

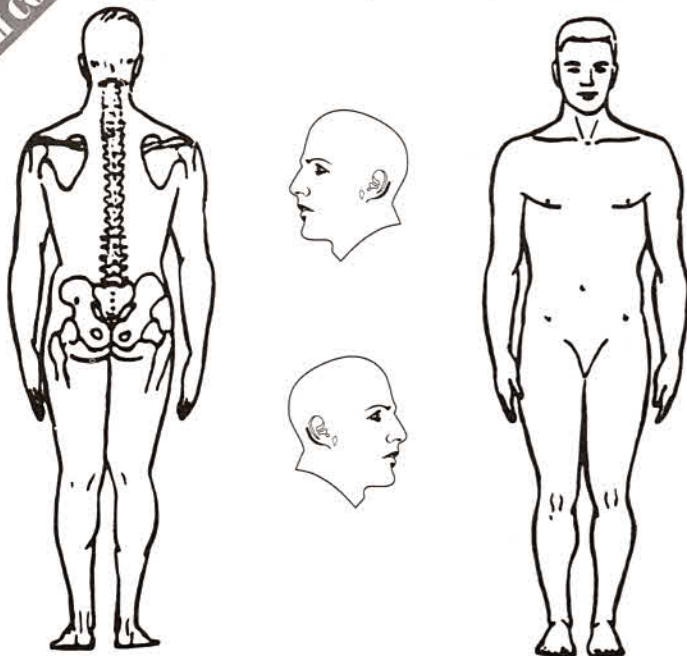
APPLICATION FOR TREATMENT

PERSONAL INFORMATION

Name: _____ Today's Date: ____ / ____ / ____
Address: _____ City/State/Zip: _____
E-mail Address: _____
Birth Date: ____ / ____ / ____ Age: _____ Are you Pregnant: Yes No
Employer's Name & Address: _____
Occupation: _____ Work Phone No.: _____ Home Phone No.: _____
Who referred you to our office: _____
What type of care do you desire: Temporary Relief Lasting Correction Best Care Possible

CURRENT HEALTH CONDITION

Please circle the exact location of any pain you are experiencing. Then describe the type of pain, i.e. dull, sharp, constant, on & off, etc.



In order of importance, list the health problems you are most interested in getting corrected:

- 1) _____
- 2) _____
- 3) _____
- 4) _____
- 5) _____

In order of severity, list those body functions that you are unable to perform, or that produce pain upon performance, i.e. walking, sitting, bending, etc.

- 1) _____
- 2) _____
- 3) _____
- 4) _____
- 5) _____

When was the first time you noticed this problem:

Describe any accidents, falls, injuries, sudden movements, etc. that may have caused your problem: _____

Have you had any similar health problems or injuries before? Yes No If yes, please explain: _____

Names of all other doctors you have seen for this problem: _____

Diagnosis and type of treatment you received (please include where and when you received treatment, and the results):

Has your health problem been: Improving Worsening Staying the Same

Please describe anything you do that improves your condition, or worsens it: _____

Please check off and describe how this problem interferes with your work and/or personal life:

Home Activities Effected: _____

Work Activities Effected: _____

Have you missed any work days? Yes No If yes, dates missed: _____

Recreational Activities Effected: _____

Rest or Sleep Effected: _____

(Please complete reverse side.)

**PREVIOUS
HEALTH HISTORY**

During the last year, has a doctor treated you for any health problem? Yes No

If yes, please explain: _____

Have you ever received Chiropractic care? Yes No If yes, please list the doctor's name, location of office and for what problems: _____

Please check off the drugs you are now taking: Pain Killers Muscle Relaxers Anti-inflammatory
 Blood Pressure Medication Insulin Birth Control Pills Tranquilizers Diet Pills
 Nerve Medication Sleeping Pills Anti-depressants Other (please list): _____

List the approximate dates of any accidents, operations or serious injuries (including broken bones) you have had: _____

If you have been in an automobile accident, when? This Year Last Year Past 5 Years Over 5 Years

Please check off the following that apply to you within the past 2 years: Went to a Health Spa
 Purchased Vitamins Purchased Health Foods Received a Massage

Please explain why you choose to do any of the above: _____

**FAMILY
HEALTH HISTORY**

Marital Status: Married Single Widowed Divorced Separated

Names & Ages of Children: _____

Name of wife or husband: _____

Spouse's Employer: _____ Business Phone: _____

**FINANCIAL
RESPONSIBILITY**

Who is responsible for your bill? I am Spouse (Spouse's Birthdate: ____/____/____)
 My Employer Insurance Other: _____

Type of Insurance: Worker's Comp. Health Automobile

Insurance Company's Name & Address: _____

If you are responsible for your health care fees, payment will be made by: Cash Check Credit Card

Your fees are due and payable at the time examinations, X-rays, and treatments are received, unless other arrangements have been made in advance. X-rays remain property of this clinic.

I, the undersigned, hereby give permission for treatment.

Patient's Signature _____ Social Security No: _____ Date: ____/____/____

PERSONAL INJURY / WORKERS' COMPENSATION QUESTIONNAIRE

NAME: _____ Date of Accident: _____ Time: _____

Where did accident happen? _____

Describe the accident in your own words: _____

What was your position in car? Driver Passenger If passenger, were you sitting in Front Right Rear Left Rear

Did your vehicle strike other vehicle? Yes No Was your car struck by other vehicle? Yes No

Was the impact from: the front? from the right side? from the left side? from the rear?

At the time of impact were you: looking straight ahead? looking right? looking left?

Were both hands on steering wheel? Yes No Was your foot on brake? Yes No Were you braced for impact? Yes No

Where in the car were you after the accident? _____

Were you wearing seat belts? Yes No Did you strike anything in vehicle at time of impact? Yes No

If yes specify: Steering Wheel Dashboard Windshield Side Door Arm Rests Side Window

Please state part of body: Chest Chin Knee Shoulder Hand Head

Immediately following the accident how did you feel? _____

Were you unconscious? Yes No In a daze? Yes No Did you go to hospital? Yes No

If you went to hospital, when? At time of accident Yes No Next day Yes No

How did you get to hospital? Ambulance Yes No Private Transportation Yes No

Did the ambulance attendants place you in: Neck Collar Yes No Splints: Yes No Brace: Yes No

Name of Hospital _____

Attended by Dr. _____ Were you x-rayed at hospital? Yes No

If so, what was the diagnosis? _____

Were you admitted to the hospital? Yes No How long did you stay? _____

What treatment was rendered? _____

What recommendations were made? See own doctor? Yes No See orthopedic doctor? Yes No

Physical Therapy Yes No

Have you seen any other doctor as a result of this accident? Yes No

Doctor's name _____

Is your pain constant? Yes No Is the pain on and off? Yes No Sharp? Yes No Dull? Yes No

Other _____

Is your pain worse when arising from a chair? Yes No Is it made worse by straining? Yes No By coughing? Yes No

By sneezing? Yes No By straining when moving your bowels? Yes No

Do you have any numbness or tingling in your arms? Yes No In your hands? Yes No In your fingers? Yes No

In your legs? Yes No In your feet? Yes No In your toes? Yes No

What is your most comfortable position? Sitting Yes No Lying on your right side Yes No Lying on your left side? Yes No

Lying on your back Yes No On your stomach Yes No Standing Yes No

Other _____ Is it difficult for you to move around in bed? Yes No

Does stretching and twisting worsen the pain? Yes No

Do any of the following relieve your pain? Heating Pad Hot Bath Shower Ice Pack

Does a brace (if you have tried one) help relieve the pain? Yes No

Does a change in heel height worsen the pain? Yes No Do you feel better moving around? Yes No Or resting? Yes No

Do you have a firm mattress? Yes No Do your knees ache or hurt? Yes No Do you have cramps in your leg? Yes No

In arm? Yes No Have you had any change in your bowel habits? Yes No

Have you lost any time from work because of this accident? Yes No

If yes, give dates of time lost. From _____ To _____

Totally disabled from _____ to _____ Partially disabled from _____ to _____

BEFORE YOUR ACCIDENT, estimate your total lifting effort ability:

- How much weight? Maximum Average
- How far could you carry this weight? _____ For how long a period of time? _____
- Was this lifting done at work? Yes No Or at home or elsewhere? Yes No
- How often did you carry this amount of weight? _____

AFTER YOUR ACCIDENT, describe your total lifting ability:

- How much weight can you now lift without experiencing pain, discomfort, or restriction of motion? _____
- Did you experience this pain, discomfort or restriction of motion before your accident? Yes No
- How far can you carry this weight now? _____ And for how long a period of time? _____
- How often can you carry this weight? _____
- Are you now limited in your lifting ability in some body position that you were previously not? Yes No
If so, specify position _____
- What symptoms does lifting produce? _____
- How long do these symptoms last? _____

Are you presently able to:

- | | | | | |
|------|------------------------------------------------|-------------------------------------------|-------------------------------------------|---------------------------------------------|
| LIFT | <input type="checkbox"/> Very Heavy _____ lbs. | <input type="checkbox"/> Heavy _____ lbs. | <input type="checkbox"/> Light _____ lbs. | <input type="checkbox"/> Sitting _____ lbs. |
| WORK | <input type="checkbox"/> Very Heavy _____ lbs. | <input type="checkbox"/> Heavy _____ lbs. | <input type="checkbox"/> Light _____ lbs. | <input type="checkbox"/> Sitting _____ lbs. |

What positions can you work in with a MINIMUM DEMAND of physical effort?

With Minimum Demand of physical effort, what positions can you work in PART-TIME and for how long?

- Standing Walking Sitting

With Minimum Demand of physical effort, can you work in a SITTING POSITION with some degree of walking or standing activity?

- Yes No

Do you feel that you cannot perform any physical work activity? Yes No

Do you feel that you cannot perform any mental work? Yes No

Relate your BEFORE injury capacity (mark 'B') and your AFTER injury capacity (mark 'A') for performing activities:

- | | | | | |
|--------------|--------------|---------------|-----------------|------------|
| 1. Walking | Normal _____ | Limited _____ | Difficult _____ | Pain _____ |
| 2. Standing | Normal _____ | Limited _____ | Difficult _____ | Pain _____ |
| 3. Sitting | Normal _____ | Limited _____ | Difficult _____ | Pain _____ |
| 4. Bending | Normal _____ | Limited _____ | Difficult _____ | Pain _____ |
| 5. Stooping | Normal _____ | Limited _____ | Difficult _____ | Pain _____ |
| 6. Lifting | Normal _____ | Limited _____ | Difficult _____ | Pain _____ |
| 7. Pushing | Normal _____ | Limited _____ | Difficult _____ | Pain _____ |
| 8. Pulling | Normal _____ | Limited _____ | Difficult _____ | Pain _____ |
| 9. Climbing | Normal _____ | Limited _____ | Difficult _____ | Pain _____ |
| 10. Reaching | Normal _____ | Limited _____ | Difficult _____ | Pain _____ |
| 11. Gripping | Normal _____ | Limited _____ | Difficult _____ | Pain _____ |
| 12. Kneeling | Normal _____ | Limited _____ | Difficult _____ | Pain _____ |
| 13. Balance | Normal _____ | Limited _____ | Difficult _____ | Pain _____ |
| 14. Fatigue | Normal _____ | Limited _____ | Difficult _____ | Pain _____ |

Generally speaking, is your inability to perform these functions due to Pain Weakness Structural limitations Nerves?

Do you have normal sexual function? Yes No

Are you able to take care of your personal self, such as dressing, bathing, etc? Yes No Or do you require assistance? Yes No

Do you feel your present condition is temporary? Yes No Or permanent? Yes No

Patient's Signature: _____

Date: _____

Patient Name: _____ Number _____

HWBP _____ Chiropad _____

Activities of Daily Living

Please circle all of the activities below that are affected by your condition. (Those activities that you cannot do or avoid performing, that cause you pain or aggravate your condition when performed.)

General:

- Bending
- Chewing
- Climbing stairs
- Exercising
- Getting in/out of auto
- Getting out of a chair
- Kneeling
- Lifting
- Lifting children
- Lying in bed
- Playing piano
- Reaching behind
- Reaching overhead
- Reading
- Running
- Sexual intercourse
- Sitting
- Sitting in recliner
- Sleeping
- Standing
- Swimming
- Using telephone

- Using typewriter/computer
- Walking

- Vacuuming
- Washing dishes

Exercise:

- Baseball
- Basketball
- Cycling
- Golf
- Hockey
- Lifting weights
- Running
- Soccer
- Tennis
- Working out in Gym

Personal Grooming:

- Brushing teeth
- Combing hair
- In/out bathtub
- Putting on bra
- Putting on socks
- Shaving

Travel:

- Driving
- Flying
- Riding (passenger)

Housework:

- Caring for pets
- Carrying groceries
- Cooking
- Doing Laundry
- Dusting
- Ironing
- Making beds

Yard work:

- Gardening
- Hammering
- Mowing lawn
- Painting
- Raking leaves
- Sawing

Patient's signature: _____ Date: _____

For Office Use Only

Smoker _____ Non Smoker _____ Former Smoker _____ H _____ W _____ BP _____ P _____

Health _____

ADL's _____

Prescriptions

Medication

- Active NKM _____
- Allergies NKDA _____

Nutrition

- Active NKNS _____
- Allergies NKNA _____

FAMILY HEALTH HISTORY

To help the doctor determine if your health problem is hereditary: 1) please check off (✓) the health problems of your family members; 2) leave blank those health problems they don't have; 3) circle those relatives who live within 30 miles of you, as some hereditary conditions are affected by a similar climate.

Patient Name: _____ **Date:** _____

HEALTH PROBLEM	MOTHER	FATHER	BROTHER(S)		SISTER(S)		SPOUSE	CHILDREN		
	Age ()	Age ()	Age ()	Age ()	Age ()	Age ()	Age ()	Age ()	Age ()	Age ()
Allergies										
Arm Pain – Numbness/Tingling										
Arthritis										
Asthma										
Back Pain										
Bursitis, Tendinitis										
Cancer										
Constipation										
Diabetes										
Disc Problems										
Emphysema										
Epilepsy										
Hand Pain – Numbness/Tingling										
Hay Fever										
Headaches										
Heart Trouble										
High Blood Pressure										
Insomnia										
Kidney Trouble										
Leg Pain – Numbness/Tingling										
Liver Trouble										
Low Blood Pressure										
Migraine										
Neck Pain										
Nervousness										
Neuritis										
Neuralgia										
Pinched Nerves										
Scoliosis										
Shoulder Pain										
Sinus Trouble										
Stomach Trouble										
Whiplash										

If any of your immediate family members (Mother, Father, brother, sister, or children) are deceased, please list their age at death and cause: _____



Dr. Gerald A.Nadeau - Dr. Robert G. Nadeau
336 Center St., Auburn, ME 04210 ~ T: (207) 777-1104 F: (207) 777-7354 ~ drgnadeau@gmail.com

HIPPA NOTICE TO PATIENT

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice.

Patient Name: _____ Date of Birth: _____

Address: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email Address: _____

I, _____ authorize Nadeau Chiropractic Associates to discuss Information pertaining to my appointments, treatments, financial matters and In case of an Emergency to:

Name: _____

Phone Number: _____

I acknowledge that I have received and had the opportunity to review the Notice of Privacy Practices on the date below on behalf of Nadeau Chiropractic Associates. I understand that this information can and will be used to: Conduct, plan and direct my treatment and follow up among the healthcare providers who may be directly and indirectly involved in providing my treatment. Obtain payment from third party payers. Conduct normal healthcare operations such as quality assessments and accreditation.

I understand that the notice describes the uses and disclosures of my protected health information by Nadeau Chiropractic Associates and informs me of my rights with respect to my protected health information.

Patient's Signature or legal Representative

Today's Date

Print Name of Patients Representative

Legal Representative Relationship

FOR OFFICE USE

We have made every effort to obtain written acknowledgement of receipt of our Notice of Privacy from this patient but it could not be obtained because:
___ The patient refused to sign ___ Due to emergency situation it was not possible to obtain an acknowledgement ___ Communication barriers prohibited obtaining the acknowledgement



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Notice of Receipt of Privacy Notice of Nadeau Chiropractic Associates

By signing below, I acknowledge that I have received and reviewed the Privacy Notice of Nadeau Chiropractic Associates, in force as of April 14, 2003 and all of my questions have been answered to my satisfaction in language that I can understand.

Name of Individual (printed)

Signature of Individual

Signature of Legal Representative
(e.g., Attorney-In-Fact, Guardian,
Parent if a minor):

Relationship

Date Signed ____/____/____

Witness:_____



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AUTOMOBILE ACCIDENT QUESTIONNAIRE

Name: _____ Date: _____

Date of accident: _____

Type of vehicle you were in: _____

Other vehicle type: _____

Were you the driver? _____

If you were the passenger, where were you sitting? _____

Were you wearing a seatbelt? _____ Were you wearing a lap belt? _____

Did your vehicle have an airbag? _____ If so, did it deploy? _____

What were the road conditions? (wet, dry, icy, gravel, pavement) _____

Type of impact? (side, front, rear-end) _____

Was your vehicle stopped or moving at the moment of impact? _____

How much damage was sustained by the vehicles in the accident? _____

Was your vehicle drivable after the accident? _____

Were you aware the accident was going to happen? _____

Did you brace yourself? _____

How many vehicles in the collision? _____

Were you knocked unconscious? _____

How did you feel immediately following the collision? _____

How did you feel hours or days later? _____

Did you go to the emergency room? _____ If so, what was done at the ER? _____

Have you had any treatments before coming to my office today? _____ If so, what? _____

How did you respond to this treatment? _____

Have you lost time from work due to this accident? _____

Did this accident occur in the course of your work? _____

Have you had an automobile accident in the past? _____ If so, what areas of the body were injured? _____

What symptoms were you having before this collision? _____

Have you retained an attorney? _____ If so, name and address: _____

Patient Signature: _____ Date: _____



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PERSONAL INJURY
PATIENT INFORMATION

Name: _____

Phone: _____

Address: _____

Your Auto Ins. Co.: _____

Phone: _____

Address: _____

Major Medical Ins. Co.: _____

Phone: _____

Address: _____

RESPONSIBLE PARTY INFORMATION

Name: _____

Phone: _____

Address: _____

Auto Insurance Co. Involved: _____

Phone: _____

Address: _____

Claim Handler: _____

Claim Number: _____



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**Irrevocable
Assignment, Lien and Authorization
Insurance Benefits and Attorney**

To Whom it May Concern:

I hereby authorize and direct you, my insurance company, and/or my attorney, to pay directly **Nadeau Chiropractic Associates** such sums may be due and owing this Office for services rendered me, both by reason of accident or illness, and by reasons of any other bills that are due this Office, and to withhold such a sums from any disability benefits, medical payment benefits, no-fault benefits, health and accident benefits, Worker's Compensation benefits, or any other insurance benefits obligated to reimburse me or from any settlement, judgment or verdict on behalf as may be necessary to adequately protect said Office. I hereby further give lien to said Office against any and all insurance benefits named herein and any and all proceeds of any settlement, judgment or verdict which may be paid to me as a result of the injuries or illness for which I have been treated by said office. This is to act as an assignment of my rights and benefits to the extent of the Office's services provided.

In the event that my insurance company obligated to make payments to me upon the charges made by this Office for their services refuses to make such payment, upon demand by me of this Office, I hereby assign and transfer to this Office any and all causes of action that I might have or that might exist in my favor against such company and authorize this Office to prosecute said cause of action either in my name or in the Office's name and further I authorize this Office to compromise, settle or otherwise resolve such claim or cause of action as they see fit.

I understand that I remain personally responsible for the total amounts due the Office for their services. I further understand and agree that this Assignment, Lien, and Authorization does not constitute any consideration for the Office to await payments and they may demand payments from me immediately upon rendering services at their option.

I authorize the Office to release any information pertinent to my case to any insurance company, adjuster or attorney to facilitate collecting collections under the Assignment, Lien and Authorization. I agree that the above mentioned Office be given Power of Attorney to endorse/sign my name on any and all checks for payment of my doctor bill.

I further understand and agree that if this Office must take any action to collect an outstanding balance on my account, I will be responsible for payment of and will reimburse the Office for all costs of such collection efforts, including but not limited to all court costs and attorney fees.

Signed _____ Date: _____

Witness: _____ Date: _____



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Personal Injury Claims

If you are receiving care from Nadeau Chiropractic Associates because of an automobile accident, fall, or as a result of other sudden trauma, we will bill your personal health insurance carrier, as well as, any and all liability insurers involved. If you do not have health insurance, regular payments must be made if responsibility has not been accepted by another insured.

We will be glad to cooperate with attorneys, insurers, adjusters and other parties involved in your case, and will release information to them with your specific authorization. We cannot, however, suspend monthly billings or assign responsibility for payment of your account to other parties without their written consent.

Because Nadeau Chiropractic Associates has no control over the outcome of any lawsuits resulting from your injury, responsibility for payment of your account remains with you.

Should you decide to discontinue care without a proper discharge from Nadeau Chiropractic Associates, all unpaid services will be billed directly to you. If you have an attorney who has signed a lien form acknowledging your outstanding bill here in our office, we will continue to bill you however will withhold any collection procedures of the unpaid amount until settlement has been made. If you do not have an attorney protecting your interest, payment arrangements must be made to clear any remaining balance.

Patient name: _____

Witness: _____

Date: _____

VERIFICATION OF INSURANCE COVERAGE

Nadeau Chiropractic Associates _____ Date/Time _____

PATIENT INFORMATION

Name: _____ DOB: _____ Patient # _____

Relationship to Insured: Self ___ Spouse ___ Child ___

INSURED INFORMATION (POLICY HOLDER)

Name: _____ TID# _____

DOB: _____ Group # _____

INSURANCE PAYER INFORMATION

Carrier Name: _____

Name of Insurance Representative: _____

Phone: _____ Electronic Claims to _____

Mail Claims to: _____

COVERAGE DETAILS

CPT CODE COVERAGE

Effective Date: _____
Referral Needed: ___ Yes ___ No
Deductible: ___ Yes ___ No Amount: \$ _____
Met? ___ Yes ___ No Next Due _____
Copay: \$% _____
X-Rays Covered: ___ Yes ___ No
Out of Pocket Amount: \$ _____
Visit Limit: _____

97140 Manual Therapy ___ Yes ___ No
98943 M8 ___ Yes ___ No
29200 – 29500 ___ Yes ___ No
99201 – 99204 ___ Yes ___ No
Taping Codes ___ Yes ___ No

BENEFITS SUMMARY

Pre-Existing Conditions: ___ Yes ___ No
Carryover Clause for Deductible: ___ Yes ___ No

REPORTING REQUIREMENTS

Special Reports Needed: ___ Yes ___ No If yes, when _____

The Doctor's treatment plan will be based upon what he determines is in the best interest for your health and benefit. Please note: We have no influence over your insurance company's reimbursement policies or rationales for denials. We will report clinical information to your Primary Care Physician and insurance company to ensure maximum benefit reimbursement. However, please be aware that you will be responsible for the cost if your insurance company limits the number of adjustments, exams or services, (ie: modalities, exercises, etc.).

We recommend that you verify your chiropractic insurance coverage as well.

Patient Signature: _____ Date: _____

Witness: _____ Date: _____