WORK / COMP HISTORY

Name of Patient:_____ Phone: (_____)

Address:_____City_____State_____Zip_____

Birthdate: ____/____/____ Sex_____S/S # _____

Insurance 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_____Are you off work? ( )Yes ( )No

Previous Workers Compensation Injury? ( ) Yes ( ) No

Accident reported to employer? ( )Yes ( )No Name of person reported accident to_____

Injured at:_____City_____State_____ Zip_____

Length of time worked there prior to accident:_____

Type of work being done at time of injury:_____

In your own words, please describe accident:_____

_____

_____

Have you been treated by another doctor for this accident? ( ) Yes ( ) No

If yes, please list doctor's name and address:_____

_____

What type of treatment did you receive?_____

How long were you treated by this doctor?_____

Are you: ( ) Improved ( ) Unchanged ( ) Getting Worse

What types of medicines are you taking?_____

_____

Do these medicines help? ( ) Yes ( ) No ( ) Don't Know

Have you had physical therapy? ( ) Yes ( ) No If Yes, how often?

( ) Daily ( ) Every Other Day ( ) Several Times a Week ( ) Weekly

( ) Every Other Week ( ) Monthly ( ) Other_____

Does the physical therapy help? ( ) Yes ( ) No ( ) Don't Know

Prior to this accident, have you ever had any of the physical complaints similar to what you have now? ( ) Yes ( ) No ( ) Don't Know

If yes, describe:_____

_____

Were these similar complaints the results of a previous accident(s)? ( ) Yes ( ) No

Please provide details of accident(s):_____

_____

_____

Have you had any other serious accidents which required medical care? ( ) Yes ( ) No
Describe:_____

Have you had any serious illnesses that required hospitalization? ( ) Yes ( ) No
Describe:_____

_____

_____

Have you had any surgeries? ( ) Yes ( ) No
If yes, list type of surgery and date:_____

_____

_____

Have you had any nervous or mental illnesses? ( ) Yes ( ) No
Have you had psychiatric care? ( ) Yes ( ) No
Have you received a medical discharge from the Armed Forces? ( ) Yes ( ) No
Have you returned to work since this accident? ( ) Yes ( ) No
If you have returned to work since you accident, please fill out the information below:

Date	Employer	Occupation	Light Duty/Reg. Duty	Full-Time/Part-Time

Current Medical Complaints

Back Pain:

1. Currently, I have pain in my: ( ) Low Back ( ) Mid Back ( ) Upper Back
2. My pain began: ( ) Gradually ( ) Suddenly
3. I have pain: ( ) Sometimes ( ) All of the time
4. My pain goes into my: ( ) Right Leg ( ) Left Leg ( ) Both
5. I have tingling and/or numbness in my: ( ) Right Leg ( ) Left Leg ( ) Both
6. My pain is worse when I:
   - Cough or Sneeze ( ) Yes ( ) No
   - Sit ( ) Yes ( ) No
   - Bend ( ) Yes ( ) No
   - Walk ( ) Yes ( ) No
   - Lift ( ) Yes ( ) No
   - Push ( ) Yes ( ) No
   - Pull ( ) Yes ( ) No
7. My back is worse with sexual activity ( ) Yes ( ) No
8. My pain wakes me up during the night ( ) Yes ( ) No
9. Changes in the weather affect my pain ( ) Yes ( ) No

Neck Pain:

1. My Neck pain began: ( ) Gradually ( ) Suddenly
2. I have pain: ( ) Sometimes ( ) All of the Time
3. My pain goes into my: ( ) Right Arm ( ) Left Arm ( ) Both
4. I have tingling and/or numbness in my: ( ) Right Arm ( ) Left Arm ( ) Both
5. My pain is worse when I:
   - Cough or Sneeze ( ) Yes ( ) No
   - Bend Forward ( ) Yes ( ) No
   - Lift ( ) Yes ( ) No
   - Push ( ) Yes ( ) No
   - Pull ( ) Yes ( ) No
   - Turn my Head ( ) Yes ( ) No
6. My pain wakes me up during the night ( ) Yes ( ) No
7. Changes in the weather affect my pain ( ) Yes ( ) No
8. I have neck stiffness ( ) Yes ( ) No
9. I have headaches ( ) Yes ( ) No
10. If I do get headaches, they occur ( ) Sometimes ( ) All of the Time

Other Pain:

Please describe any current medical complaints which 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%-66%, and "continuously" means 67%-100% of the day).

1. In a typical 8-hour workday, I: (Circle # of hours / 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

2. On the job, I perform the following activities:

	NOT AT ALL	OCCASSIONALLY	FREQUENTLY	CONTINUOUSLY
Bend/Stoop	( )	( )	( )	( )
Squat	( )	( )	( )	( )
Crawl	( )	( )	( )	( )
Climb	( )	( )	( )	( )
Reach Above Shoulder Level	( )	( )	( )	( )
Crouch	( )	( )	( )	( )
Kneel	( )	( )	( )	( )
Balancing	( )	( )	( )	( )
Pushing/Pulling	( )	( )	( )	( )

3. On the job, I lift:

	NOT AT ALL	OCCASSIONALLY	FREQUENTLY	CONTINUOUSLY
Up to 10 pounds	( )	( )	( )	( )
11 to 24 pounds	( )	( )	( )	( )
25 to 34 pounds	( )	( )	( )	( )
35 to 50 pounds	( )	( )	( )	( )
51 to 74 pounds	( )	( )	( )	( )
75 to 100 pounds	( )	( )	( )	( )

4. Do you have to bend over while doing any lifting? ( ) Yes ( ) No
5. Are your feet used for repetitive movements, such as in operating foot controls? ( ) Yes ( ) No
6. Do you use your hands for repetitive actions; such as:

	SIMPLE GRASPING	FIRM GRASPING	FINE GRASPING
Right Hand	( ) Yes ( ) No	( ) Yes ( ) No	( ) Yes ( ) No
Left Hand	( ) Yes ( ) No	( ) Yes ( ) No	( ) Yes ( ) No

7. Are you required to work on unprotected heights? ( ) Yes ( ) No
   Describe: _____
8. Are you required to be around moving machinery? ( ) Yes ( ) No
   Describe: _____
9. Are you exposed to marked changes in temperature and humidity? ( ) Yes ( ) No
   Describe: _____
10. Are you required to drive automotive equipment? ( ) Yes ( ) No
    Describe: _____
11. Are you exposed to dust, fumes, and/or gases? ( ) Yes ( ) No
    Describe: _____
12. Please list any additional comments: _____

Signature: _____ Date: _____

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INFORMED CONSENT FOR CHIROPRACTIC TREATMENT AND CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physiotherapy, massage therapy, yoga, pilates and diagnostic x-rays, on my (or on the patient named below, for whom I am legally responsible) by the doctor, chiropractic assistant, intern, pilates/yoga instructor or massage therapist affiliated with the chiropractic office of Tyra L. Beavers D.C.

I understand that, as in the practice of medicine, in the practice of chiropractic care there are some risks to treatment, including but not limited to, fractures, disc injuries, strokes, dislocations, sprains, bruising and swelling. I do not expect the doctor to be able to anticipate and explain all risks and complications. I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based on the facts then known, and is in my best interests.

I have read, or have had read to me, the above consent. By signing below I agree to the above, and allow the doctor, chiropractic assistant, intern, pilates/yoga instructor or massage therapist affiliated with the chiropractic office of Tyra L. Beavers D.C. to perform such. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

_____
Patient's name (Please Print)

_____ _____
Patient Signature Date

_____ _____
Guardian's Signature Date

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Patient Name:

* PLEASE READ AND INITIAL ALL BOXES BELOW*	Patient Initial
FINANCIAL RESPONSIBILITY FOR SERVICES: I hereby authorized my insurance benefits be paid directly to Tyra Beavers, DC. I understand that I may have financial responsibility for all or portion of the charges for the professional services rendered and will remit appropriate payment at the time of service, including co-payments / co-insurance and charges for services which are not covered by my insurance.	
COPAYMENT POLICY: If applicable, at the time of check-in, I will be required to pay a co-payment. If I do not pay my co-payment, I understand that I will be billed any appropriate fees due and if not paid within 30 days 15% interest will accrue weekly and a $25.00 late fee applied.	
INSURANCE COVERAGE: I acknowledge that it is my responsibility to understand the benefits and limitations on benefits under my insurance or health plan and to contact my insurance carrier/ health plan if I have questions. You will receive services today with the understanding that in the event your coverage is not effective you will be billed and held financially responsible for the services rendered.	
RELEASE OF INFORMATION: I authorize the release of my medical records or other information necessary to allow my health insurance to process my medical claims and for other purposes in relation to this offices health care operation. Additional information provided in our Notice of Privacy Practices.	
24 HOUR CANCELLATION POLICY: I understand that there is a $50 late cancellation charge for any appointment not cancelled within 24 hours.	
FEE FOR FORMS: I understand that if I request to have any forms or letters written or emailed by Dr. Beavers I will be required to pay a fee starting at $15.00. The following are some examples of these forms: jury duty excuse, disability, accident reports, off work slips and school and camp forms.	
ON-TIME ARRIVAL POLICY: I understand that I must arrive on time for my scheduled appointment. If I arrive late for my scheduled appointment I understand that it may be necessary to reschedule my appointment. Our physicians attempt to maintain an "on-time" schedule, but I understand that urgent or complex needs for patients with prior appointment may cause my physician to be late for my appointment.	
FEES FOR PATIENT HEALTH INFORMATION: I hereby understand that I will be charged a reasonable cost based fee for providing copies of patient health information, including the cost of copying (supplies and labor), postage (if individual has request that the information be mailed).	
CONSENT FOR TREATMENT OF MINOR: I hereby authorize Dr. Tyra Beavers, DC to perform diagnosis tests and to administer treatment as she deems necessary to my minor child (Child's Name)	

I certify that I have read and fully understand the above. Anything that I did not understand was explained to me. I have additional questions.

Signature: _____ Date:_____
If a minor, signature, name, and date of parent / guardian:

Signature: _____ Date:_____

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Disclosure of Fee's / Payment Policy

99202	Evaluation / Management – Expanded	$125.00
99203	Evaluation / Management – Detailed	$155.00
99212	Established Patient E&M – Limited	$125.00
99213	Established Patient E&M – Expanded	$155.00

97012	Traction, Mechanical	$45.00
97014	Electrical Stimulation	$45.00
97026	Infrared	$45.00
97110	Therapeutic Exercises	$55.00
97112	Neuromuscular	$55.00
97140	Manual Therapy Technique	$60.00
97035	Ultrasound	$45.00
97124	Full Body Massage 1 hr (Cash Patient)	$95.00

98940	Manipulative treatment 1-2 regions	$65.00
98941	Manipulative treatment 3-4 regions	$75.00
98942	Manipulative treatment 5 regions	$85.00
98943	Manipulative treatment extra spinal 1 or more regions	$65.00

I have read the above codes and fees and understand the cost of my care with my treating doctor. I understand that I am responsible for payment of all deductibles and co-payments/ co-insurance related to my care. I understand that if I have a balance for medical services not paid, I will make a minimum payment of $50.00 each month or 20% (auto-debit) of the outstanding balance whichever is greater. If my balance is not paid in a timely and monthly fashion, I promise to pay any and all collections, court, and attorney fees in the collection of my account. I further understand that if my treatment is associated with a personal injury or accident claim, all medical bills will be paid at 100% of the above fee schedule regardless of the outcome of my case. I understand that if a check or debit is returned for insufficient funds, I will be charged a $25.00 service charge. I further understand that if my insurance company declines payment, I authorize Tyra Beavers, DC to file small claims on my behalf against my insurance company as a method of collection. I further understand that I will be present at the court date if needed. I have read and fully understand the above financial terms and prices.

Print Name: _____

Signature: _____ Date: _____

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HIPAA 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. PLEASE REVIEW IT CAREFULLY.

This Practice is committed to maintaining the privacy of your protected health information ("PHI"), which includes information about your health condition and the care and treatment you receive from the Practice. The creation of a record detailing the care and services you receive helps this office to provide you with quality health care. This Notice details how your PHI may be used and disclosed to third parties. This Notice also details your rights regarding your PHI. The privacy of PHI in patient files will be protected when the files are taken to and from the Practice by placing the files in a box or brief case and kept within the custody of a doctor or employee of the Practice authorized to remove the files from the Practice's office.

NO CONSENT REQUIRED

The Practice may use and/or disclose your PHI for the purposes of:

(a) Treatment – In order to provide you with the health care you require, the Practice will provide your PHI to those health care professionals, whether on the Practice's staff or not, directly involved in your care so that they may understand your health condition and needs.
(b) Payment – In order to get paid for services provided to you, the Practice will provide your PHI, directory or through a billing service, to appropriate third party payers, pursuant to their billing and payment requirements.
(c) Health Care Operations – In order for the Practice to operate in accordance with applicable law and insurance requirements and in order for the Practice to continue to provide quality and efficient care, it may be necessary for the Practice to compile, use and/or disclose your PHI.

The Practice may use and/or disclose your PHI, without a written Consent from you, in the following additional instances:

(a) De-identified information – Information that does not identify you and, even without your name, cannot be used to identify you.
(b) Business Associate – To a business associate if the Practice obtains satisfactory written assurance, in accordance with applicable law, that the business associate will appropriately safeguard your PHI. A business associate is an entity that assists the Practice in undertaking some essential function, such as a billing company that assists the office in submitting claims for payment to insurance companies or other payers.
(c) Personal Representative – To a person who, under applicable law, has the authority to represent you in making decisions related to your health care.
(d) Emergency situations –
    a. For the purpose of obtaining or rendering emergency treatment to you provided that the Practice attempts to obtain your Consent as soon as possible; or
    b. To a public or private entity authorized by law or by its charter to assist in disaster relief efforts, for the purpose of coordinating your care with such entities in an emergency situation.
(e) Communication barriers – If, due to substantial communication barriers or inability to communicate, the Practice has been unable to obtain your Consent and the Practice determines, in the exercise of its professional augment, that your Consent to receive treatment is clearly inferred from the circumstances.
(f) Public Health Activities – Such activities include, for example, information collected by a public health authority, as authorized by law, to prevent or control disease and that does not identify you and, even without your name, cannot be used to identify you.
(g) Abuse, Neglect, or Domestic Violence – to a government authority if the Practice is required by law to make such disclosure. If the Practice is authorized by law to make such a disclosure, it will do so if it believes that the disclosure is necessary to prevent serious harm.

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(h) Health Oversight Activities – Such activities, which must be required by law, involve government agencies and may include, for example, criminal investigations, disciplinary actions, or general oversight activities relating to the community's health care system.
(i) Judicial and Administrative Proceeding – For example, the Practice may be required to disclose your PHI in response to a court order or a lawfully issued subpoena.
(j) Law Enforcement Purposes – In certain instances, your PHI may have to be disclosed to a law enforcement official. For example, your Phi may be the subject for a grand jury subpoena. Or, the Practice may disclose your PHI if the Practice believes that your death was the result of criminal conduct.
(k) Coroner or Medical Examiner – The Practice may disclose your PHI to a coroner or medical examiner for the purpose of identifying you or determining your cause of death.
(l) Organ, Eye or Tissue Donation – If you are an organ donor, the Practice may disclose your PHI to the entity to whom you have agreed to donate your organs.
(m) Research – If the Practice is involved in research activities, your PHI may be used, but such use is subject to numerous governmental requirements intended to protect the privacy of your PHI and that does not identify you and, even without your name, cannot be used to identify you.
(n) Avert a Threat to Health or Safety – The Practice may disclose your PHI if it believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to an individual who is reasonably able to prevent or lessen the threat.
(o) Workers' Compensation – If you are involved in a Workers' Compensation claim, the Practice may be required to disclose your PHI to an individual or entity that is part of the Workers' Compensation system.

Appointment Reminders

- Your health care provider or a staff member may disclose your health information to contact you to provide appointment reminders. If you are not at home to receive an appointment reminder, a message will be left on your answering machine, voice mail, or with the person who answers the call.
- You have the right to refuse us authorization to contact you to provide appointment reminders. If you refuse us authorizing, it will not affect the treatment we provide to you.

Electronic Communication: Email, Fax, or Text / Medical Records Release (PHI)

- We may use these unsecure methods of communication to obtain medical records. You may opt out of those methods in writing. By signing below you adhere to these risks.

Sign-in Log

This Practice maintains a sign-in log for individuals seeking care and treatment in the office. This sign-in sheets are located in a position where staff can readily see who is seeking care in the office, as well as the individual's location within the Practice's office suite. This information may be seen by, and is accessible to, others who are seeking care or services in the Practice's offices.

Family / Friends

The Practice may disclose to your family member, other relative, a close personal friend, or any other person identified by you, your PHI directly relevant to such person's involvement with your care or the payment for your care unless you direct the Practice to the contrary. This Practice may also use or disclose your PHI to notify or assist in the notification (including identifying or locating) a family member, a personal representative, or another person responsible for your care, of your location, general condition or death. However, in both cases, the following conditions will apply:

a) If you are present at or prior to the use or disclosure of your PHI, the Practice may use or disclose your PHI if you agree, or if the Practice can reasonably infer from the circumstances, based on the exercise of its professional judgment that you do not object to the use or disclosure.

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b) If you are not present, the Practice will, in the exercise of professional judgment, determine whether the use or disclosure is in your best interests and, if so, disclose only the PHI that is directly relevant to the person's involvement with your care.

AUTHORIZATION
Uses and/or disclosures, other than those described above, will be made only with your written Authorization.

Your Right to Revoke Your Authorization
You may revoke your authorization to us at any time; however, your revocation must be in writing.

Restrictions
You may request restrictions on certain use and/or disclosure of your PHI as provided by law. However, the Practice is not obligated to agree to any requested restrictions. To request restrictions, you must submit a written request to the Practice's Privacy Officer. In your written request, you must inform the Practice of what information you want to limit, whether you want to limit the Practice's use or disclosure, or both, and to whom you want the limits to apply. If the Practice agrees to your request, the Practice will comply with your request unless the information is needed in order to provide you with emergency treatment.

You Have a Right to
Inspect and obtain a copy your PHI as provided by 45 CFR 164.528. To inspect and copy your PHI, you are requested to submit a written request to the Practice's Privacy Officer. The Practice can charge you a fee for the cost of copying, mailing or other supplies associated with your request.

Receive confidential communications or PHI by alternative means or at alternative locations. You must make your request in writing to the Practice's Privacy Officer. The Practice will accommodate all reasonable requests.

Prohibit report of any test, examination or treatment to your health plan or anyone else for which you pay in cash or by credit card.

Receive an accounting of disclosures of your PHI as provided by 45 CFR 164.528. The request should indicate in what form you want the list (such as paper or electronic copy).

Receive a paper copy of this Privacy Notice from the Practice upon request to the Practice's Privacy Officer.

Request copies of PHI in electronic format if this office maintains your records in that format.

Amend your PHI as provided by 45 CFR 164.528. To request an amendment, you must submit a written request to the Practice's Privacy Officer. You must provide a reason that supports your request. The Practice may deny your request if it is not in writing. If you do not provide a reason in support of your request, if the information to be amended was not created by the Practice (unless the individual or entity that created the information is no longer available), if the information is not part of your PHI maintained by the Practice, if the information is not part of the information you would be permitted to inspect and copy/ and/or if the information is accurate and complete. If you disagree with the Practice's denial, you will have the right to submit a written statement of disagreement.

Receive notice of any breach of confidentiality of your PHI by the Practice.

Complain to the Practice or to the Office of Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, HHH Building, Washington, D.C. 20201, (202) 619-0257. Email: ocrmail@hhs.gov if you believe your privacy rights have been violated. To file a complaint with the Practice, you must contact the Practice's Privacy Officer. All complaints must be in writing.

I acknowledge that I was provided a copy of the Notice of Privacy Practices that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

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PRACTICE'S REQUIREMENTS

1. **The Practice:**

   - **Is required by federal law to maintain the privacy of your PHI and to provide you with this Privacy Notice detailing the Practice's legal duties and privacy practices with respect to your PHI.**
   - **Is required to abide by the terms of this Privacy Notice.**
   - **Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for your entire PHI that it maintains.**
   - **Will distribute any revised Privacy Notice to you prior to implementation.**
   - **Will not retaliate against you for filing a complaint.**

Patient Name: _____

Patient Signature: _____ **Date:** _____

Authorized Facility Signature: _____ **Date:** _____