Dr. William Bucur --16995 W Greenway Rd. Suite 102/ Surprise, Az. 85388/ 623-433-8895

WORKER'S COMPENSATION INTAKE FORM

PATIENT INFORMATION:

Last Name: _____ First Name: _____ M: _____ Male / Female

Address: _____Apt# _____ City: _____ State: _____ Zip:_____

Home : (_ __)_____-_____Cell: (_ __)_____-_____ Work: (__ _)____-_____DOB: _____/_____/_____

E-Mail: _____SSN:_____-_____-_____

Marital Status: Married Single Divorced Widowed

Occupation: _____ Medical Practitioner: _____

Employer_____Address: _____ City: _____

State: _____ Spouse Name: _____ DOB: _____/_____/_____ Age: _____

WORK/ INJURY INFORMATION:

Did you report this injury to your manager: _____

Manager's Name: _____ Title: _____

Date of Injury: _____ Time of Injury: _____

Address where injury occurred: _____

Employer Name: _____

Employer Address: _____

How injury occurred: _____

NAME AND ADDRESS OF WHERE THE INSURANCE CLAIMS SHOULD BE SENT:

Name of Insurance Company for the Employer: _____

Phone #: _____ Fax #: _____

Contact Person at Insurance Company: _____

Address: _____

Claim # _____ Policy #: _____

I VERIFY AND ACKNOWLEDGE THAT ALL INFORMATION IS CURRENT AND CORRECT: (Please sign below)

Signature of Patient: _____ Date: _____

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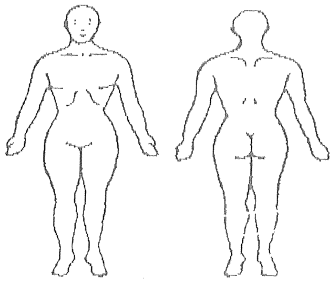
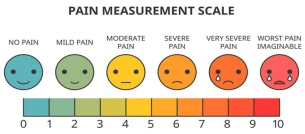
Please circle most affected areas below:



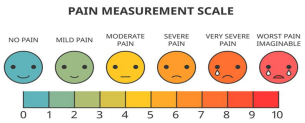
DESCRIBE AREA OF COMPLAINT - Begin with the area causing the most distress. (circle the words that appy)

Area #1 _____ **Tone - (Circle) - Dull Sharp Achy/Soreness Stiff/Tightness Numbness/Tingling**



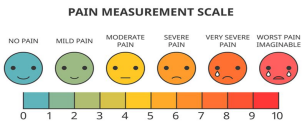
Rate - _____ **Frequency – (Circle) - Constant Intermittent Occasional**

Area #2 _____ **Tone - (Circle) - Dull Sharp Achy/Soreness Stiff/Tightness Numbness/Tingling**



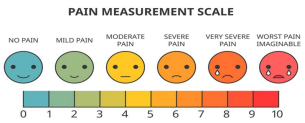
Rate - _____ **Frequency – (Circle) - Constant Intermittent Occasional**

Area #3 _____ **Tone - (Circle) - Dull Sharp Achy/Soreness Stiff/Tightness Numbness/Tingling**



Rate - _____ **Frequency – (Circle) - Constant Intermittent Occasional**

Area #4 _____ **Tone - (Circle) - Dull Sharp Achy/Soreness Stiff/Tightness Numbness/Tingling**



Rate - _____ **Frequency – (Circle) - Constant Intermittent Occasional**

1. Have you tried anything to relieve the pain? If so, what? _____ Results: **Yes No**

2. Have you seen any other doctors for this condition? If yes, who? _____ Results: **Yes No**

3. Are you currently under drug/medical care? **Yes No** Condition _____ Results: **Yes No**

4. Previous Chiropractic Care: _____ Approx. date of last visit: _____/_____/_____

5. Previous Spinal Injuries? **YES NO** _____ Automobile Accidents? **YES NO**

6. How many & when _____ Exercise Problems or Injuries? **YES NO**

7. Exercise**:** **Often Occasionally** 8. Difficulty Sleeping? **YES NO** 9. Position that Relieves Tension? **Side Stomach Back**

10. Previous Injuries or Broken Bones: _____

11. Surgeries: When:_____Area:_____

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Please circle all that apply to you:

Allergies	Arthritis	Asthma	Blood Clots
Blood Pressure	Cholesterol	Chronic Pain	Depression
Diabetes	Digestion Issues	Eczema	Epilepsy
Hearing & Ear	Heart Disease	Heart Attack	HIV/AIDS
Hepatitis (A,B,C)	Infectious Disease	Joint Replacements	Lung Conditions
Menopause	Mental Health	Migraine	Neurological Issues
Shingles	Sleep Disorder	Thyroid	Other:_____

Pregnancy: Due Date:_____# of weeks: _____

I VERIFY AND ACKNOWLEDGE THAT ALL INFORMATION IS CURRENT AND CORRECT: (Please sign below)

Print Patient Name: _____

Signature of Patient: _____ Date: _____

GREENWAYCOTTON CHIROPRACTIC and Body Harmony Massage
LASER PAIN CENTERS of AMERICA SURPRISE
DISC CENTERS of AMERICA SURPRISE
NEURODoc NEUROPATHY TREATMENT CENTERS SURPRISE
Dr. William Bucur --16995 W Greenway Rd. Suite 102/ Surprise, Az. 85388/ 623-433-8895

Financial Agreement

I will pay in full for services at the time of my appointment unless I have insurance coverage that requires another arrangement, or I make a different agreement with my provider.

My initials indicate that I have read and agree with each item below.

Professional Fees

_____ Any co-payment or co-insurance will be due in full at the time of service.

_____ All initial appointment fees are due upon first day of service. Special financial arrangements must be discussed by the second appointment.

_____ A $25 processing fee will be charged for any NSF fees on each return of payment.

_____ A $40 fee will be charged for missed appointments and cancelled appointments inside of 24 hours. All payments will be processed to the credit card on file that same day. Late arrivals to sessions may require to be shortened in order to accommodate others whose appointments follow yours. Depending upon how late you arrive, your therapist will then determine if there is enough time remaining to start a treatment. Regardless of the length of the treatment actually given, you will be responsible for "full cost" of the cost of that session. Out of respect and consideration for your therapist and other customers, please plan accordingly and be on time.

Authorization of Release of Records

I authorize the release of any medical information necessary to process my claim and/or for better treatment in this office including x-rays, MRIs, Lab tests, etc.

Payment and Assignments of Services

It is my responsibility to know what services are covered by my insurance plan. I have reviewed carefully the section in my insurance coverage booklet that describes the coverage of benefits for the services that will be provided at this office. I will call my plan administrator with any questions. I will pay for any services I receive that are not covered or denied by my insurance plan.

I will provide full and accurate insurance information in advance of my appointment, or will pay for the appointment on a self-pay basis. I will present my insurance card at the time of my appointment. I will provide updated insurance information promptly in the case of any changes.

I understand that I, not my insurance company, am responsible for full payment of my fees. I understand that insurance billing is provided by my healthcare provider as a courtesy, but I remain the responsible party.

I understand that, if after 90 days my insurance company has not responded I will receive a statement. I agree to pay my balance in full at that time. I understand that I will be reimbursed promptly if and when the insurance payment arrives.

I understand that, if my account is referred to a collection specialist due to nonpayment, I will pay any applicable collection fees.

I understand that, "Authorization to Pay the Doctor" I hereby authorize payment directly to Greenway/Cotton Chiropractic of the insurance benefits otherwise payable to me.

I understand that, Personal Injury/Auto Claim_____ Non Personal Injury/Auto Claim _____ in the case that I choose Non Personal Injury/Auto Claim, I state that I was not involved in any auto accident or personal injury caused by any other party. I further state that my diagnostic test or treatment is not the result of an injury while on the job or by any other person related to my employment.

I understand that, In the case of auto carrier or workman's compensation claims, whether settled or unsettled, I understand that I am responsible for all costs of chiropractic care which become payable within 30 days after the end of treatment and am held to the same rules as mentioned in the balance held policy noted above.

I understand that I am solely responsible for any and all missed, canceled or reschedule appointment fees whether the charges are in relation to an auto case or otherwise. I understand that my credit card will be charged at the time of the occurrence, if I am unable to give proper notice of more than 24 hours prior to my schedule appointment

Dispute Procedure

In the event of a dispute between myself and Greenway/Cotton Chiropractic whether for charges, procedures or balances I owe, I hereby waive the statute of limitations on collections and/or recovery. I also understand that litigation is certain once balances owed reaches 120 days past due, and I agree to pay all litigation costs incurred by Greenway/Cotton Chiropractic as a result of inaction to timely payment of my account. I understand and agree to pay a 50% collection fee on any outstanding balances due that are turned over to a collection agency.

By signing this document, I hereby agree to abide by all mentioned policies, authorizations, assignments, and procedures.

Signature of patient: _____ **Date:** _____

HIPPA Privacy Rule: Consent for Purposes of Treatment, Payment and Healthcare Operations

I acknowledge that Greenway/Cotton Chiropractic "Notice of Privacy Practices Abridged Edition" has been provided to me.

I understand I have a right to review the entire Greenway/Cotton Chiropractic Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Greenway/Cotton Chiropractic. The Notice of Privacy Practices for Greenway/Cotton Chiropractic also provided on request at the main administration desk of this practice. This Notice of Privacy Practices also describes my rights and Greenway/Cotton Chiropractic duties with respect to my protected health information. Greenway/Cotton Chiropractic reserves the right to change the privacy practices that are described in the Notice of Privacy Practices.

I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

PATIENT ACKNOWLEDGEMENT

By signing my name below, I acknowledge receipt of the above stated notice and my understanding and agreement to its terms.

_____ _____

Signature of Patient or Personal Representative **Date**

_____

Print Name of Patient or Personal Representative

_____

Description of Personal Representative's Authority

GREENWAYCOTTON CHIROPRACTIC and Body Harmony Massage
LASER PAIN CENTERS of AMERICA SURPRISE
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Informed Consent to Chiropractic & Massage Services

- **I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy, massage therapy and diagnostic X-rays, on me (or on the patient named below, for whom I am legally responsible) by the licensed doctor of chiropractic who now or in the future work at the clinic or office listed below or any other office or clinic.**
- **I consent to the opportunity to discuss with the doctor of chiropractic or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.**
- **I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.**
- **I hereby consent to massage therapy to be performed by affiliate Massage Therapist within the office and acknowledge that if I experience any pain or discomfort within the massage session**
- **I have read, or have had read to me, the above consent. I consent to the opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. 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. I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort.**
- **I further understand that Massage Therapy should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment of which I am aware.**
- **Because Massage should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I fail to do so.**
- **Cupping/Gua Sha: I understand that cupping therapy will leave bruise-like marks that will last several days depending on the severity of my condition. While most marks fade and disappear after a few days, there are times when marks could take up to 15 days to clear and in rare cases, it has been reported that marks have taken up to 21 days to fully clear.**
  - **Contraindications: 1. Hemophilia or other bleeding/clotting disorders 2. Patients taking blood thinners 3. Weak patients or those who have been ill 4. Abdomen and lower back on pregnant women 5. Diabetics. Especially those with uncontrolled blood sugar as they may not be able to feel pain properly 6. Those who are unable to experience heat or pain properly 7. Those who have circulatory conditions *8. Those who are unsure if their condition is contraindicated should seek guidance from their primary care physician prior to receiving cupping therapy.***
  - **I understand that bruising, discoloration and/or soreness will likely occur following this treatment and may take days or weeks to fully resolve. I further understand that the above-listed conditions are contraindicated for cupping therapy and I have informed my therapist/physician of any and all medical conditions, even those not listed as contraindications. I further understand that there is a potential for burns and/or blisters due to the fire/heat aspect of the treatment. This is a rare but not unexpected occurrence. (Initials) _____**
- **Improper Conduct: This is a Therapeutic Massage session and any sexual remarks or advances will terminate the session and understand I will be liable for payment of the scheduled treatment. I understand the Massage Therapist practitioner reserves the right to refuse services to me for any reason that the Therapist deems necessary. Male and *female* modest will be considered will not be exposed or touched at any time. Professional draping will be used for your privacy and comfort. Our policy requires therapists to leave the room prior to disrobing/undressing and use draping with sheets/ blankets at all times during every massage session.**
  (Initials) _____

Patient Signature_____ Date _____

Consent to Treatment of a Minor: By my signature below, I hereby authorize the spa and its therapists to provide massage and related services to my minor child or dependent as we deem necessary. Additionally, I have read, verified, and agree with all information on this form. I understand that I may be present during any massage received by child. This authorization is valid until and unless it is revoked by me in writing. Name of Parent or Guardian (please print):

_____

Patient/Parent/Guardian Signature_____ Date _____

Witness/ Personnel: _____Date: _____

IRREVOCABLE HEALTHCARE POWER OF ATTORNEY

TO: Attorney / Insurance Carrier

_____

_____

_____

_____

From: Greenway/303 Chiropractic P.C.,
dba Greenway/Cotton Chiropractic,
16995 W. Greenway Rd., Ste 102
Surprise, AZ, 85388

I, _____ (HEREAFTER, "PRINCIPAL") OF GREENWAY/303 CHIROPRACTIC P.C., COUNTY OF MARICOPA, IN THE STATE OF ARIZONA, do appoint above doctor (hereafter, "Attorney"), as my true and lawful attorney in fact. In Principal's name, and for Principal's use and benefit, said Attorney is hereby authorized to:

1. Endorse any and all checks or other forms of reimbursement made payable to Principle (or members of Principal's family) by and health insurance companies which relate to medical treatment provided by Attorney to Principal (or members of Principal's family) over to Attorney.

2. Demand and direct any and all health insurance companies, during the course of Principal's (or members of Principal's family) medical treatment with Attorney on personal injury cases or major medical matters, to make all reimbursement checks for such treatment payable to Attorney and to send such checks directly to Attorney.

This Special Power of Attorney is created for Attorney's benefit to secure Attorney's right to payment for healthcare services provided and shall be irrevocable throughout the duration of the healthcare services provided by Attorney to Principle arising from any injury or major medical conditions sustained either by Principal or members of Principal's family.

Giving and Granting to said attorney full power and authority to do all and every act and thing whatsoever requisite and necessary to be done relative to any of the foregoing as fully to all intents and purposes as Principal might or could do if personally present.

All that said attorney shall lawfully do or cause to be done under the authority of this power of attorney is expressly approved.

_____ _____
Signature Date

Sworn to or Affirmed before me this: _____, 20_____
(Date)

My Commission Expires: _____ _____
(Notary Public)

NOTICE OF PRIVACY PRACTICES

Abridged Edition

Effective April 14, 2003, the Department of Health & Human Services has implemented protection for patient health care information. It outlines who we may disclose information to without your authorization and how we can disclose your protected health information with your authorization as well as how you can gain access to your personal health information or to make a complaint to the Department of Health & Human Services if you feel your protected health information was used in an improper way. This notice will give you a brief description of our entire privacy practices.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

So that this office can treat you, receive payment for that treatment and run our health care operation, we may use your protected health information without your authorization to send to third party payers, administrators, etc.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION THAT MAY BE MADE WITH YOUR WRITTEN AUTHORIZATION

With your signed authorization we may make communications with you to promote products and services that may not be for a specific purpose of providing treatment advice. You have the right to revoke this authorization. Other permitted and required uses and disclosures that may be made without your authorization or opportunity to object – we may disclose to a member of your family, a relative, a close friend or other person you identify, your protected health information that directly relates to that person's involvement in your health care. We may also disclose your protected health information to an authorized public or private entity as required by law.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES THAT MAY BE MADE WITHOUT YOUR CONSENT, AUTHORIZATION OR OPPORTUNITY TO OBJECT

We may use or disclose your protected health information in the following situations:

- Required by law
- Health Oversight
- Legal Proceedings
- Research

Your rights – You may inspect or obtain a copy of your protected health information for as long as we maintain that information unless protected by federal law.

RIGHT TO REQUEST A RESTRICTION OF YOUR PROTECTED HEALTH INFORMATION

You may ask us not to use or disclose any part of your protected health information for the purpose of treatment, payment or health care operation. Also, you may request that any part of your protected health information not be disclosed to your family members or friends who may be involved in your care. Your request must be in writing and state specific restrictions requested and to whom it applies.

RIGHT TO REQUEST TO RECEIVE CONFIDENTIAL COMMUNICATION FROM US BY ALTERNATIVE MEANS OR AT AN ALTERNATIVE LOCATION

You may request that you receive these communications from us at an alternative location or by alternative means than is normally provided to other patients.

RIGHT TO AMEND YOUR PROTECTED HEALTH INFORMATION

You may request an amendment to your protected health information for as long as we maintain your protected health information. In certain cases we may deny your request for an amendment.

RIGHT TO RECEIVE AN ACCOUNTING OF CERTAIN DISCLOSRUES WE HAVE MADE

You have the right to receive an accounting if we receive a request for disclosure of information for purposes other than treatment, payment and health care operations

RIGHT TO OBTAIN A PAPER COPY OF THIS NOTICE

You have the right to receive a complete copy of our privacy practices by paper or electronically.

COMPLAINTS

If you believe your privacy rights have been violated, you may complain to us or to the Secretary of Health & Human Services. This notice was published and becomes effective (updated) January 1st, 2018.