FALLS HEALING ARTS, S.C.
Worker s Compensation Form

1. PATIENT INFORMATION Today s Date _____

Patient Name (First, MI, Last) _____

Address _____ City, State, Zip _____

Phone Home# _____ Work#_____ ext. _____ Cell# _____

Sex ___ M ___F Age _____ Birthdate _____ SS#_____

___Single ___Married ___Widowed ___Divorced ___Other Height _____ Weight _____

Your Employer _____ ___Full Time ___Part Time

2. INSURANCE INFORMATION

___Cash/Credit ___Medicare ___Medicaid ___Health Insurance ___Worker s compensation ___Personal Injury/Auto

3. ACCIDENT INFORMATION

Is this condition due to an accident? ___Yes ___No Date and Time:_____

Type of accident ___Auto ___Work ___Home ___Other _____

Attorney Name (if applicable) _____

Was your accident directly related to your work? ___Yes ___No

Briefly describe the events that occurred just before and during your accident: _____

_____

Give the address where the accident occurred:(if other than employer s address) _____

_____

Was anyone else present during your accident? ___Yes ___No

Did you report your accident to your employer? ___Yes ___No

What recommendations did your employer make just after your accident? _____

_____

4. PATIENT CONDITION

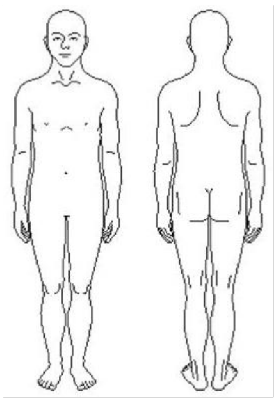
Reason for visit _____

When did your symptoms appear? _____

What caused this problem? _____

What makes the symptoms worse? _____ What makes the symptoms better? _____

Shade and code areas to indicate location of pain or discomfort: (use codes below)



Right View Left View

Numbness	- - - - -
Pins and Needles	+++++
Burning	XXXX
Dull Ache	ooooo
Stabbing Pain	/ / / / /

Rate the severity of your pain on a scale from 1 (minimal) to 10 (severe) _____

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your ___work ___sleep ___daily routine ___recreation

Activities or movements that are painful to perform ___sitting ___standing ___walking ___bending

___lying down other_____

IN CASE OF EMERGENCY, CONTACT _____

Phone # _____ Relationship _____

Blood Pressure _____ ***Pulse*** _____ ***Height***_____ ***Weight*** _____

_____ Enter Vitals in SOAP note _____Scan in pt file

5. HEALTH HISTORY

What treatment have you already received for your condition? ___medications ___surgery ___physical therapy ___chiropractic ___none other _____

Name and address of other doctor(s) who have treated you for your condition? _____

_____

Date of last:

Physical Exam _____ Spinal X-Ray_____ Spinal Exam _____ Chest x-ray _____

Dental x-ray _____ MRI, CT-scan, Bone scan _____ Blood Test _____ Urine test _____

Place an X next to yes or no to indicate if you have had any of the following:

Aids/HIV	___yes ___no	Glaucoma	___yes ___no	Pinched Nerve	___yes___no
Alcoholism	___yes ___no	Gonorrhea	___yes ___no	Pneumonia	___yes___no
Allergy shots	___yes ___no	Goiter	___yes ___no	Polio	___yes___no
Anemia	___yes ___no	Gout	___yes ___no	Prostate Problems	___yes___no
Anorexia	___yes ___no	Heart Disease	___yes ___no	Prosthesis	___yes___no
Appendicitis	___yes ___no	Hepatitis	___yes ___no	Psychiatric Care	___yes___no
Arthritis	___yes ___no	Hernia	___yes ___no	Rheumatoid Arthritis	___yes___no
Asthma	___yes ___no	Herniated Disc	___yes ___no	Rheumatic Fever	___yes___no
Bleeding Disorders	___yes ___no	Herpes	___yes ___no	Scarlet Fever	___yes___no
Breast Lump	___yes ___no	High Cholesterol	___yes ___no	STD's	___yes___no
Bronchitis	___yes ___no	Kidney Disease	___yes ___no	Stroke	___yes___no
Bulimia	___yes ___no	Liver Disease	___yes ___no	Suicide Attempt	___yes___no
Cancer	___yes ___no	Measles	___yes ___no	Thyroid Problems	___yes___no
Cataracts	___yes ___no	Migraine	___yes ___no	Tonsillitis	___yes___no
Chemical Dependency	___yes ___no	Miscarriage	___yes ___no	Tuberculosis	___yes___no
Chicken Pox	___yes ___no	Mononucleosis	___yes ___no	Tumors, Growths	___yes___no
Diabetes	___yes ___no	Multiple Sclerosis	___yes ___no	Typhoid Fever	___yes___no
Emphysema	___yes ___no	Mumps	___yes ___no	Ulcers	___yes___no
Epilepsy	___yes ___no	Osteoporosis	___yes ___no	Vaginal Infections	___yes___no
Fracture	___yes ___no	Pacemaker	___yes ___no	Whooping Cough	___yes___no
Hand Dominance	_____R____L	Parkinson's	___yes ___no	Other: _____	

EXERCISE	WORK ACTIVITY	HABITS
___None	___Sitting	___Smoking Packs/Day _____
___Moderate	___Standing	___Alcohol Drinks/Wk _____
___Daily	___Light Labor	___Coffee/Caffeine Cups/Day ____
___Heavy	___Heavy Labor	___High Stress Level Reason _____
Are You Pregnant? ___Yes ___No	Due Date: _____	

6. INJURIES/SURGERIES YOU HAVE HAD

	Description	**Date**
Falls:		
Head Injuries:		
Broken Bones:		
Dislocations:		
Surgeries:		

7. MEDICATIONS / ALLERGIES / VITAMINS / HERBS / MINERALS

_____

_____

_____

Falls Healing Arts S.C.

Consent to Treat:

The primary treatment used by Doctors of Chiropractic is the spinal adjustment. We will primarily use that procedure to treat you. The doctor may use his or her hands or a mechanical device upon your body in such a way as to move, or adjust, your joints. Additionally, other treatments may be used to help you, and will be explained to you at the time the Doctor decides to utilize these techniques or treatments.

The side effects associated with a chiropractic adjustment are extremely rare. Initially, a small amount of soreness may be expected in certain cases, but this can be discussed with the Doctor. Any other concerns or questions may also be discussed with the Doctor.

By signing below you state that you are wiling to undergo a chiropractic examination, x-rays of the spine or the area(s) involved (if indicated), and chiropractic treatment as may be outlined by the Doctor after the examination has been done.

In addition, it is important to understand that health and accident insurance policies are arrangements between you and your insurance carrier. As a courtesy to you, our office will bill your insurance company under normal circumstances and will complete any necessary forms to assist you in collection of payment from your insurance company assuming you have assigned benefits to be paid directly to our office. However, please understand that you are personally responsible for any and all charges regardless if your insurance company pays or not.

Signature: _____ Date: _____

Consent to treat minor child: _____

Relation: _____

Consent for Use and Disclosure of Health Information

This notice describes how chiropractic and medical information about you may be used and disclosed, your rights as a patient, and ways for you to get additional information on our policies.

Our clinic has always been very protective and respectful of your personal information. Under new federal regulations (the HIPPA Privacy Act), we have adopted additional guidelines to ensure the proper use, confidentiality and disclosure of your health information.

We May Release or Disclose Your Health Information:

- For treatment purposes to another health care provider or clinic if we refer you, or to providers or staff within our clinic that are taking part in your care.
- For billing and collection purposes, we may release records of your health care and information that you have provided to your insurance carrier or other financially responsible parties.
- For operational purposes within our clinic for quality control, office administration, record keeping, staff or provider training.

Specifically, you authorize the release of any information pertinent to your case to any insurance company, adjuster, or attorney involved in this case for the purpose of obtaining payment on your health claims.

We may also use your personal health information to contact you regarding your appointments, to send you information about our clinic or office events, or to share treatment options. We will not disclose information about you to anyone outside our office without your written approval.

You have the right to inspect or obtain a copy of the information we will use for these purposes. You have the right to amend your records at this office. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization, it will not affect the care provided to you or the reimbursement avenues associated with your care. Requests to inspect, copy or amend your health related information should be provided to the front desk in writing.

We normally provide information about your health to you in person at the time you receive care from us. We may also mail information to you regarding your health care or about the status of your account. If you would like to receive this information at an address other than your home, or if you would like the information in a different form, please advise us in writing as to your preferences.

Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities, you should direct your complaint in writing to the Clinic Director.

If you would like further information about our privacy policies and practices, please see the "NOTICE OR PRIVACY PRACTICES" binder in reception or ask for a copy at the front desk.

By supplying my home phone number, mobile phone number, email address, and any other personal contact information, I authorize my health care provider to employ a third-party automated outreach and messaging system to use my personal information, the name of my care provider, the time and place of my scheduled appointment(s), and other limited information, for the purpose of notifying me of a pending appointment, a missed appointment, courtesy call, balances due, or other communications. I also authorize my healthcare provider to disclose to third parties, who may intercept these messages, limited protected health information (PHI) regarding my healthcare events. I consent to receiving messages from the automated outreach and messaging system, when necessary.

_____	_____	_____
Name (Printed Please)	Signature	Date

If you are a minor, or if you are being represented by another party:

_____	_____	_____
Name (Printed Please)	Signature	Date

FALLS HEALING ARTS WORKER'S COMPENSATION POLICY

FALLS HEALING ARTS
275 N. Main Street
Sheboygan Falls, WI 53085
(920) 467-8690

If you are currently coming in under a Worker's Compensation accident/injury, please use the following as a guide to help you through the process, as Worker's Compensation can be very confusing.

Most employers and their insurance companies want to make sure that you receive the care necessary to allow you to recover from your injuries. Unfortunately, some companies have cumbersome administrative procedures that require you to see second opinion doctors or fill out additional paperwork.

If you are hurt at work because of what you think is work related exposure:

1. Immediately report your accident or ailment to your supervisor. Make sure to have a completed written report. Continue to keep your employer informed about any changes in your injury. When a worker reports an injury, the employer shall offer the worker the right to select a doctor of the worker's choice for treatment. Failure to notify the employer or insurance company of the initial selection or of a second choice of doctor can lead to a disputed claim and the possibility of the injured employee having to pay for the entire cost of treatment.

2 Your employer reports to its insurance company and to the Worker's Compensation Division. You do not have to file a claim yourself if you reported the injury.

3. You, or your group health policy, can never be charged for care which is covered under worker's compensation

4. It is important that you follow the prescribed treatment schedule and make every effort to return to work, within medical restrictions, as soon as possible after an injury, to ensure maximum medical improvement in the shortest amount of time possible to receive compensation benefits.

We have the responsibility as a health care provider for deciding when you have reached a plateau of healing or returned to the state of health you were in just prior to your care. An insurance company cannot end your care. That is the decision of the health professional team you choose. If you ever receive a letter which implies that you must end your care, please bring it to our attention, and the attention of your lawyer.

If you ever have a question or a problem, please let us help. We care about you and your health.

KEY STEPS IN WORKER'S COMPENSATION

1. If you are hurt at work or become ill because of what you think is work related exposure:

- Immediately report your accident or ailment to your supervisor. Continue to keep your employer informed about any changes in your injury.
- Seek first aid and medical attention.
- Remember that delays can affect not only your health, but also possible compensation benefits.

2. Your employer reports to its insurance company (or internal claims office if self-insured), and to the Worker's Compensation Division. You do not have to file a claim yourself if you reported the injury.

3. Your medical costs will be paid. If you miss more than three days of work and are found eligible, you will receive compensation for lost wages. Worker's Compensation also provides benefits to dependents of workers who die after work-related accidents. If your injury or illness is compensable:

- You will get a check from the insurance company or from your own self-insured employer, usually within 14 days after your injury. In some cases, it may take longer.
- There is a three-day waiting period, excluding Sunday. However, if you are off work more than seven days, you will receive compensation for the first three days after the injury date. Any additional compensation for a permanent disability, such as an amputated limb, will be determined later, after you return to work or the healing period ends.

4. It is important that you make every effort to return to work, within medical restrictions, as soon as possible after an injury. Your employer and your doctor must agree to your returning to some form of work; it is important that you talk to them about returning. If you cannot return at all because of your accident, other options may be available (See "What If I Can't Return To My Job?" inside this pamphlet).

UNDERSTANDING WORKER'S COMPENSATION

INFORMATION FOR CHIROPRACTIC PATIENTS

To Our Worker's Compensation Patients:

Most employers and their insurance companies want to make sure that you receive the care necessary to allow you to recover from your injuries. Unfortunately, some companies have cumbersome administrative procedures that require you to see second opinion doctors or fill out additional paperwork.

The insurance company may send you letters regarding the care you are receiving from us. Sometimes these letters are confusing and difficult to understand. This is especially true when an insurance company tells you that chiropractic care is no longer necessary for you injury.

Here are a few things you should know:

- The insurance company cannot end your care. That is our decision. If you ever receive a letter which implies that you must end your care, please bring it to our attention.

- We have the responsibility for deciding when you have:

    - Reached a plateau of healing
    - Returned to the state of health you were in just prior to your injury.

- You, or your group health policy, can never be charged for that care which is covered under worker's compensation. If the insurance company questions whether care was necessary, it is our responsibility to work with the insurance company. You will never be charged for any of this care.

Worker's compensation can be confusing. If you ever have a question or a problem, let us help. We care about you and your health.

May I Choose My Own Doctor?

You may choose any chiropractor, physician, psychologist or podiatrist licensed in the state. By agreement with your employer, you may choose a doctor not licensed in this state. If you later select a second doctor, you must notify your employer or the insurance company.

In an emergency, the employer may arrange for your treatment until you are able to choose your own doctor. Your employer or the insurance company has the right to have you examined occasionally by a doctor of its choice. Your compensation may be delayed if you do not agree to have these examinations.

You have the right to every type of treatment which is reasonable and necessary to cure you, as ordered by your doctor. This includes hospitalization, therapy, tests and prosthetic devices. Medicine is paid for, as is any reasonable travel expense necessary to receive treatment.

What Injuries Are Covered by the Law?

The law covers both mental and physical harm from either accidents or occupational diseases. If you work only in one place, such as a factory, store or office, your injury will usually be covered only if it occurs at work. If your work requires travel, you are covered at all times while traveling, including the time you are eating or sleeping, unless you deviate form regular work duties for a private or personal reason.

All compensation and medical payments are based on medical reports from you doctor. If your doctor does not make prompt and regular reports to the insurance company of your employer (if self-insured), your payments may be delayed.

If the insurer refuses to make payments, it must notify you, explain the reason for refusing payment and inform you of your appeal rights.

Who Pays the Medical Bills?

Your employer is required to pay your medical expenses and mileage. Send any bills you receive to your medical expenses, send itemized receipts to your employer of its insure for reimbursement.

An insurer or self-insured employed may challenge a health care provider's fee as unreasonable to treatment an unnecessary. If so, it may refuse to pay the charge in question and must notify the provider of the dispute. Once a provider receives notice of a dispute about fees or treatment, the provider may not ask you to pay the bill. If you receive a bill for treatment when such a dispute exits, please contact the Worker's Compensation Division.

What If My Claim is Disputed?

If there is a dispute over your claim between you and the employer or insurer that cannot be settled by talking it over, you may request the Division to resolve it by holding a hearing and issuing an order.

You may file an application for a hearing if your employer does not report your accident, or if you believe you can prove that you did not receive all your benefits. You must have medical proof of your claim. This proof is the written opinion of a chiropractor, physician, psychologist or podiatrist. Send the medical report with the application.

You should contact your employer and the insurer before applying for a hearing to find out exactly what is disputed. You may request the form to apply for a hearing by contacting any of the Division offices. You will also receive additional written information explaining the hearing process.

What If I Can't Return to My Job?

Some workers may not be able to return to the same type of work they did before injury or illness. Keep in contact with your employer and your doctor to see if you can return to work early on a restricted basis, perhaps in a modified job if necessary. This could help ease you back into working again.

If your doctor or employer indicates that you cannot return to your former job, you may contact the insurer to request assistance from either public or private vocational rehabilitation services. One resource is the State Division of Vocational Rehabilitation (DVR), which has offices throughout the state (see your local telephone directory under State of Wisconsin, Department of Health and Social Services). General questions about your claim should be addressed to you employer, its insurer, or the Worker's Compensation Division. For further information, call the WC Division at (608) 266-1343.

If you do not have a job at the end of your healing period (temporary total or partial disability), you may apply for Unemployment Compensation benefits at your local UC office.

How Long Is My Claim Open?

You must report the injury to your employer within two years to qualify for worker's compensation. If the injury is reported or a payment is made within two years, the claim is usually held open by law for 12 years from the date of the injury or the date of last payment to you. This can be important if your condition changes during this time. In the case of occupational disease, there is no time limit for filing a claim. It is important to save your records of the last payment for 12 years.