South Windsor Neck & Back
Relief today . function for life!

Dr. Christopher A. Colby, DC

PATIENT INFORMATION

Patient Name: _____

Referred by: _____ Marital Status: Single ☐ Married ☐ Divorced ☐ Widowed ☐

Address: _____ City: _____ Zip Code: _____

Telephone: _____ Cell: _____ Work: _____

Social Security #: _____ Email address: _____

Date of Birth: _____ Age: _____ Sex: Male ☐ Female ☐

Employer/ School: _____ Position/ Grade: _____

Emergency Contact: _____ Telephone: _____

Primary Care Physician: _____ Telephone: _____

Physician's Address: _____

PERSON RESPONSIBLE FOR PAYMENT

Responsible Party: _____ Telephone: _____

Self ☐ Mother ☐ Father ☐ Step Parent ☐ Spouse ☐ Other (Specify) ☐ _____

Address: _____ Zip Code: _____

Date of Birth: _____ Social Security #: _____

Employer: _____

PAYMENT IS DUE AT THE TIME OF SERVICE UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE

I understand that my insurance company may require a referral for care. If I do not have a valid referral, my insurance company could refuse to pay for my care. If my insurance company requires referrals and I fail to obtain a referral, I agree to assume responsibility for payment of my charges. I understand I am responsible financially if my insurance is not covering my visits. I hereby give South Windsor Neck & Back, LLC permission to release my records to my other doctors and to my health insurance company, including psychiatric, substance abuse and AIDS related information. Further, I acknowledge that I have access to and understand the HIPAA privacy agreement; I understand that I may contact the office manager if I have further questions or complaints and that I am entitled to receive a written copy of these policies at my request. I also understand that I am entitled to receive updates upon request if the Privacy Policy is amended or changed.

Signature: _____ Date: _____

1330 Sullivan Avenue ▪ South Windsor, CT 06074 ▪ Tel. (860) 644-2437 ▪ Fax (860) 644-8590
www.FunctionForLife.com

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PERSONAL INJURY INFORMATION

Patient's Name: _____ Job Title: _____

Employer/ Company Name: _____

Any lost time from work? □ Yes / □ No Dates Missed: _____

Were you working at the time of the accident? □ Yes / □ No Has this Claim been reported? □ Yes / □ No

Claim Number: _____ Date & Time of Injury/ Onset? _____

Your Insurance Company? _____ Other Insurance Company? _____

Adjuster's Name: _____ Adjuster's Phone Number: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Do you have MedPay Coverage on your auto policy? □ Yes / □ No / □ Don't know Limits? _____

ATTORNEY INFORMATION

Do you have an attorney representing you in this matter? □ Yes / □ No

If yes, please provide attorney's information:

Attorney's Name: _____ Attorney's Phone Number: _____

Address: _____ City: _____ State: _____ Zip Code: _____

ACCIDENT INFORMATION

Were you the Driver? _____ or Passenger? _____/ Where was the car hit? **Front** R / L or **Rear** R / L **Other**: _____

Were you wearing your seat belt? □ Yes / □ No

Your Vehicle: Year: _____ Make: _____ Model: _____

Other Vehicle: Year: _____ Make: _____ Model: _____

Location of Accident: _____

(street) (city) (state)

Road Conditions: Dry _____ Wet: _____ Ice: _____ Other: _____

Mechanism of Injury:

Hit from behind while/ Stopped: _____ Slowing: _____ Driving: _____ Other: _____

_____ Hit head on

_____ Side Impact: Driver side / Passenger side

_____ Lost control of car

_____ Hit other car

_____ Other: _____

Did you brace yourself for the impact? □ Yes / □ No

Was your head turned? □ Yes / □ No Right / Left

Were there any collisions after? □ Yes / □ No If yes, how many? _____

Did airbags deploy? □ Yes / □ No Estimate damage to your car? $_____

How far was your car pushed? _____ Did your seat break? _____

Did you strike any portion of your body? □ Yes / □ No

_____ Head/ _____Chest/ _____Face/ _____Knee(s)/ _____Arms/ Other: _____

Did you: _____ lose consciousness/ _____feel "dazed"/ _____Disoriented/ confused/ Other: _____

Please describe how the accident happened in detail:

_____

_____

_____

Name(s) of witnesses (if any):

_____

_____

_____

Did you seek treatment at the hospital/ any other providers after the incident? If yes, please list the provider's name and phone number, provider's specialty and reason(s) you were treated.

Provider's Name/ Specialty: *Provider's Phone Number:* *Reason:*

_____

_____

_____

When did you first consult a physician:

_____ the day of the accident/ _____ the day after the accident / _____several days later

Did you have any:

_____ Exam/ _____X-Rays/ _____MRI's/ _____ Injections/ _____Physical therapy

Were you given any medications? (Please list them): _____

Were you given an out of work note? (Dates out): _____

PAST HISTORY

Have you ever been injured in any prior car or work accidents? □ Yes / □ No

Have you ever been given an impairment rating/ disability rating? □ Yes / □ No

If yes, what % and what area(s)? _____

Please list the dates and injuries sustained in any previous accidents.

Date: *Area Injured:* *Treated with:* *Any residual pain/problems:*

_____

_____

_____

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Patient Name: _____ Account# _____

Previous Chiropractic Care? When? _____

Name of Chiro.?/ Practice? _____

Which type(s) of care are you interested in? **Check all that apply.**

- ☐ Pain Relief
- ☐ Corrective care. I am interested in fixing the cause of my problem, if possible
- ☐ Wellness/ Preventative Care
- ☐ Nutrition consultation. If yes, for what issues? _____
- ☐ Other: _____

CHIEF COMPLAINT(S): _____

Date of onset: _____

How did it happen? _____

Were you working at the time? ☐ Yes ☐ No

What makes it feel better? _____

What makes it feel worse? _____

How does it feel? (sharp, shooting, stiff, dull, aching etc.) _____

What time of day is it best? _____ Worst? _____ ☐ No timing

How severe is it? **(1-10)** with 0 being no pain and 10 being unbearable pain? _____

What other providers have you seen for this condition? ☐ MD ☐ DC ☐ PT ☐ Other: _____

Are you still seeing them? ☐ Yes ☐ No

Prior examinations:	What area of the body?	What hospital/ location?
☐ X-Ray	_____	_____
☐ MRI	_____	_____
☐ Cat Scan	_____	_____
☐ Blood work		_____
☐ Other: _____		_____

Do you have a permanent disability rating? ☐ No ☐ Yes _____% Location: _____

What activities have been affected by this condition? _____

When was the last time you felt really good? _____

What are your goals with care? _____

If we were your "Health Genies", what would be your ONE wish? _____

General

	Not Applicable
	Anxiety/Depression
	Change in appetite
	Difficulty sleeping
	Excessive bleeding
	Excessive thirst
	Fatigue
	Fever
	Heat/cold intolerance
	Loss of appetite
	Nausea/vomiting
	Night sweats
	Sudden weight change
	Swollen glands

Illnesses

	Not Applicable
	AIDS
	Asthma
	Arthritis
	Cancer
	Diabetes
	Fibromyalgia
	Glaucoma
	Heart disease
	Hepatitis
	Hypertension
	High cholesterol
	Immune disorder
	Kidney stones
	Osteoporosis
	Prostate disease
	Shingles
	Skin condition
	Stroke
	Tuberculosis
	Thyroid disease
	Ulcer

Neurological

	Not Applicable
	Dizziness
	Fainting
	Headaches
	Head trauma
	Numbness/tingling
	Seizures
	Weakness

Chest

	Not Applicable
	Cough
	Heart palpitations
	Chest pain
	Shortness of breath

Orthopedic

	Not Applicable
	TMJ
	Neck pain
	Mid back pain
	Low back pain
	Shoulder pain
	Elbow pain
	Wrist pain
	Hand pain
	Pelvic/SI pain
	Hip pain
	Knee pain
	Ankle pain
	Foot pain

Eyes/Ears

	Not Applicable
	Blurred vision
	Double vision
	Eye pain
	Ear pain
	Loss of hearing
	Ringing in the ears

Nose/Throat

	Not Applicable
	Chronic discharge
	Hoarseness
	Nosebleeds
	Sinus problems
	Trouble swallowing

Abdomen

	Not Applicable
	Change in stool
	Constipation
	Diarrhea
	Food allergy
	Heartburn
	Pain

Urine

	Not Applicable
	Awaken to urinate
	Burning sensation
	Excessive urination
	Incontinence
	Urinary retention

Woman

	Not Applicable
	Breast masses
	Endometriosis
	Irregular menstruation
	Perimenopausal
	PMS

Habits

	Not Applicable
	Alcohol
	Balanced diet
	Coffee
	Regular exercise
	Stress
	Tobacco

Family History

	Not Applicable
	Arthritis
	Bladder/kidney disease
	Cancer
	Diabetes
	Heart disease
	High blood pressure
	Neurological/stroke
	Thyroid disease

Allergies (list)

Surgeries (list w/ dates)

Medications (list)

Vitamins (list)

Patient's Signature: _____ Date: _____

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Back Index

ACN Group, Inc. - Form BI-100

ACN Group, Inc. Use Only rev 11/13/02

Patient Name _____ **Date** _____

This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ The pain comes and goes and is very mild.
① The pain is mild and does not vary much.
② The pain comes and goes and is moderate.
③ The pain is moderate and does not vary much.
④ The pain comes and goes and is very severe.
⑤ The pain is very severe and does not vary much.

Sleeping

⓪ I get no pain in bed.
① I get pain in bed but it does not prevent me from sleeping well.
② Because of pain my normal sleep is reduced by less than 25%.
③ Because of pain my normal sleep is reduced by less than 50%.
④ Because of pain my normal sleep is reduced by less than 75%.
⑤ Pain prevents me from sleeping at all.

Sitting

⓪ I can sit in any chair as long as I like.
① I can only sit in my favorite chair as long as I like.
② Pain prevents me from sitting more than 1 hour.
③ Pain prevents me from sitting more than 1/2 hour.
④ Pain prevents me from sitting more than 10 minutes.
⑤ I avoid sitting because it increases pain immediately.

Standing

⓪ I can stand as long as I want without pain.
① I have some pain while standing but it does not increase with time.
② I cannot stand for longer than 1 hour without increasing pain.
③ I cannot stand for longer than 1/2 hour without increasing pain.
④ I cannot stand for longer than 10 minutes without increasing pain.
⑤ I avoid standing because it increases pain immediately.

Walking

⓪ I have no pain while walking.
① I have some pain while walking but it doesn't increase with distance.
② I cannot walk more than 1 mile without increasing pain.
③ I cannot walk more than 1/2 mile without increasing pain.
④ I cannot walk more than 1/4 mile without increasing pain.
⑤ I cannot walk at all without increasing pain.

Personal Care

⓪ I do not have to change my way of washing or dressing in order to avoid pain.
① I do not normally change my way of washing or dressing even though it causes some pain.
② Washing and dressing increases the pain but I manage not to change my way of doing it.
③ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
④ Because of the pain I am unable to do some washing and dressing without help.
⑤ Because of the pain I am unable to do any washing and dressing without help.

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor.
③ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
④ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
⑤ I can only lift very light weights.

Traveling

⓪ I get no pain while traveling.
① I get some pain while traveling but none of my usual forms of travel make it worse.
② I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
③ I get extra pain while traveling which causes me to seek alternate forms of travel.
④ Pain restricts all forms of travel except that done while lying down.
⑤ Pain restricts all forms of travel.

Social Life

⓪ My social life is normal and gives me no extra pain.
① My social life is normal but increases the degree of pain.
② Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
③ Pain has restricted my social life and I do not go out very often.
④ Pain has restricted my social life to my home.
⑤ I have hardly any social life because of the pain.

Changing degree of pain

⓪ My pain is rapidly getting better.
① My pain fluctuates but overall is definitely getting better.
② My pain seems to be getting better but improvement is slow.
③ My pain is neither getting better or worse.
④ My pain is gradually worsening.
⑤ My pain is rapidly worsening.

Back Index Score

Neck Index

ACN Group, Inc. - Form NI-100

ACN Group, Inc. Use Only rev 11/13/02

Patient Name _____ **Date** _____

This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ I have no pain at the moment.
① The pain is very mild at the moment.
② The pain comes and goes and is moderate.
③ The pain is fairly severe at the moment.
④ The pain is very severe at the moment.
⑤ The pain is the worst imaginable at the moment.

Sleeping

⓪ I have no trouble sleeping.
① My sleep is slightly disturbed (less than 1 hour sleepless).
② My sleep is mildly disturbed (1-2 hours sleepless).
③ My sleep is moderately disturbed (2-3 hours sleepless).
④ My sleep is greatly disturbed (3-5 hours sleepless).
⑤ My sleep is completely disturbed (5-7 hours sleepless).

Reading

⓪ I can read as much as I want with no neck pain.
① I can read as much as I want with slight neck pain.
② I can read as much as I want with moderate neck pain.
③ I cannot read as much as I want because of moderate neck pain.
④ I can hardly read at all because of severe neck pain.
⑤ I cannot read at all because of neck pain.

Concentration

⓪ I can concentrate fully when I want with no difficulty.
① I can concentrate fully when I want with slight difficulty.
② I have a fair degree of difficulty concentrating when I want.
③ I have a lot of difficulty concentrating when I want.
④ I have a great deal of difficulty concentrating when I want.
⑤ I cannot concentrate at all.

Work

⓪ I can do as much work as I want.
① I can only do my usual work but no more.
② I can only do most of my usual work but no more.
③ I cannot do my usual work.
④ I can hardly do any work at all.
⑤ I cannot do any work at all.

Personal Care

⓪ I can look after myself normally without causing extra pain.
① I can look after myself normally but it causes extra pain.
② It is painful to look after myself and I am slow and careful.
③ I need some help but I manage most of my personal care.
④ I need help every day in most aspects of self care.
⑤ I do not get dressed, I wash with difficulty and stay in bed.

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
③ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
④ I can only lift very light weights.
⑤ I cannot lift or carry anything at all.

Driving

⓪ I can drive my car without any neck pain.
① I can drive my car as long as I want with slight neck pain.
② I can drive my car as long as I want with moderate neck pain.
③ I cannot drive my car as long as I want because of moderate neck pain.
④ I can hardly drive at all because of severe neck pain.
⑤ I cannot drive my car at all because of neck pain.

Recreation

⓪ I am able to engage in all my recreation activities without neck pain.
① I am able to engage in all my usual recreation activities with some neck pain.
② I am able to engage in most but not all my usual recreation activities because of neck pain.
③ I am only able to engage in a few of my usual recreation activities because of neck pain.
④ I can hardly do any recreation activities because of neck pain.
⑤ I cannot do any recreation activities at all.

Headaches

⓪ I have no headaches at all.
① I have slight headaches which come infrequently.
② I have moderate headaches which come infrequently.
③ I have moderate headaches which come frequently.
④ I have severe headaches which come frequently.
⑤ I have headaches almost all the time.

Neck Index Score _____

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Attorney Name: _____

Address: _____

_____

RELEASE OF MEDICAL RECORDS AND DOCTOR'S LIEN

I do hereby authorize South Windsor Neck & Back, LLC to furnish you, my attorney a full report of their examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident/ injury in which I was involved.

I hereby authorize and direct you my attorney, to pay directly to said doctor such sums as may be due and owing him for medical services rendered me both by reason of this accident and by reason of any other bills that are due to his office and to withhold such sums form any settlement, judgement or verdict as may be necessary to adequately protect said doctor. I hereby further give a lien on my case to said doctor against any and all proceeds of my settlement, judgement, or verdict which may be paid to you, my attorney, or myself as the result of the injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by him for services rendered protection and in consideration of his awaiting payment. I further understand that such payment is not contingent on any settlement, judgement or verdict by which I may eventually recover said fee.

Please acknowledge this letter by signing below and returning to the doctor's office. I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment, but will require me to make payment on a current basis.

D.O.I.: _____ _____
Patient Name (Print)

Dated: _____ _____
Patient Signature

The undersigned, being attorney of record for the above patient, does hereby agree to observe all the terms of the above, and agree to withhold such sum from any settlement, judgement or verdict as may be necessary to adequately protect said doctor which is named above.

Dated: _____ _____
Attorney's Signature

Policy on Personal Injury Appointments

Personal injury and worker's compensation cases involve not only medical issues, but also legal issues, it is important that you understand the following policies regarding care and treatment at our office. Furthermore, should Dr. Colby be asked to appear in court or at a deposition regarding your case, they may be asked under oath about the nature of your injuries and your adherence to the treatment plan.

Inconsistent treatment scheduling by you, along with missed appointments, may result in an insurance carrier or defense lawyer claiming that your injuries did not require treatment. It is our policy that if you miss three scheduled visits without a serious reason you may be dismissed from care in this office and you will be asked to choose another doctor to manage your care. In addition, if you have an attorney, they must be informed about significant failure to attend scheduled treatment. There also may be a charge for appointments that are not rescheduled with at least 24 hours notice given.

From a medical point of view, injured tissues and joints do not heal well if inconsistent management occurs. Long term medical consequences may result causing unnecessary pain and suffering. We make every effort to schedule or reschedule your visits so that you obtain maximum medical benefit from each visit.

If you have any questions regarding individual treatment protocol, please ask Dr. Colby.

_____

Patient Name (Printed)

_____ _____

Patient Signature Date

_____

Witness

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Dr. Christopher A. Colby, DC

PATIENT FINANCIAL AGREEMENT

In electing to receive care at this office I understand that it is office policy for payment to be made at the time services are rendered unless special arrangements have been made in advance. I also understand that it is my contractual obligation with my insurance company to obtain referrals, if needed, and make co-payments at the time services are rendered.

As a courtesy, the staff at South Windsor Neck & Back will attempt to Verify my insurance benefits for me, however, I understand that on rare occasions the information provided to my doctor by my insurance company regarding co-pay or deductible amounts may be inaccurate or incomplete and that it is ultimately my responsibility to be aware of the type of coverage that my plan provides.

In the event that I am billed for services rendered, I understand full payment is due immediately upon my receipt of an invoice. I also understand that a late fee of 12% per annum or $10.00/ monthly billing cycle, whichever is greater, will be imposed as long as my account is past due. In the event that my account becomes seriously delinquent, I understand that I will ultimately be responsible for all costs associated with the collection of fees including reasonable attorney fees and court costs. I understand that South Windsor Neck & Back, LLC will impose a $30.00 fee for returned checks due to insufficient funds. I understand that there is a $25.00 fee for missed appointments if not cancelled at least 24 hours in advance, and missed appointment fees are not covered services by my insurance plan. I also acknowledge that I am wholly responsible for any difference in payment between the amount of my insurance benefits and the full and total bill plus accrued interest and/ or late fees.

Personal injury cases: I understand that I have a financial obligation to pay South Windsor Neck & Back, LLC for services rendered to me regardless of my settlement or the inapplicability of my insurance. I understand that in the event that my case does not reach a favorable settlement, I must pay South Windsor Neck & Back, LLC immediately for services rendered.

_____ _____

Patient or Guardian Date

_____ _____

Witnessed by: Date

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INFORMED CONSENT

As with any health care delivery system, we cannot promise a cure for any symptom, disease, or condition. We will always give you our best care. If we feel as if we can't help you, or if your results are not acceptable, we will refer you to another health-care provider who we feel will best address your situation. All health care procedures have inherent benefits and risks and every patient is unique, therefore treatment needs to be tailored to each patient's particular health situation. Even though the risk for complications are very small, we implement specific tests and procedures that likely reduce the potential for injury even further. What you are being asked to sign is simply a confirmation that you have been informed of the following rare, but potential risks. In addition, your doctor will discuss treatment alternatives available so that you may make an informed decision about your health care. If you have any questions about your health care, please ask the doctor. When you have a full understanding, please sign and date the form below.

Examination: In instances when it is necessary to obtain advanced imaging, patients will be referred to an appropriate facility. *If there is any possibility that you are pregnant, please inform us prior to having any tests performed.* If applicable, please inform us of any metallic implants prior to undergoing MRI scanning.

Treatment: Chiropractic Manipulation ("adjustment"): The doctor may use his hands or a mechanical device upon the body in such a way as to move your joints in appropriate directions. This procedure may cause an audible "clicking" or "popping" noise to be heard coming from your joints, which is normal and not cause for alarm.

Pain: Occasionally, after introducing a new series of exercises, a patient may feel some discomfort. Also, while most patients feel better after manipulation, there may occasionally be a temporary increase in soreness in an area of receiving treatment. If either of these situations occur, please notify us so that appropriate recommendations may be given. We may also need to modify your treatment in the future.

Fractures: Fractures caused by chiropractic treatment are extremely rare. They tend to occur most frequently in patients with osteoporosis or weakened bones. Evidence of osteoporosis can be detected on X-Rays and/ or during a complete history and physical examination. If detected, the most appropriate treatment for your condition will be utilized to minimize the possibility of fracture.

Disk Injury: Chiropractic treatment is appropriate for the treatment of many kinds of back problems, including some disk problems. However, there is always a possibility that treatment may aggravate or cause a problem, especially if the disk is already in a severely weakened state to begin with. This occurs so rarely that statistics to quantify the probability are unavailable. Estimates place the risk or serious injury at about one complication per *100 million* low back manipulations.

Stroke: There are reported cases of stroke associated with visits to medical doctors, physical therapists and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke; rather, recent studies indicate that patients may be consulting with medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there is a stroke already in process. However, you are being informed of this reported association because a stroke may cause serious neurological impairment or even death. The possibility of such injuries occurring in association with upper cervical adjustment is extremely remote. The overall incidence of stroke in the general population is about two per 1,000 people. In comparison, the overall average risk of death from taking non-steroidal anti-inflammatory drugs (aspirin, Ibuprofen, Advil, Motrin, Naproxen, etc.) is about 4 per 10,000 patients.

I have read and understand this consent form and hereby authorize and direct Dr. Colby and his associates or assistants to provide services, as they deem reasonable and customary.

Patient's Signature: _____ Date: _____

Printed Name of Patient: _____ Witnessed by: _____

South Windsor Neck & Back
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Dr. Christopher A. Colby, DC

X-RAY CONSENT FORM

The doctor will explain that the purpose of the X-Ray about to be taken is to analyze the spine for vertebral subluxations and to determine the appropriateness of the chiropractic spinal adjustment. If the doctor discovers a non-chiropractic "unusual finding" when viewing the X-Ray, I will be informed. I then must determine if I should seek the advice of an additional health care provider for advice, diagnosis, or treatment for the unusual finding. I understand that seeking advice from another type of health care provider should not interfere with the subluxation correction care provided by this office.

Females only: I understand that to the best of my knowledge, I am not pregnant at this time. I hereby authorize South Windsor Neck & Back, LLC to take X-Rays as necessary to determine the status of my spine. I will assume all responsibility for any effects on a fetus potentially present.

Additionally, I understand that all X-Ray charges will be submitted to my insurance company (companies) as a courtesy, but more often than not, X-Rays are a denied charge through insurance and I understand that ultimately all financial costs will be my responsibility.

Patient's Signature: _____ Date: _____

Printed Name: _____ Witnessed by: _____

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

PICA

1. MEDICARE (Medicare#)	MEDICAID (Medicaid#)	TRICARE (ID#/DoD#)	CHAMPVA (Member ID#)	GROUP HEALTH PLAN (ID#)	FECA BLK LUNG (ID#)	OTHER (ID#)	1a. INSURED'S I.D. NUMBER (For Program in Item 1)
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		3. PATIENT'S BIRTH DATE MM DD YY SEX M F					4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street)		6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other					7. INSURED'S ADDRESS (No., Street)
CITY	STATE	8. RESERVED FOR NUCC USE					CITY STATE
ZIP CODE	TELEPHONE (Include Area Code)						ZIP CODE TELEPHONE (Include Area Code)
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO:					11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. EMPLOYMENT? (Current or Previous) YES NO					a. INSURED'S DATE OF BIRTH MM DD YY SEX M F
b. RESERVED FOR NUCC USE		b. AUTO ACCIDENT? PLACE (State) YES NO					b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE		c. OTHER ACCIDENT? YES NO					c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME		10d. CLAIM CODES (Designated by NUCC)					d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? YES NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) A. B. C. D. E. F. G. H. I. J. K. L.	ICD Ind.	22. RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1								NPI	
2								NPI	
3								NPI	
4								NPI	
5								NPI	
6								NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO	28. TOTAL CHARGE $	29. AMOUNT PAID $	30. Rsvd for NUCC Use
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED DATE	32. SERVICE FACILITY LOCATION INFORMATION a. b.		33. BILLING PROVIDER INFO & PH # ( ) a. b.		

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

South Windsor Neck & Back
Relief today ... function for life!

Dr. Christopher A. Colby, DC

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Printed Name of Patient _____

Previous Name (if applicable) _____

Date of Birth _____

Telephone Number _____

SEND INFORMATION TO: (Please be specific)

Provider Name/ Organization: _____

Address: _____

_____

Phone #: _____ Fax #: _____

INFORMATION TO BE RELEASED FROM: (Please be specific)

Provider Name/ Organization: _____

Address: _____

_____

Phone #: _____ Fax #: _____

INFORMATION TO BE DISCLOSED:

Complete History, including X-Rays, MRI's, CT Scans in your possession for date(s) of service:

_____

If the patient (guardian) is unable to sign, please indicate such and the authority to act of the person who is signing for the patient.

Date _____ Signature of Patient/ Representative _____ Relationship to Patient _____