

Welcome to Dr. J. J. Levine's office. Prepare for health!

Last Name: _____	First Name: _____	M.I.: _____
Street: _____	Apt. #: _____	
City: _____	State: _____	Zip Code: _____
Email (for our office use only): _____		
Home Phone: (____) _____ - _____	Work Phone: (____) _____ - _____	ext. _____
Cell phone: (____) _____ - _____	Fax Line: (____) _____ - _____	
Birth date: __/__/____	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	SSN: _____ - _____ - _____
	Height _____	Weight _____
If married, spouse's name: _____ & spouse's birth date: __/__/____		
<input type="checkbox"/> Spouse's or <input type="checkbox"/> Roommate's name & cell phone: _____: (____) _____ - _____		
Emergency contact name (other than above): _____		
Emergency contact's home: (____) _____ - _____ and their cell: (____) _____ - _____		
# of children: ____ Names and ages: _____		
How did you hear of us, or whom may we thank for referring you? _____		

<p>Have you had an accident (major or minor) within the past 2 years? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, what type of accident? <input type="checkbox"/> Auto <input type="checkbox"/> Work <input type="checkbox"/> Other: _____</p> <p>If yes, what date & time did this accident occur? __/__/____ : ____ am pm</p> <p><i>If you are seeking care due to an accident it is possible care may be provided at no out of pocket cost to you.</i></p> <p><i>If seeking care due to an injury please ask the receptionist for the "accident questionnaire" at this time.</i></p> <p><input type="checkbox"/> I am <input type="checkbox"/> I am not seeking care due to an auto or work injury Initial here _____</p>
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<p>Do you have health insurance coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Do you have a secondary insurance policy? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, please provide the receptionist with your insurance card(s) <u>now</u>. She will make a photocopy and our office will inform you of your coverage. Most insurance companies <u>cover</u> our services.</p> <p>Primary insured's name: _____ their SSN _____ - _____ - _____ & birth date __/__/____</p> <p>Relationship to insured: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other: _____</p> <p>Your marital status: <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> Legally Separated</p> <p>Your student status: <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Non-student</p> <p>Your employment status: <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Retired</p> <p>Your employer: _____ Spouse's employer, if married: _____</p> <p>I realize my health insurance company will be billed as a service to me. Until my benefits can be verified, I will be responsible for payment of care today. If I have coverage, the amount I pay today will be applied to my deductible and/or my daily co-insurance payments. If I do not have coverage the doctor will discuss an affordable plan with me. I may also be asked to help pursue the insurance company in small claims court if necessary.</p> <p align="right">Initial here _____</p>

<p>Your initial visit today will include an extended evaluation with Dr. J. J. Levine. If necessary, x-rays will be taken. Because you are here due to an accident, the regular fees for today's visit will be paid in full by auto or worker's compensation insurance. If your claim is denied, we will ask you to pay for today's visit.</p> <p>Signature _____ Today's date __/__/____</p>
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AUTHORIZATION TO RELEASE AUTOMOBILE INSURANCE INFORMATION

Today's date ____/____/____

Dear _____,
(auto insurance company and/or attorney)

I authorize and request you, my automobile insurance company, to release all policy information to my doctor's office. Please provide my doctor with the following information:

Name of my auto Insurance Co.: _____
Mailing address of my auto ins. Co.: _____
Phone number: _____
Fax number: _____
Is there medical payments coverage on my policy? _____
The limit of medical payments coverage: \$ _____
Is there uninsured motorist coverage on my policy? _____
The limit of uninsured motorist coverage: \$ _____
The adjuster's name: _____
The adjuster's supervisor: _____
Claim #: _____
Signed by _____ Print your name _____

Thank you for providing this information and faxing this letter to my doctor's office at the facsimile number underlined below:

Dr. Jonathan J. Levine
3330 South Price Road, Suite D-110
Tempe, Arizona 85282
24-hour mobile phone: (480) 206-5039
Phone: (480) 345-2080 (Monday, Wednesday, and Friday)
24-hour facsimile: (480) 345-2199

Thank you,
Patient/insured's printed name _____
Patient/insured's address _____
Patient/insured's phone # _____
Patient auto insurance policy # _____

Patient/insured's signature _____
Date ____/____/____

Please fax completed form to: (480) 345-2199 attn. Dr. J.J. Levine & staff.

Auto Accident and Injury Questionnaire
(PLEASE PRINT CLEARLY)

Last name: _____ First: _____ MI: _____

What do you prefer to be called? _____ Birth date: ____/____/____

Date of auto accident: ____/____/____ State: AZ Other _____

Time: ____: ____ am pm (circle)

Most auto and work **injury care is provided at no out of pocket cost to you.** However, in order **to provide care at no out of pocket cost we need the following information:**

Please provide the receptionist with the following so copies can be made of:

1. Your auto insurance card.
2. Your health insurance card.
3. The police report.
4. The other driver's name, address and auto insurance company information.
5. If applicable, your attorney's name, address and phone.

The name of your auto insurance company: _____

Address of your auto ins. company: _____

Your auto insurance company's phone number: (_____) _____

Your agent's name: _____ Your policy #: _____

How are you related to the policy holder? Self Spouse Child Other _____

Have you contacted your auto insurance company regarding this accident? Yes No

Were you at fault in this accident? Yes No

Was the vehicle you were in yours? Yes No...

If no, name and phone of vehicle owner: _____ (_____) _____

Make/model/year of vehicle you were in: _____

Was there another driver/vehicle at fault in this accident? Yes No

Name of driver at fault (person who hit you): _____

Address of person who hit you: _____

Phone number of person who hit you: (_____) _____

Name of auto insurance company of driver at fault: _____

Address of his/her auto insurance company: _____

Name of primary insured on policy if other than at fault driver: _____

His/her policy #: _____ Claim # if assigned: _____

Make/model/year of vehicle other party was driving: _____

Witnesses information: Name: _____ Phone (_____) _____

Have you retained an attorney? No Yes, name: _____

Name of firm: _____ Phone: (_____) _____

Address of firm: _____

Notify your attorney **you've chosen Dr. J.J. Levine** & wish **not** to be referred elsewhere.

Signature of patient

Today's date

Auto accident injury questionnaire page 2

Last name: _____ First: _____ MI: _____
Age: _____ Male Female Are you pregnant? No Yes, due ___/___/___

These questions help us understand how the impact affected you physically/mentally

Date of accident: ___/___/___ Time ___ : ___ am pm
What state in the USA were you in at the time of this accident? _____
Did the police arrive at the scene? Yes No
Did the police issue a ticket? No Yes...who was sited? _____
At what crossroads did the impact occur: _____
Which direction were you traveling? East West North South
Which direction was the other party traveling? East West North South
Was your vehicle hit: From behind In the front Left side Right side
Approximate speed of your vehicle just prior to impact: _____ mph
Approximate speed of the vehicle that hit you: _____ mph
Was anyone with you in the vehicle? No Yes, how many others: _____
Where were you seated? Driver Front passenger Back left Back right
Was your seatbelt: A Shoulder harness w/ lap belt Lap belt only Off/not worn
Did your head hit anything? Nothing Steering wheel Windshield Air bag
Did your chest hit anything? Nothing Steering wheel Windshield Air bag
Did your shoulder(s) hit anything? Nothing Steering wheel Windshield Air bag
Did your airbag deploy? Yes No My vehicle did not have an airbag
Did you sustain any: Cuts Bruises Stitches Other _____
Did you loose consciousness? Yes No
Did paramedics arrive at the scene? Yes No
If yes, were you treated on site? Yes No
Were you taken to the hospital? Yes No
If yes, did the hospital take x-rays? Yes No Date of hospital visit: ___/___/___
If yes, did the hospital prescribe medications: Yes No List: _____
Name of hospital: _____ Phone: (_____) _____
Treatment received: _____
Did you see any other doctor for your injuries? Yes No
If yes, name of doctor: _____ Phone: (_____) _____
Type of Doctor: _____
Treatment received: _____

Do you have any previous illnesses that would relate to this case? Yes No
If yes, describe _____

Signature of patient

Today's date

Auto accident injury questionnaire page 3

Last name: _____ First: _____ MI: _____

Please describe how your **BODY FELT** and your **PHYSICAL CONDITION**:

DURING the accident: _____

IMMEDIATELY AFTER the accident: _____

LATER that day: _____

THE NEXT day: _____

In your own words, describe exactly how the accident happened, in detail:

CHECK ALL SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT:

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Irritability | <input type="checkbox"/> Numbness in toes | <input type="checkbox"/> Buzzing in Ears |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Faced Flushed |
| <input type="checkbox"/> Neck Stiff | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Loss of Balance |
| <input type="checkbox"/> Upper back pain | <input type="checkbox"/> Head seems Heavy | <input type="checkbox"/> Depression | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Middle back pain | <input type="checkbox"/> Sensitivity to Light | <input type="checkbox"/> Loss of Taste | <input type="checkbox"/> Difficulty sleeping |
| <input type="checkbox"/> Low back pain | <input type="checkbox"/> Ringing in Ears | <input type="checkbox"/> Loss of Memory | <input type="checkbox"/> Nervousness |
| <input type="checkbox"/> Shoulder pain | <input type="checkbox"/> Stomach Ache | <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Pins & Needles in Arms |
| <input type="checkbox"/> Arm Pain | <input type="checkbox"/> Loss of Smell | <input type="checkbox"/> Tension | <input type="checkbox"/> Pins & Needles in Legs |
| <input type="checkbox"/> Leg Pain | <input type="checkbox"/> Visual weakness | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Numbness in Fingers |
| <input type="checkbox"/> Waist | <input type="checkbox"/> Constipation | <input type="checkbox"/> Hands Cold | <input type="checkbox"/> Cold Sweats |
| <input type="checkbox"/> Feet Cold | <input type="checkbox"/> Fever | <input type="checkbox"/> Other _____ | |

CHECK ALL THAT APPLY TO YOUR FAMILY HISTORY:

- | | | | |
|---------------------------------------|---------------------------------|--|---|
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Stroke | <input type="checkbox"/> Seizures | <input type="checkbox"/> Cardiovascular disease |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Cancer | <input type="checkbox"/> Abnormal blood pressure | |

Since this injury occurred, are your symptoms Getting Worse Same Improving

Do you notice any activity restrictions as a result of this accident? Yes No

If yes, describe _____

Your occupation: _____

Have you lost time from work as a result of this injury? Yes No

If yes, complete the following questions.

Unable to Work from ____/____/____ through ____/____/____

Full Time Part Time

Are you being compensated for time lost from work? Yes No

Patient's signature

Today's date

FEE SCHEDULE APPLIED TO ALL INSURANCE COMPANIES

The average office visit fee applied to all insurance companies is approximately \$199.00. You are only responsible for a daily co-insurance payment and payment(s) toward any remaining annual deductible you may have. Our office will discuss your financial responsibility with you.

Initial new patient evaluation/consultation 2 nd opinion (99273)	\$190.00
Initial new patient detailed evaluation/consultation (99203)	\$150.00
X-ray series of 5 (72040-72100)	\$250.00
Report of x-ray/orthopedic findings between doctor and patient (99272)	\$150.00
Muscle Testing (95831 or 97750)	\$150.00
Computerized Range of Motion Test w/ report (95851)	\$210.00
Extended daily re-examination/evaluation of patient (99213-25)	\$ 70.00
Computerized neurological/temperature graph instrumentation (93740)	\$ 40.00
3-4 region spinal adjustment/CMT (98941)	\$ 55.00
Therapeutic exercise (97110)	\$ 45.00
Therapeutic activities (97530)	\$ 46.00
Neuromuscular re-education (97112)	\$ 35.00
Myofacial release (97140)	\$ 44.00
Cold or hot therapy spray (97010)	\$ 20.00

The above fees are based on Fee Facts pricing, a consensus and poll of doctors fees nationwide
Many of the above fees are billed to the insurance company on the same date of service

I understand the average daily office visit fee applied to all insurance companies is \$199.00.

I understand each code and/or multiple codes above will be billed to my insurance company on the same date of service. I accept these fees and understand the doctor is to be paid in full for all services I receive. I understand, as a service to me, the doctor pays a billing service and a documentation service then awaits reimbursement from my insurance company. By signing below, I make known the co-insurance payment of my care would be a financial hardship to me.

I am only responsible for a daily co-insurance payment and payment(s) toward my annual deductible, while my health insurance is being billed.

I understand if my care is associated with an injury/accident claim, all bills will be paid at 100% of the above fee schedule regardless of the outcome of my case. I understand automobile insurance companies and worker's compensation companies pay for auto/work injury care in full.

I understand most auto and work injury care is provided at no out of pocket cost to me.

I further agree, if any insurance company refuses payment, to authorize the doctor to file suit in small claims court, on my behalf, against the insurance company, as a method of collection. I agree to be present at the court date if needed.

I have fully read and understand these terms and fees.

Patient's signature

Print your name

____/____/____
Today's date

Health Care Authorization Form (HIPPA Privacy Practices)

Here at Dr. J. J. Levine's office we ask you for a few specific authorizations

All information you provide to us is confidential in nature and will only be referenced when contacting you, the insurance company, or another relative facility. By signing this form I give permission to **Dr. Jonathan J. Levine's Office** to use all information I provide, as this office deems appropriate.

By signing below I give this office permission to:
Send me birthday cards, holiday-related cards, and thank you cards and gifts.
Call me and/or leave messages for me on an answering machine.
Provide me information on treatment and other health related information.
Allow staff and other patients to view my name on the sign in register.
When I refer another patient, list my name in the monthly newsletter for recognition.
Take my picture for the "well adjusted patients" bulletin board that is inside the office.
Treat me in a semi-open room where others may see me if passing by in the hall.
File a health care provider lien to bind insurance companies to forward payment.
Display any testimonial I may write in order to share my success with others.

I am aware other persons in this office may overhear my protected health information during the course of care. I also understand my information may be overheard by other patient's at the front desk or in other areas of the office. Should I need to speak with the doctor privately at any time, the doctor will provide a room for these conversations.

By signing this form I am giving **Dr. Jonathan J. Levine's Office** permission to use and disclose my private protected information in accordance with the directives listed above.

Acknowledgement of Receipt of Notice Of Privacy Practices

Please feel free to read the binder located on the front reception counter. I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand I have the following rights and privileges:
I have the right to review the notice prior to signing this consent.
I have the right to object to the use of my health information for directory purposes.
I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

This authorization shall expire on the following date: No expiration date

The patient identified below authorizes Dr. Jonathan J. Levine's Office to use & disclose protected health information in accordance with all items described.

Patient's signature: _____

Please print your name: _____

Patient's SSN: _____ **Date of Birth:** ____ / ____ / ____

MEDICAL REPORTS AND DOCTOR'S LIEN

I authorize and direct the attorney I choose to note *my doctor of choice* for accident care:

Dr. J.J. Levine (Tax ID: 860828044)

3330 South Price Road, Suite D-110 Tempe, Arizona 85282

Office: (480) 345-2080 Mobile: (480) 206-5039 Facsimile: (480) 345-2199

I hereby authorize and direct my doctor, Dr. J. J. Levine, to:

- °Correspond with the attorney representing me in regard to my accident claim.
- °Furnish my attorney with all medical records produced in Dr. J.J. Levine's office.
- °Provide my attorney and all insurance companies with extended examination reports, diagnosis, prognosis, daily progress notes, treatment notes, dismissal report, bills, and all records produced in this office prior to or during my care.
- °To file a lien in order to hold liable parties and carriers responsible for payment.

I hereby authorize and direct you, my attorney, to:

- °Correspond with Dr. J. J. Levine, my treating physician, in regard to my accident.
- °Inform Dr. J.J. Levine regarding the status of my case.
- °Pay Dr. J. J. Levine directly all sums of money due him for services rendered to me.
- °To forward medical payments to Dr. J.J. Levine immediately as received/if received.
- °To withhold all sums of money from any settlement, judgment, or verdict as may be necessary to adequately protect Dr. J.J. Levine.
- °To pay my accident care in full to Dr. J.J. Levine and issue all checks/drafts to him and to forward all said checks/drafts to his address above.
- °To honor the recorded lien and my request and make payment to Dr. J.J. Levine.

Patient's signature

Patient's printed name

Date

FOR ATTORNEY'S USE ONLY:

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 Dr. J.J. Levine.

Attorney's signature

Attorney's printed name

Date

Please sign above, date, and return original to Doctor's office. Keep a copy for your file.

A photocopy of this document shall be considered as valid as the original.

**NOTICE TO INSURANCE COMPANY OF ASSIGNMENT
AUTHORIZATION TO ISSUE CHECKS OR DRAFTS TO DOCTOR'S OFFICE**

To: _____
Insurance Company responsible for payment

1. I _____ ID# _____
Patient's name

do hereby **AUTHORIZE AND DIRECT** any and all checks or drafts relative to treatment rendered by Dr. Jonathan J. Levine, which are issued by the above named insurance company, and which represent sums payable to me, the patient, or on my behalf be made payable to the order of:

Dr. Jonathan J. Levine
3330 South Price Road, Suite D-110
Tempe, Arizona 85282

I authorize all relative health care payments be made out to doctor and forwarded to doctor's office.

2. I further **AUTHORIZE AND DIRECT** you to send all of said checks or drafts to:
Dr. Jonathan J. Levine

3330 South Price Road, Suite D-110
Tempe, Arizona 85282

3. I further **AUTHORIZE AND DIRECT** Dr. Jonathan J. Levine to provide care to me and to release all health care information necessary for the processing and payment of any health insurance claim he submits.

4. I understand Dr. Jonathan J. Levine is providing care and waiting for reimbursement from the insurance company as a service to me. In order for this service to continue I hereby grant Dr. Jonathan J. Levine, Power of Attorney to negotiate any draft or check amount for the services rendered by Dr. Jonathan J. Levine's office. In the event the insurance company denies payment, Dr. Jonathan J. Levine may retain the unpaid balance of his bill for all care provided to me in this office, through small claims court, at 100% of his billing. Any amount paid out of my pocket for relative dates of service will be forwarded to me, the patient, directly, after the doctor's bill has been satisfied in full.

5. Our office will make every effort to collect from the insurance company. Our success rate is excellent. However, if these efforts are exhausted, and the services of a collection agency become necessary, I understand I will be responsible for the agency fees at thirty percent of my total bill (the insurance company will be billed first).

6. In the event any insurance company obligated by contracted agreement to make payment to me or to Dr. Jonathan J. Levine refuses to make such payment upon demand by Dr. Jonathan J. Levine, D.C., I hereby agree to sign a small claims action at that time, or personally reimburse the doctor and pay my balance in full at that time. If Dr. Jonathan J. Levine is not reimbursed within a reasonable amount of time from the date of dismissal from this office or if I do not reimburse him directly and pay my balance in full, I hereby assign and transfer Dr. Jonathan J. Levine, the cause of action that exists in my favor against any such insurance company, and authorize Dr. Jonathan J. Levine to prosecute said action, either in my name or the insurance company's name, and further authorize Dr. Jonathan J. Levine to collect on his said portion of claim for amount of services he provides.

Patient's Signature
By signing above, the co-payment of my
Care would be a financial hardship on me.

_____/____/20_____
Date

Witness

Dr. J. J. Levine, D.C.
480.345.2080
3330 South Price Road Suite D-110 Tempe, AZ 85282

Informed Consent for Chiropractic Care

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective. 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. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks and alternatives.

Chiropractic is a science and art which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may effect the restoration and preservation of health. Health is a state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

One disturbance to the nervous system is called a vertebral subluxation. This occurs when one or more of the 24 vertebrae in the spinal column become misaligned and/or do not move properly. This causes alteration of nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by an adjustment. An adjustment is the specific application of forces to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine. Adjustments are usually done by hand but may be performed by handheld instruments. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included.

If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

Print Name	Signature	Date
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Consent to evaluate and adjust a minor child:

I, _____ being the parent or legal guardian of _____ have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care.

Pregnancy Release:

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual cycle: _____

Signature	Date
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