

Personal Injury Questionnaire

Date: _____

Name: _____ Age: _____ M S W D Spouse's Name: _____

Occupation and for How Long? _____ Children (number / ages) _____

Date of Accident? _____ Please describe your accident: _____

For the Questions Below, Please Feel Free to 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

Your vehicle damage: Front Back Driver's Side Passenger's Side Did your vehicle hit anything? 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 any other body part hit against anything within your 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 accident? No Yes: _____

Did you feel pain later on? No Yes How soon after? _____

Where did you go right after the accident: Ambulance Hospital Work Home Other: _____

Have you seen any specialist(s) for this condition? Name/Location: _____

Have any x-rays/MRI's/CT scans been taken? No Yes Medicine prescribed? No Yes Braces, supports, or canes issued? No Yes

How many doctor visits have you had so far?

Ever had similar pain/symptoms/problems in the involved areas before? No Yes: _____

Any previous vehicle accidents? No Yes When: _____

Have you missed **any** time from work due to the accident? No Yes Dates out of work since accident: _____

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

Is your pain/symptom(s): Improving Getting Worse Changing in Character or Location The Same

Today's Date: _____ Patient: _____ File: _____

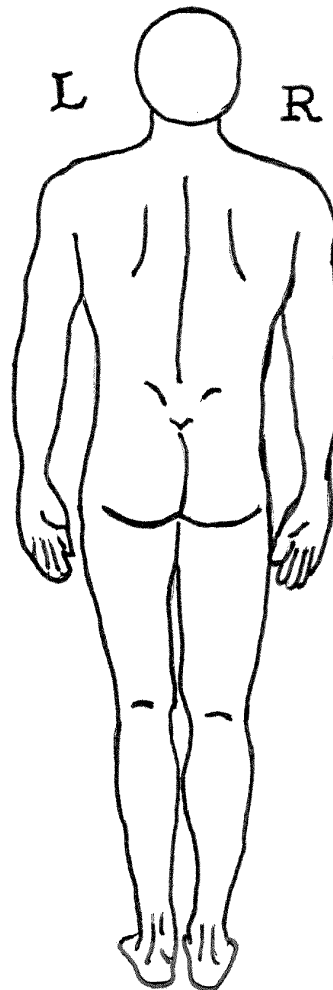
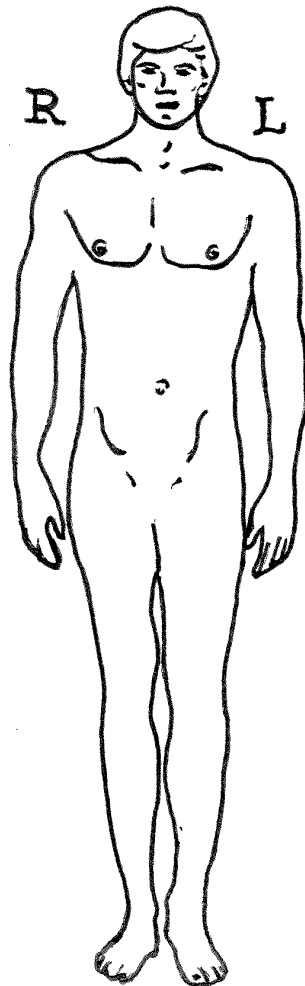
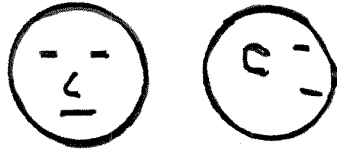
CIRCLE, MARK, COLOR-IN OR IDENTIFY AREAS OF YOUR BODY THAT HAVE A PROBLEM.

Feel free to use the symbols in the box below to describe the type(s) of pain or sensations you experience.

>>>	Aching Pain
XXX	Burning Pain
==	Numbness
OOO	Pins & Needles
////	Stabbing Pain

FOR FACE OR HEAD PAIN:

Rt Side Lt Side Both



List Each Area Of Pain Or Complaint Separately.

1. Area of Pain: _____

The pain is... Constant Comes & goes; lasting for _____ minute(s) hour(s) day(s) week(s)

In general symptoms are better in: AM Midday PM Symptoms do not change with time of day.

In general symptoms are worse in: AM Midday PM Symptoms do not change with time of day.

In general is pain constant and unrelated to movement? Yes No Does this pain wake you up from sleep? Yes No

How intense is your pain? Please grade it from 1 to 10

no pain 1 2 3 4 5 6 7 8 9 10 the most intense
pain imaginable

The pain is aggravated by: _____

The pain is relieved by: _____

2. Area of Pain: _____

The pain is... Constant Comes & goes; lasting for _____ minute(s) hour(s) day(s) week(s)

In general symptoms are better in: AM Midday PM Symptoms do not change with time of day.

In general symptoms are worse in: AM Midday PM Symptoms do not change with time of day.

In general is pain constant and unrelated to movement? Yes No Does this pain wake you up from sleep? Yes No

How intense is your pain? Please grade it from 1 to 10

no pain 1 2 3 4 5 6 7 8 9 10 the most intense
pain imaginable

The pain is aggravated by: _____

The pain is relieved by: _____

3. Area of Pain: _____

The pain is... Constant Comes & goes; lasting for _____ minute(s) hour(s) day(s) week(s)

In general symptoms are better in: AM Midday PM Symptoms do not change with time of day.

In general symptoms are worse in: AM Midday PM Symptoms do not change with time of day.

In general is pain constant and unrelated to movement? Yes No Does this pain wake you up from sleep? Yes No

How intense is your pain? Please grade it from 1 to 10

no pain 1 2 3 4 5 6 7 8 9 10 the most intense
pain imaginable

The pain is aggravated by: _____

The pain is relieved by: _____

4. Area of Pain: _____

The pain is... Constant Comes & goes; lasting for _____ minute(s) hour(s) day(s) week(s)

In general symptoms are better in: AM Midday PM Symptoms do not change with time of day.

In general symptoms are worse in: AM Midday PM Symptoms do not change with time of day.

In general is pain constant and unrelated to movement? Yes No Does this pain wake you up from sleep? Yes No

How intense is your pain? Please grade it from 1 to 10

no pain 1 2 3 4 5 6 7 8 9 10 the most intense
pain imaginable

The pain is aggravated by: _____

The pain is relieved by: _____

Past Medical History:

Check the boxes below if you've ever been medically treated for, been diagnosed with, or had significant medical problems with any of the following conditions **in the past:**

- | | | | | |
|--|--|---|---|---|
| <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 Pain | <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 Pain | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Frequent Urination | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Knee/Leg Pain | <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Menstrual Irregularity | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Chronic Cough |
| <input type="checkbox"/> Foot or Ankle Pain | <input type="checkbox"/> Constipation | <input type="checkbox"/> Menstrual Cramps | <input type="checkbox"/> Limb Edema | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Sprained Ankles | <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"/> Other:_____ |

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

List **all** medicines you currently take:

Social History:

- Do you smoke? No Yes How much ? _____
- Do you consume alcohol? Daily Weekly Seldom Never
- Do you crave "sweets"? Daily Weekly Seldom Never
- Do you eat "fast" food? Daily Weekly Seldom Never
- Coffee/Caffeine per day? _____ cups/cans

Family History:

Mother: _____

Father: _____

Siblings: _____

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

List any hobbies or sports you participate in:

Did you play any sports when you were younger? Which ones?

Patient Signature: _____ **Date:** _____

OFFICE POLICIES OF THE GILLMAN CHIROPRACTIC OFFICE

PERMISSION TO COMMUNICATE

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

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 BENEFITS

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 1) i received the HIPAA policies of this office and 2) I have read, understood and agreed to the above

Office Policies by My Signature: _____ Date: _____

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 is 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: _____

IRREVOCABLE ASSIGNMENT OF BENEFITS

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, I hereby assign and transfer to Dr. Scott F. Gillman any and all benefits 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 benefits.

Signed

Date

Printed Name

Date of Injury/Accident

Policy/Claim Number

Balance Due: \$ _____

Authorization for Release of Medical Records To Dr. Scott F. Gillman

I hereby authorize _____ to use or disclose the following protected health
Name of Physician / hospital

information from the medical records of the patient listed below. I understand that information used or disclosed pursuant to this authorization could be subject to redisclosure by the recipient and, if so, may

not be subject to federal or state law protecting its confidentiality.

Patient Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

THIS AUTHORIZATION OR PHOTOCOPY HEREOF DIRECTS HEALTHCARE FACILITY/PROVIDERS TO RELEASE ANY OR ALL INFORMATION REQUESTED VIA PHONE OR MAIL.

Information to be disclosed to: Dr. Scott F. Gillman
251 West Central Street
Natick, MA 01760
(Phone) 508-650-1091, (Fax) 508-650-1563

Disclose the following information for treatment dates: _____ to _____

Complete Records Xray Reports Xray Films MRI Reports

Other Specified: _____

The above information is disclosed for the following purposes: **MEDICAL/ HEALTHCARE**

I understand that I may refuse to sign or may revoke (at any time) this authorization for any reason and that such a refusal or revocation will not affect the commencement, continuation or quality of my treatment at the offices of Dr. Scott F. Gillman; except, however, if my treatment at the offices of Dr. Scott F. Gillman is for the sole purpose of creating health or obtaining information for disclosure to Dr. Scott F. Gillman then he may refuse to treat me if I do not sign this authorization.

I understand that the Authorization will remain in effect until the term of this Authorization expires or until I provide a written notice of revocation to Dr. Scott F. Gillman at the address listed above. The revocation will be effective immediately upon Dr. Scott F. Gillman's receipt of my written notice, except that the revocation will not have any effect on any action taken by the offices of Dr. Scott F. Gillman in reliance on this Authorization before it received my written notice of revocation.

This authorization will be valid for 90 days from the signature date, or until _____.

I have read and understand the terms of this Authorization and I have has the opportunity to ask questions about the use and disclosure of my health information. By my signature below, I hereby, knowingly and voluntarily, authorize the above -mentioned physician/hospital to disclose my health information in the manner described above.

Patient Signature

Printed name of patient or patient's representative

Patient File Number

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 hot packs, electric stimulation, therapeutic ultrasound, exercises, massage or other soft tissue therapies may also be used. Physical examination is physical! It involves mechanically challenging your joints and testing your muscle strengths and it can possibly lead 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 “rare,” and in one study was estimated at about 200,000 complications over a 5-year period. While complications are possible from chiropractic treatment, most are highly unlikely, but could include fractures, sprains, dislocations of joints, injury to intervertebral discs, nerves or spinal cord, or you can experience worse symptoms or new symptoms. Cerebrovascular accident such as a stroke is remotely possible and has been calculated between one in a million to one in forty million odds, about the same odds of a stroke from having your hair washed in a salon (“beauty parlor syndrome”) or 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 massage) could produce skin irritation, burns or bruises.

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

Over-the-counter analgesics, prescription medicines, surgical procedures, and hospitalization all have significant risk of side effects and serious complications which are far greater than that which is 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 reduce body mobility, induce chronic pain, and lesson 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.

Patient or Parent/Guardian

Date

Witness

ATTENDING PHYSICIAN'S REPORT

FROM: GILLMAN CHIROPRACTIC
251 WEST CENTRAL STREET
NATICK, MA 01760

TO:

ATTENTION:

FILE #:

DATE OF ACCIDENT:

1. Patient's Name and Address:

2. Age

3. Sex: M F

4. Occupation (if known)

5. History of occurrence as described by patient:

6. Diagnosis and Concurrent Conditions *:

7. When did symptoms appear?

Date:

8. When did patient first consult you?

Date:

9. Has patient ever had same or similar condition?

No [] Yes [] If "YES" state when and describe*

10. Is condition solely a result of this accident? Yes [] No []

If "NO", explain*

11. Is condition due to injury or sickness arising out of patient's employment? Yes [] No []

12. Will injury result in permanent disfigurement or defect?

Yes [] No [] Undetermined at this time [] If "YES", describe:

13. Patient was totally disabled

From: Through:

14. Patient was partially disabled

From: Through:

15. If still totally disabled the patient should be able to return to work on:

Date:

16. Total charges to date: \$

17. Estimated future charges: \$

18. Is patient still under your care for this condition? Yes [] No []

Date:

Physician: Dr. Scott F. Gillman

Signature:

EIN: 04-3113744

Address: 251 W. Central St., Natick MA 01760

Ph: (508) 650-1091 / Fax: (508) 650-1563

[] Please see the reverse side used for additional space and information