

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? _____		

Have you had an accident (major or minor) within the past 2 years? <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, what type of accident? <input type="checkbox"/> Auto <input type="checkbox"/> Work <input type="checkbox"/> Other: _____
If yes, what date & time did this accident occur? __/__/____ : ____ am pm
<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>
<i>If seeking care due to an injury please ask the receptionist for the "accident questionnaire" at this time.</i>
<input type="checkbox"/> I am <input type="checkbox"/> I am not seeking care due to an auto or work injury Initial here _____

Do you have health insurance coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have a secondary insurance policy? <input type="checkbox"/> Yes <input type="checkbox"/> No
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.
Primary insured's name: _____ their SSN _____ - _____ - _____ & birth date __/__/____
Relationship to insured: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other: _____
Your marital status: <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> Legally Separated
Your student status: <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Non-student
Your employment status: <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Retired
Your employer: _____ Spouse's employer, if married: _____
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.
Initial here _____

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.
Signature _____ Today's date __/__/____

Worker's Compensation Questionnaire
(PLEASE PRINT CLEARLY)

Last name: _____ First: _____ MI: _____
What do you prefer to be called? _____ Birth date: ____/____/____
Date of accident: ____/____/____ Time: ____: ____ am pm State: AZ Other _____
Name and address of your company: _____
Place of work injury: Same as above Other: _____
Did you report this accident to you supervisor? Yes No (If no, please report A.S.A.P)
What were you doing at the time of injury: _____
Exact details of how injury occurred: _____

Please describe how your **BODY FELT** and your **PHYSICAL CONDITION**:
BEFORE the accident I was _____
DURING the accident I felt _____
IMMEDIATELY AFTER the accident I felt _____
What injuries did you sustain during the injury: _____
Please list your current complaints and areas of pain in detail: _____

Since this work injury are your symptoms: Getting worse The same Improving
I am RIGHT LEFT handed Age: _____ Male Female
Are you pregnant? N/A Male No Yes, due date: ____/____/____
Were you hospitalized for this injury? Yes No
If yes, did the hospital take x-rays? Yes No
Date of hospital visit: ____/____/____ Date of discharge: ____/____/____
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 (circle): M.D D.C. D.O. Other _____
How many times did you visit this Doctor? _____ Medications received? _____
Treatment received: _____

Do you have any existing impairment affecting your present condition? Yes No
Are you able to do the same type of work you preformed at the time of injury? Yes No
Are you able to do lighter or different type of work than preformed at the time injury? Yes No
Before this injury, were you capable of working on an equal basis w/ others your age? Yes No
Have you ever injured this area before? No Yes If yes, when? ____/____/____
Did you fully recover from your previous injury? Yes No
In your work, do you need to favor any body part(s)? No Yes list: _____

Signature of patient

Today's date

Worker's Compensation Questionnaire (Page 2)

Last name: _____ First: _____ MI: _____

Attorney & Witness Information

Were there any witnesses? Yes No

Witnesses information: Name: _____ Phone: (____) _____

Have you retained an attorney? Yes No It is a possibility

If yes, Attorney's name: _____

Name of firm: _____ Phone: (____) _____

Address of firm: _____

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

CHECK ALL SYMPTONS 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"/> Feet Cold | <input type="checkbox"/> Constipation | <input type="checkbox"/> Hands Cold | <input type="checkbox"/> Cold Sweats |
| <input type="checkbox"/> Fever | <input type="checkbox"/> TMJ or Jaw pain | <input type="checkbox"/> Visual disturbance | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Radiating pain to _____ | <input type="checkbox"/> Spasms in _____ | | |

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 | |
| <input type="checkbox"/> Other _____ | | | |

I do hereby certify that all of my statements on this form are true, accurate and complete.

Patient's signature

Today's date

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.

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:** ____ / ____ / ____

**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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