, you may not request that we restrict the disclosure of your PHI for treatment purposes.

You have the right to request to receive confidential communications*- You have the right to request confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.*

You have the right to request an amendment to your protected health information*- If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.*

You have the right to receive an accounting of certain disclosures*- You have the right to receive an accounting of all disclosures except for disclosures : pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April 14, 2003, or six years prior to the date of this request.*

You have the right to obtain a paper copy of this *notice from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.*

COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Compliance Officer of your complaint. ***We will not retaliate against you for filing a complaint.***

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of this notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Please sign the "Acknowledgement of Receipt" shown below. You are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.

Print Name: _____

Signature: _____

Date: _____