

Full Name \_\_\_\_\_ (Nick Name: \_\_\_\_\_) Age: \_\_\_\_\_

Marital Status: M S W D Children? (#, ages): \_\_\_\_\_

Occupation: \_\_\_\_\_ Are you:  right handed  left handed  ambidextrous

Date of Vehicle Crash: \_\_\_\_\_ Who is your Primary Care Physician? \_\_\_\_\_

Describe your vehicle crash/accident:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Circle, Check, or In Any Way Describe Your Answers:**

Any poor road conditions (e.g. snow, wet, sun glare)? No Yes: \_\_\_\_\_ Using Seat-belts? No Yes  
Where were you in the vehicle? Driver Front Seat Passenger Rear Seat Passenger's Side Rear Seat Driver's Side  
Did your vehicle hit anything (e.g. guard rail, tree or other car)? No Yes: \_\_\_\_\_ Air Bag Deploy? No Yes  
Did you see the accident about to happen? No Yes Did you brace/tense-up for the collision? No Yes  
Were you looking straight ahead at the time of the collision? No Yes Was your foot on the brake? No Yes  
Did your head, chest, knees or other body part hit against anything within the vehicle? No Yes:  
Did you lose consciousness or pass-out? No Yes Did you feel: dizzy see-stars nauseous panic shaken  
Did you experience **any** pain or other symptoms immediately after the collision? No Yes:  
Where did you go after the accident: Home Work Hospital by Ambulance Other:  
Did any pain occur later or next day? No Yes How so? \_\_\_\_\_  
Have you seen any other healthcare providers (MD's, PT's, etc.) prior to your visit here?  No  Yes Please list them:

Have you had MRI, CT scan, X-Rays? No  Yes : When/Where? \_\_\_\_\_

Was pain medicine prescribed? No Yes Any braces, supports, or canes issued? No Yes  
Are pain(s)/symptom(s): Improving Getting Worse Changing in Character or Location The Same  
Ever had similar pain/symptoms/problems in the involved areas before? No Yes:

Ever been to a chiropractor?  No  Yes When & Why?: \_\_\_\_\_

Any previous vehicle crashes?  No  Yes When? \_\_\_\_\_

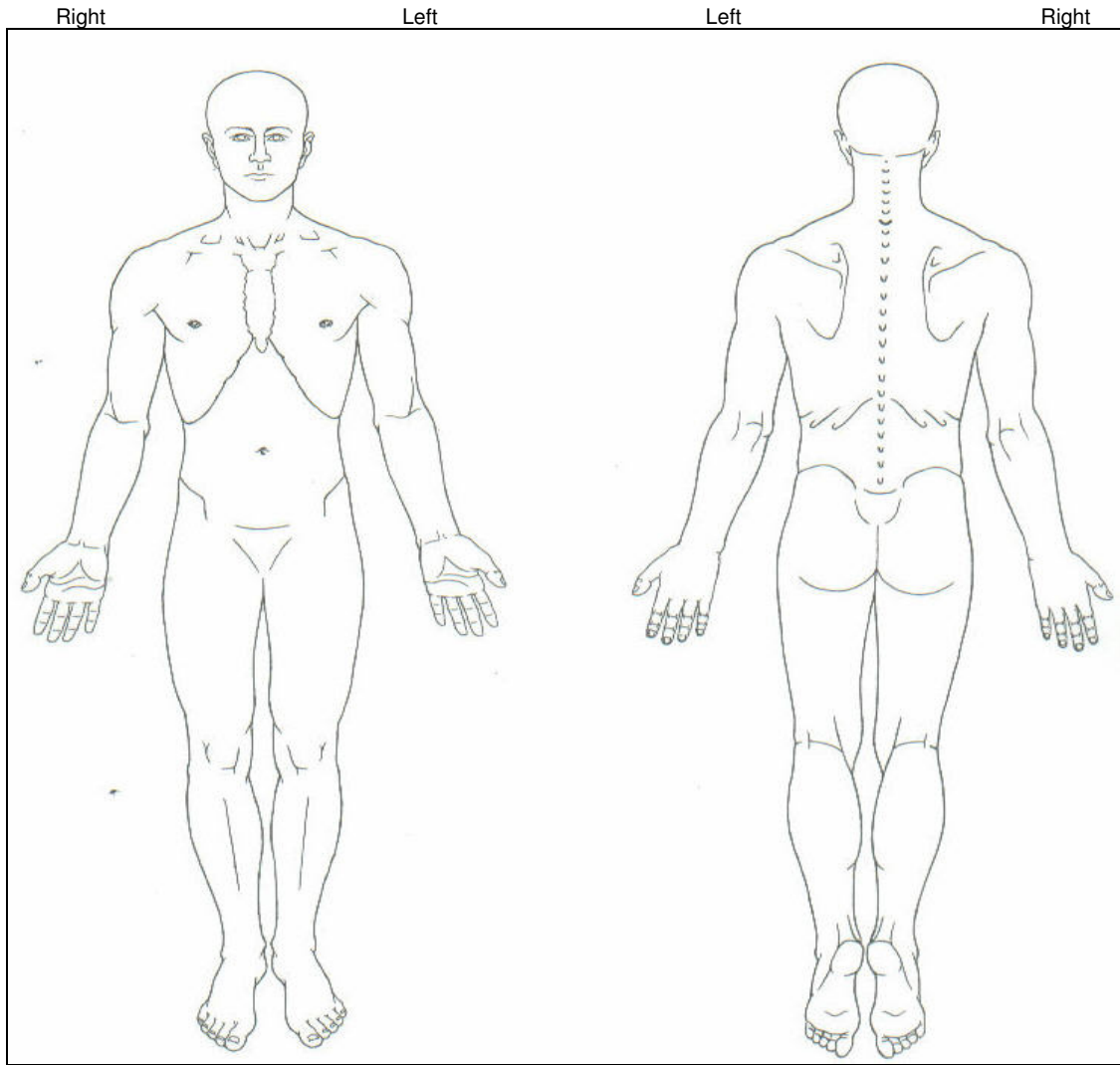
Any previous work-related injury?  No  Yes When? \_\_\_\_\_

Did you lose any time from work as caused by the accident? No Yes What dates? \_\_\_\_\_

Currently working limited hours? No Yes Working light duty? No Yes

Did you have any work limitations or disabilities **prior** to the accident? No Yes

**Using the diagram below, circle or mark the where you feel pain, aching, numbness/tingling, or any other symptom.**



**Describe Each Problem or Painful Body Region Separately (as best you can, e.g. "headaches," or "lower back," or "knee").**

Pain or Problem Area #1: \_\_\_\_\_

Are symptoms?:  Constant  Comes & Goes; Grade your pain from 0 (no pain) to 10 (unbearable): 0 1 2 3 4 5 6 7 8 9 10

What provokes or alleviates your symptoms? \_\_\_\_\_

Pain or Problem Area #2: \_\_\_\_\_

Are symptoms?:  Constant  Comes & Goes; Grade your pain from 0 (no pain) to 10 (unbearable): 0 1 2 3 4 5 6 7 8 9 10

What provokes or alleviates your symptoms? \_\_\_\_\_

Pain or Problem Area #3: \_\_\_\_\_

Are symptoms?:  Constant  Comes & Goes; Grade your pain from 0 (no pain) to 10 (unbearable): 0 1 2 3 4 5 6 7 8 9 10

What provokes or alleviates your symptoms? \_\_\_\_\_

**Past Medical History:**

Check the box for any condition for which – **in the past** - you've been medically treated for, been diagnosed with, or had significant medical problems.

- |  |  |   |   |   |
|--|--|---|---|---|
| <input type="checkbox"/> Back Pain           | <input type="checkbox"/> Concussion            | <input type="checkbox"/> Irritable Bowel        | <input type="checkbox"/> HIV +              | <input type="checkbox"/> Nervousness          |
| <input type="checkbox"/> Neck Pain           | <input type="checkbox"/> Struck Unconscious    | <input type="checkbox"/> Digestion Problems     | <input type="checkbox"/> Hepatitis          | <input type="checkbox"/> Depression           |
| <input type="checkbox"/> Numbness/Tingling   | <input type="checkbox"/> Eye Injuries          | <input type="checkbox"/> Heart Problem          | <input type="checkbox"/> Mononucleosis      | <input type="checkbox"/> Anxiety              |
| <input type="checkbox"/> Sciatica            | <input type="checkbox"/> Sinus Problems        | <input type="checkbox"/> Kidney Problem         | <input type="checkbox"/> Anemia             | <input type="checkbox"/> Chemical Addiction   |
| <input type="checkbox"/> Jaw Pain/TMJ        | <input type="checkbox"/> Shortness of Breath   | <input type="checkbox"/> Thyroid Problem        | <input type="checkbox"/> Excessive Thirst   | <input type="checkbox"/> Eating Disorder      |
| <input type="checkbox"/> Headaches           | <input type="checkbox"/> Dizziness             | <input type="checkbox"/> Liver Problem          | <input type="checkbox"/> Night Sweats       | <input type="checkbox"/> Allergies            |
| <input type="checkbox"/> Shoulder            | <input type="checkbox"/> Chest Pains           | <input type="checkbox"/> Gall Bladder Problem   | <input type="checkbox"/> Weight Loss        | <input type="checkbox"/> Difficulty Breathing |
| <input type="checkbox"/> Elbow/Arm           | <input type="checkbox"/> High Blood Pressure   | <input type="checkbox"/> Lung Disease           | <input type="checkbox"/> Frequent Urination | <input type="checkbox"/> Asthma               |
| <input type="checkbox"/> Carpal Tunnel Syn.  | <input type="checkbox"/> Arteriosclerosis      | <input type="checkbox"/> Menstrual Irregularity | <input type="checkbox"/> Diabetes           | <input type="checkbox"/> Chronic Cough        |
| <input type="checkbox"/> Knee Problems       | <input type="checkbox"/> Constipation          | <input type="checkbox"/> Menstrual Cramps       | <input type="checkbox"/> Limb Edema         | <input type="checkbox"/> Cancer               |
| <input type="checkbox"/> Foot or Ankle       | <input type="checkbox"/> Sleep Disorder        | <input type="checkbox"/> Prostate Problem       | <input type="checkbox"/> Bruise Easily      | <input type="checkbox"/> Lumps or Tumors      |
| <input type="checkbox"/> Tendonitis/Bursitis | <input type="checkbox"/> Fractures             | <input type="checkbox"/> Uterus/Ovary Prob's    | <input type="checkbox"/> Chronic Fatigue    | <input type="checkbox"/> <b>Other:</b>        |
| <input type="checkbox"/> Sprained Ankle(s)   | <input type="checkbox"/> Osteoporosis ('penia) | <input type="checkbox"/> Skin Diseases          | <input type="checkbox"/> Lymes Disease      | <input type="checkbox"/> <b>Other:</b>        |

List **all** surgeries, **any** major injuries or **any** hospitalizations you had in the past. Do you have any residual issues?

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List **all** medicines, herbs/vitamins you currently take (attach or email a list if you prefer);

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**Social History:**

- Do you smoke?     No     Yes    How much ? \_\_\_\_\_
- Consume alcohol?     Daily     Weekly     Seldom     Never
- Do you eat "fast" food?     Daily     Weekly     Seldom     Never
- Caffeine Beverages/Day     4-6     2-3     1-2     Seldom/Never

**Family Medical History:**

**Diabetes, Heart Ds., Arthritis, Cancer**

- Father:
- Mother:
- Siblings:

Do you have a regular exercise program?     No     Yes    If yes, what and how often?

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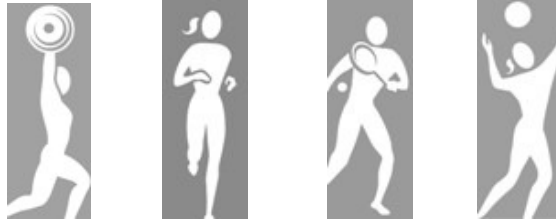
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List any hobbies or sports you participate in:

Were you very active in any particular sports when you were younger (e.g. high school track, college football)?

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



## **PATIENT INFORMED CONSENT TO TREATMENT**

**The Nature Of Chiropractic Treatment:** The doctor will use his hands or mechanical devices in order to move your joints and mobilize soft tissues (e.g. muscles, ligaments). A “crack” or “pop” sound is inherent in some of the joint manipulation procedures and is a natural effect of joint movement. Various other procedures, including, but not limited to, hot packs, electric stimulation, therapeutic ultrasound, exercises, massage or other soft tissue therapies may also be used. Physical examination is physical! It involves the doctor manually challenging your joints and testing your muscle strengths and it can sometimes lead to temporary soreness or worsening of your pain.

**Possible Risks and Side Effects:** As soon as ANY doctor intervenes with your healthcare there is risk of side effects and complications. The risk of serious complications from chiropractic treatment has been described as “extremely rare.” While less serious complications are possible from chiropractic treatment, most are highly unlikely, but could include fractures, sprains/strains, injury to intervertebral discs, nerves, spinal cord, a worsening of symptoms or development of new symptoms. Cerebrovascular accident such as a stroke is highly sensationalized by the news media, but real research data proves that it is very rare, with odds calculated as one in a million to one in forty million, about the same odds of a stroke from having your hair washed in a salon (“beauty parlor syndrome”), and significantly less than the odds of being struck by lightning. Usually, side effects of treatment include transient muscular stiffness or soreness. Some people report it as feeling like they exercised new muscles for the first time. Some procedures (e.g. hot packs or deep tissue massage) could produce skin irritation, burns or bruises.

**Other Treatment Options That Could Be Considered (Just To Put Things In Perspective):**

Over-the-counter analgesics, prescription medicines, surgical procedures, and hospitalization all carry significant risk of complications, far greater than those encountered in a chiropractic office.

**Risks Of Remaining Untreated:** While it is possible that your symptoms can go away with no treatment at all, delay of treatment could reduce body mobility, induce chronic pain, and lessen chances of complete recovery.

**I have read the explanation above regarding chiropractic treatment. I have had the opportunity to have questions answered to my satisfaction. I freely decided to undergo the recommended treatment, and hereby give full consent to treatment.**

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Patient or Parent/Guardian

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Date

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Witness



**IRREVOCABLE ASSIGNMENT OF PROCEEDS**

TO: \_\_\_\_\_  
(Insurance Company(s)/Attorney's Name)

ADDRESS: \_\_\_\_\_

In consideration of receiving chiropractic services from Dr. Scott F. Gillman and/or d.b.a. Gillman Chiropractic, having its usual place of business at 251 West Central Street, Natick, MA 01760, Under Massachusetts Law , Chapter 106, Section 9-109 (C)(8) and 9-315 (C), I hereby assign and transfer to Dr. Scott F. Gillman any and all proceeds due me including, but not limited to, my personal injury protection (PIP) benefits and/or medical payment coverage of my automobile policy, bodily injury insurance, uninsured/underinsured insurance, workers compensation or any other private insurance or health plan coverage for service rendered to me.

Further, I hereby request and direct that the above-named insurance company(s) and legal counsel/attorney pay to Dr. Scott F. Gillman such sums as may be due upon receipt of any itemized statement(s) for chiropractic services rendered to me by said doctor.

I authorize all procedures relative to treatment received, whether covered or not by my insurance plan.

I understand that I am financially responsible for: all services in excess of any plan's payment schedule, services not covered by an insurance plan, services not deemed medically necessary by an insurance carrier, services in excess the plan's benefit level, and services that are received after an insurance company's "Independent medical exam (IME)" cutoff date.

It is further understood and agreed that payment of said itemized statements by the above-named insurance company, as herein directed by me, shall be considered the same as if paid by the above-named insurance company directly to me.

A photocopy of this assignment is considered as effective and valid as the original for any successive services.

I understand this is a direct and irrevocable assignment of proceeds.

\_\_\_\_\_  
Signed

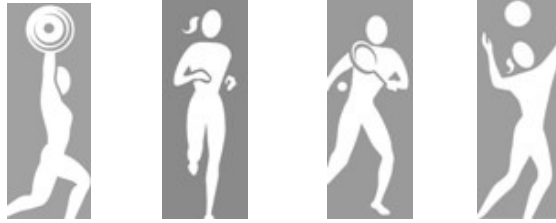
\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date of Injury/Accident

\_\_\_\_\_  
Policy/Claim Number

Balance Due: \$ \_\_\_\_\_ As of: \_\_\_\_\_



**Dr. Scott F. Gillman**  
**The Gillman Chiropractic Office**

### **Auto Accident – PIP Insurance Policy**

Massachusetts “no-fault” insurance entitles injured persons 100% coverage for health care under what is known as Personal Injury Protection (PIP). The maximum PIP benefit for an auto accident is \$8,000 per person, per accident. If you have any additional benefits, such as “Med Pay,” then your auto insurance cover sheet will state it. Otherwise, once \$2000 of your PIP benefit are exhausted, Massachusetts’ law requires you to utilize your personal health plan for the remaining \$6,000 of your benefit. Your personal insurance copayments, as well as any healthcare outside of the terms of your personal health insurance plan is paid by PIP. Any additional healthcare bills beyond the \$8,000 must be paid directly by you or from monies acquired from legal settlements.

The Gillman Chiropractic Office will, as a courtesy to you, submit your bills to the insurance carrier and await reimbursement. This service will be performed only if all necessary information (below) is received and verified. Services that are your full responsibility include: services not covered or not deemed medically necessary by an insurance carrier, services rendered at a different care-level than the insurance company assumes, and services different than what the insurance company utilization control process dictates and services that are received after an IME cutoff date.

For the Gillman Chiropractic Office to submit your healthcare bills to your insurance carriers, the following criteria must be met:

- An *accident report* must be filed with the police and your insurance carrier and we must have verification that this was done or have a copy on file.
- You must provide this office the following information:  
Insurance policy number, claim number, insurance representative’s name, and any insurance information about the other party/vehicle involve, your attorneys information (If one is involved).
- Agree to our policies and sign the following forms:
  1. *Assignment of Benefits*
  2. *Insurance Agreement forms*

Other things you must understand:

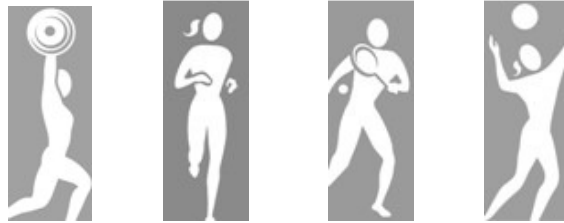
Your automobile insurance policy is an agreement between you and your auto insurance company. The Gillman Chiropractic office only has contract agreements with certain managed healthcare plans (e.g. Tufts, Blue Cross’) that limit services or fees. We have no contracts with PIP carriers.

If we ever, for any reason, deem your account delinquent, then we no longer will await reimbursement from insurance carriers or law offices, but will instead bill you directly or send you to a collection agency.

Sign below if you read and understood this form:

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

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



## OFFICE POLICIES OF THE GILLMAN CHIROPRACTIC OFFICE

### **PERMISSION TO COMMUNICATE (HIPPA)**

I authorize and give permission to Dr. Scott F. Gillman and his staff and/or associates to communicate with me by regular mail, email, phone calls to my home, work, wireless phone, or answering machine(s). I understand that communication will be in regards to appointments, clerical issues and clinical issues. I understand that due diligence will be employed in being discrete about any clinical issues conveyed via the above modes of communication. I understand that I have the right to refuse certain types of communication by notifying Dr. Scott F. Gillman or his staff in writing.

### **AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION (HIPPA)**

I hereby authorize Dr. Scott F. Gillman or his assigned staff members to release information contained in my medical record to any and all insurance carriers from whom I may be due benefits, to my primary care physician or other healthcare providers associated with my treatment, to the state chiropractic society in the event their assistance is needed on my behalf, and to my attorney of record (if an attorney is involved).

### **ASSIGNMENT OF PROCEEDS**

Under Massachusetts Law, Chapter 106, Section 9-109(C)(8) and 9-315(C), I hereby instruct and direct that payments for my services be sent directly to Dr. Scott F. Gillman or the Gillman Chiropractic Office and not to me, my guardians, my estate, or my attorney, regardless of any assignment of benefits my attorney or others may present on my behalf, and regardless of the date such other assignment or instruction may be signed by me or presented by others.

- I hereby instruct and direct that payments for health care provided me by Dr. Scott F. Gillman, as reflected in bills for such service that he may present, as may be due me under terms of a contract of health insurance, or as a result of an action at court, settlement, structured settlement, judgment, verdict or arbitration award which I may receive or be due, be sent directly to Dr. Scott F. Gillman. This instruction shall be considered irrevocable, and shall survive me, and my period of care under Dr. Gillman forever and without exception.
- Regarding only payment for Dr. Gillman's services to me as reflected in bills he presents I hereby rescind any and all assignments of benefit presented by my attorney of any date prior to this date to any party receiving this notice.

Also, under all circumstances, I direct and instruct that any monies sent to any party as payment for the services at the Gillman Chiropractic Office, following receipt of office bills and or statements, BE MADE PAYABLE SOLELY TO DR. GILLMAN.

### **COLLECTION POLICY AGREEMENT**

- I hereby acknowledge that I am ultimately fully responsible for the payment of all charges or fees for services provided me regardless of any contract of insurance, any action at court, any settlement, structured settlement, judgment, verdict or arbitration award which I may receive or be due, or the course or outcome of any dispute regarding same. I also understand that I may be charged a 1.5% monthly interest charge for any patient balances unpaid after 30 days.
- I agree to deliver to Dr. Gillman any check, draft or funds that I receive from any source intended as payment for services rendered me by Dr. Gillman within 10 calendar days of receipt by me and to be responsible for 1.5% month interest accrued for failure to deliver money after 30 days.
- I agree to reimburse Dr. Gillman for all reasonable collection costs he incurs that arise from collection actions he takes against me in the process of settling my account.

### **APPOINTMENT POLICY**

***We reserve the right to charge a \$30 fee for appointments that are blatantly missed or appointments that are cancelled without notice of at least four (4) hours. The \$30 fee is your bill, not your insurance company's bill.***

I acknowledge that I received these HIPAA and office policies and have read, understood and agreed to them per my signature:

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