Victor J. Tomassetti, D.C.

GENERAL INFORMATION - Please take a moment to fill the information below.

Name:_____ Date:_____

Home Phone:_____ Cell Phone:_____

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

Email:_____

Date of Birth:_____ Age:_____ Handed (circle one): Right/Left

Sex: (circle): M F Date of Injury:_____ .Social Security:_____

Please initial if we may leave messages on your answering machine or voicemail:_____

Employer:_____ Occupation:_____

Primary Care Dr:_____ Phone #:_____

Chiropractor:_____ Phone#:_____

***Do you have health insurance? (Circle) Yes No

Insurance:_____ ID:_____

Were you involved in personal injury? (Please answer question below)

*** Do you have auto insurance? (Circle) Yes No

Insurance:_____ ID:_____

Attorney (if applicable) _____

Address: _____ City._____ State._____ Zip:_____

Attorney's Number:_____ Fax:_____

DISCLOSURE TO FAMILIES AND LOVED ONES (Emergency Contacts)

I authorize Victor J Tomassetti, D.C. to disclose my health care information and to discuss my health care needs to those that I designate. I further authorize the release of my billing information and give these individuals the ability to pick up prescriptions and/or medications on my behalf. These individuals will be considered my emergency contacts. Without authorization, no information may be shared. I authorize Victor J. Tomassetti, D.C. to disclose my health information with the following people: **PLEASE PRINT**

Name:_____ Relationship._____ Phone#:._____

Name:_____ Relationship:_____ Phone #:_____

BY SIGNING BELOW, I ACKNOWLEDGE THAT I HAVE READ, UNDERSTAND, AND AGREE TO ABIDE BY THE ABOVE AND THAT ALL INFORMATION GIVEN IS TRUE AND CORRECT.

Signature of Patient or Patient Representative:_____ Date:_____

Victor J. Tomassetti, D.C.

MOTOR VEHICLE ACCIDENT QUESTIONAIRE

Thank you in advance for taking the time to develop this form. This will help us to better cover all of your pain complaints and provide you with the best treatment.

NAME: _____ DATE:_____

Date of Injury:_____ DOB:_____

Referring Doctor: _____ Last 4 of SS#_____

Accident Details:

1. Vehicle Information:

   Year-_____

   Make & Model_____ *(ex. Toyota Camry, etc.)*

2. Where were you seated {circle): Driver/Front passenger/Rear left/Rear right
3. Were you wearing your seatbelt{circle}: Yes / No
4. Were the airbags deployed (circle): Yes / No
5. What was your body position at impact (circle):

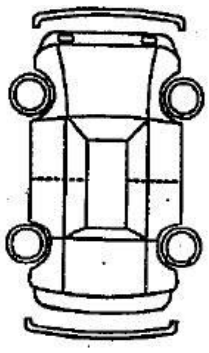
-Looking straight / looking right / looking left, Body twisted: Left / Right

-Both hands on wheel / Right hand on wheel / Left hand on wheel / Hands in lap

-Right foot on brake/ Right foot on gas/ Left foot on floorboard/ Both feet on floorboard

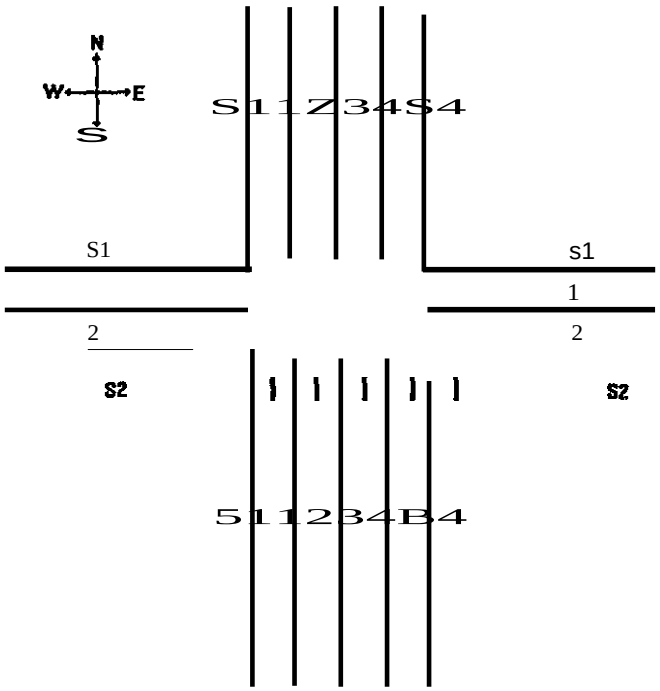
6. Where was the damage to your vehicle:

Front: *Driver Side (front)* *Passenger Side (front)*



7. What kind of vehicle struck you:_____

8. If possible, please **roughly draw** out what happened in this accident:



Pleasebriefly describe accident:

_____

_____

_____

9. How fast was your vehicle traveling (approximately) _____ Mph

10. How fast was the other vehicle traveling (approximately):_____ Mph

11. Were you prepared for the impact and /or did you brace yourself (circle): Yes *I* No

12. Did you lose consciousness (circle): Yes / No

13. Were you in a daze, felt dizzy, disoriented, confused, etc. (circle): Yes / No

A. Forhow long?_____(forex. 5minutes,1hour)

14. Where did you go for medical treatment :_____

15. Were you taken by ambulance: Yes / No

After a head injury or accident some people experience symptoms which can cause worry or nuisance. We would like to know if you now suffer from any of the symptoms listed below. As many of these symptoms occur normally, we would like you to compare yourself now with before the accident. For each one. **Please circle the number closest to your answer.**

0 = Not experienced at all, 1 = No more of a problem, 2 = A minor problem, 3 = A moderate problem, 4 = A severe problem

Compared with before the accident, do you now (i.e., over the last 24 hours) suffer from:

Headaches	0	1	2	3	4
Feelings of Dizziness	0	I	2	3	4
Nausea and/or Vomiting	0	I	2	3	4
Noise Sensitivity, easily upset by loud noise	0	1	2	3	4
Sleep Disturbance	0	1	2	3	4
Fatigue, tiring more easily	0	1	2	3	4
Being irritable, easily angered	0	I	2	3	4
Feeling Depressed or Tearful	0	1	2	3	4
Feeling Frustrated or Impatient	0	1	2	3	4
Forgetfulness, poor memory	0	1	2	3	4
Poor Concentration	0	1	2	3	4
Talking Longer to Think	0	1	2	3	4
Blurred Vision	0	1	2	3	4
Light Sensitivity, Easily upset by bright light	0	I	2	3	4
Double Vision	0	1	2	3	4
Restlessness	0	1	2	3	4

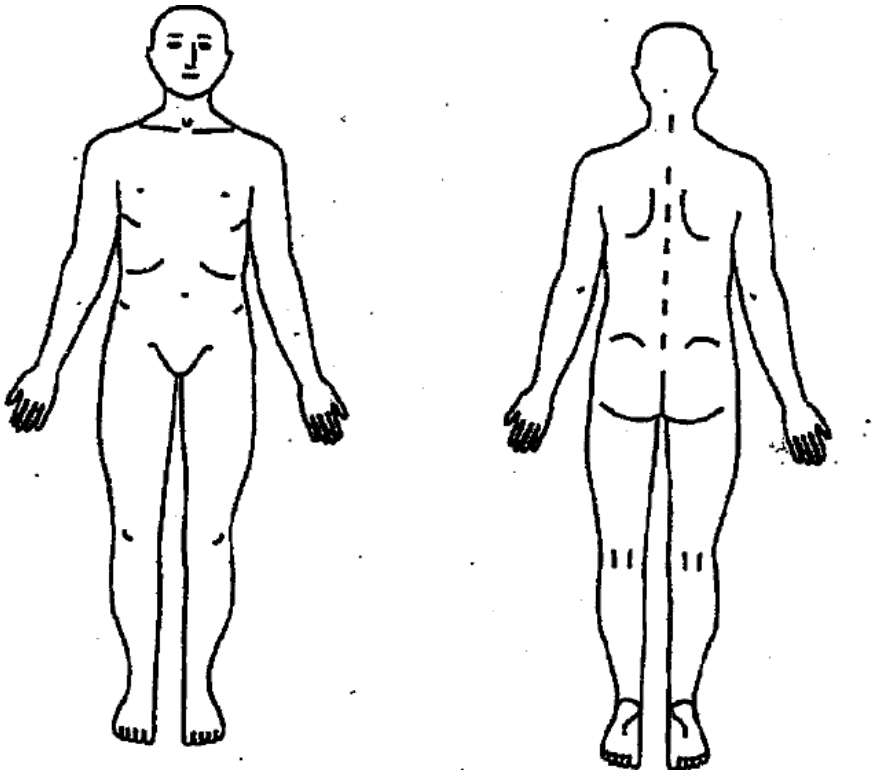
Are you experiencing any other difficulties? (please list)

1. _____	0	1	2	3	4
2. _____	0	1	2	3	4

B2. Pain drawing

Mark the area on your body where you feel the described sensations. Use the appropriate symbol. Mark areas of radiation. Include all affected areas.

Numbness	**……**	**INC Sensitivity**	**0000**
Constant	**xxx**	**Sharp Twinge**	**////**
Throbbing Ache	**xxx**		



What is your pain level at rest:

NO PAIN 1 2 3 4 5 6 7 8 9 10 WORST PAIN IMAGINABLE

What is your pain level with activity:

NO PAIN 1 2 3 4 5 6 7 8 9 10 WORST PAIN IMAGINABLE

How would you describe your pain (circle):

Deep Pressure	Tightness	Spasms
Tingling	Numbness	Pinprick
Burning	Sharp Shooting	Stabbing

Is your pain (circle): Constant Intermittent

Since the accident, is your pain {circle): Unchanged Worse Better

What makes your pain worse (circle):

Activity- Bending / Lifting / Walking / Sitting /_____

What makes your pain better {circle):

Medications / Ice / Heat / Chiropractic / Rest /_____

Do you have any weakness (circle): Yes / No.

If Yes, where (circle): Left: Arm Leg
Right: Arm Leg

Any loss of control of your bowel or bladder since the accident {circle): Yes / No

What treatments have yon had following since this accident (circle):

Physical therapy Heating pad Ice pack Injections Chiropractic

Epidural injections Surgery Massage Medications Acupuncture

Are you having difficulty sleeping since the accident {circle): Yes / No

How has this accident affected your life? (Ex. difficulty driving)_____

_____

_____

Have you missed work (circle): Yes/ No, If yes how much:_____

Have you returned to work (circle): Yes / No

Have you ever had another motor vehicle, work or any other type of injury?

1. _____

2. _____

3. _____

MEDICAL CONDITIONS *(Please list: such as diabetes, depression, gastric reflux):*

_____

_____

MEDICATIONS *(Tylenol, ibuprofen, Motrin, Alleve):*_____

_____

SURGERIES:_____

_____

ALLERGIES:_____

FAMILY HISTORY:
FATHER-Age__, Alive (circle): Yes/No
-major medical conditions:_____

MOTHER-Age___, Alive (circle): Yes/No
- major medical conditions:_____

SOCIAL HISTORY: Tobacco use (circle): Yes / No
Alcohol use (circle): Yes / Social / No
Drug use (circle): Yes/ No

REVIEW OF SYSTEMS: *(mark only if positive)*

General-
_Weight loss or gain
_ Fatigue
_Fever or chills

Skin-
_ Rashes
_Dryness
_ Lumps

Head-
_ Headache
_ Head injury

Ears-
_Decreased hearing
_Ringing in ears
_Earache

Eyes-
_Glasses or contacts
_Blurry or double vision
_Flashing lights

Nose-
_Discharge
_Itching
_Nosebleeds

Neck-
_Lumps
_Swollen glands

Cardiovascular-
_Chest pain
_Tightness
_Palpitations

Respiratory-
_Coughing up blood
_Shortness of breath
_Painful breathing

Gastrointestinal-
_ Constipation/Diarrhea
_ Change in appetite
_ Nausea

Urinary-
_Increased Frequency
_Incontinence
_Blood in urine

Musculoskeletal-
_Muscle or joint pain o
_Redness of joints
_Swelling of joints

Neurologic-
_Dizziness
_Fainting
_Seizures

Psychiatric-
_Nervousness
_Depression
_Memory loss

Thank you!

*Office use:*_____

INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and other licensed, doctors of chiropractic who now or in the future treat me while employed by, working and/or associated with or serving as backup for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office personnel the nature and purpose of chiropractic adjustments and other procedures.

I understand and am informed that, as in the practice of medicine, in the practice or· chiropractic there are some risks that have been associated with treatment, including, but not limited to, fractures, disc injuries, strokes, TIAs, cardiac arrest, dislocations and sprains. It should be noted that the more severe risks are extremely remote. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor ·to exercise Judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests**:**

I understand and am informed that possible alternatives to chiropractic treatment include, but are not necessarily limited to rest, physical therapy, acupuncture, massage, over the counter medication, and osteopathic/medical care involving prescription drugs and/or surgery.

I have read or have had read to me, the above consent. I have also had an 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.

Signature of Patient·

_____

Print Patient's Name

_____

Date Signed_____

Translated by (If applicable)

_____

Signature of patient's representative, if necessary, (e.g., If patient ls a minor or physically/legally Incapacitated)

_____

Print Name of Patient's Representative

_____

Date Signed_____

Date Signed _____

– Below is for Office Use Only-

This form was verbally explained to the patient or to his/her representative by_____

on_____ Initial here as evidence of having personally performed this duty:_____

Adapted from the CCA's Fact Sheet #800 on Informed Consent

VICTOR J. TOMASSETTI, D.C.

Authorization and Medical Lien

I, _____(hereinafter referred to as "PATIENT") desire to undergo an examination, consultation and any potential treatment regarding any possible injures PATIENT sustained as a result of an accident/ accident causing injury (hereinafter referred to as the "Claim") which occurred on or about _____. Patient, therefore, agrees as follows:

1. Provider's Lien. Patient hereby grants Dr. Victor J. Tomassetti (hereinafter, "PROVIDER") a lien in the form of all rights to payment from any and all proceeds derived from PATIENT's claim for personal injury arising from the Claim, in the amount of PROVIDER'S standard billing costs of services provided to PATIENT/PATIENT's children, spouse or other medical charge(s) by PROVIDER. Patient understands this agreement constitutes a lien in favor of PROVIDER, against any proceeds derived from the Claim, PATIENT authorizes and instructs his/her attorney of record,_____Esq. and any subsequent ATTORNEY'S (hereinafter, "ATTORNEY"), to pay PROVIDER all amounts owing under this lien from the proceeds of any collection of settlement of, or award or judgment on, the Claim, upon receipt of any such proceeds and before any payments are made to PATIENT. PATIENT acknowledges that this Lien is made solely for PROVIDER's additional protection and as a precondition to PROVIDER'S willingness to provide services to PATIENT. PATIENT acknowledges that he/she is directly and fully responsible to PROVIDER for payment of all medical bills submitted by PROVIDER for services rendered, that such obligation to pay is not contingent or conditioned upon the occurrence of any collection, settlement, judgment or award which PATIENT may eventually receive on the Claim, and that the collectability of the receivable(s) secured hereby is also not so contingent or conditioned on the Claim.

2. Subsequent Attorneys. Should an attorney other than ATTORNEY be substituted/ associated in this matter, PATIENT hereby instructs that substituted/associated attorney to honor this lien as though it had been executed by that attorney. "ATTORNEY" as herein used, shall refer to the attorney named herein, and/or any attorney who is subsequently substituted or associated in the handling of the PATIENT's Claim. The ATTORNEY named herein or as may be substituted/associated is directed to honor this lien whether or not it contains the signature of the ATTORNEY herein below.

3. Assignments. PATIENT acknowledges that all of PROVIDER's rights under this Lien, and the underlying obligation this Lien secures, are freely assignable/alienable, and PROVIDER may assign these rights in full to a third party (hereinafter referred to as "ASSIGNEE"). PATIENT expressly authorizes PROVIDER to furnish ASSIGNEE with all bills, medical records, and other documents which are the subject of the Lien; PATIENT expressly waives his/ her right of privacy with regard to all medical information provided to ASSIGNEE by PROVIDER.

4. Authorization. PATIENT authorizes PROVIDER to furnish ATTORNEY and witl1 all medical records pertaining to PATIENT's treatment, including reports on examination, diagnoses, treatment, prognosis, and other medical bills on record.

5. Arbitration. Any controversy, claim, or dispute between the parties, directly or indirectly, concerning this Agreement or the breach hereof, or the subject matter hereof, including questions concerning the scope and applicability of the arbitration clause, shall be finally settled by binding arbitration as provided herein. The parties shall use an arbitrator, a retired Judge in North County of San Diego, California, and

VICTOR J. TOMASSETTI, D.C.

Authorization and Medical Lien

Judgment upon the award rendered may be entered in any court having jurisdiction thereof. The arbitration shall commence no later than sixty (60) calendar days after demand is made and shall continue from day to day until completed. The prevailing party in said arbitration shall be entitled to an award of his/her/ or its reasonable attorney's fees, costs, and other arbitration expenses relating to that dispute, including the conduct of the arbitration proceeding.

6. No Interpretation against the Drafter. This agreement shall not be construed against the party preparing it, but shall be construed as if all parties jointly prepared this Agreement, and any uncertainty or ambiguity shall not be interpreted against any party.

7. Modification. No supplement, amendment, or modification of the Lien shall be binding unless it is in writing and signed by PATIENT and PROVIDER (or if an assignment has been made, by PATIENT and ASIGNEE).

8. Integrated/Entire Agreement. This Agreement and PROVIDER's statement of fees and costs which will be generated subsequent to PROVIDER's provision of services to PATIENT constitute the final, complete, and exclusive statement of the terms of the agreement between the parties and supersedes all prior and contemporaneous understandings or agreements of parties. No party has been induced to enter into this Agreement by, nor is any party relying on, any representation or warranty outside those expressly set forth in this Agreement.

9. Severability. If a court or an arbitrator of competent jurisdiction holds any provisions of this Agreement to be illegal, unenforceable, or invalid in whole or in party for any reason, the validity and enforceability of the remaining provisions, or portions of them, will not be affected, unless an essential purpose of this Agreement would be defeated by the loss of the illegal, unenforceable, or invalid provision.

10. Execution. PATIENT is represented by the counsel of his/her own choosing. PATIENT has read this Lien and PATIENT's counsel has fully explained contents to the PATIENT. PATIENT consents to the terms of this Lien and agrees to be bound by it. PATIENT understands that in the event ATTORNEY does not sign this agreement, PATIENT and ATTORNEY will still be bound by the provisions set forth herein.

11. Construction/Choice of Law. The law of the State of California shall apply in determining the meaning, effect and enforceability of this Agreement and all of its provisions.

READ, UNDERSTOOD & AGREED

PATIENT NAME:_____

PATIENT SIGNATURE:_____ DATE:_____

ATTORNEY'S NAME:_____

ATTORNEY'S SIGNATURE:_____ DATE:_____

Victor J. Tomassetti, D.C.

AUTHORIZATION TO RELEASE INFORMATION

Patient Name:_____ Date of Birth:_____

Previous Name:_____ SS#:_____

I authorize the following person, or facility to release my health information:

Name of Person or Facility:_____

Street Address:_____

City:_____ State:_____ Zip:_____

Phone Number:_____ Fax Number:_____

To be received by:

[] Dr. Victor Tomassetti

This will authorize you to permit the bearer to review, inspect, copy, and/or photocopy any of the following your possession or control:

1. X-rays- films and reports
2. Medical Reports, records, chart, and notes
3. Personal, attendance (work or school)

Photo static copies of this authorization will be considered as valid as the original This is not

an authorization to discuss this case with any insurance company representative.

Patient Signature:_____ .Date:._____

2204 El Camino Real, Suite 201 Oceanside, CA 92054
Tel: 760.757.0222 Fax: 760.757.0224

Victor J. Tomassetti, D.C.

THE FOLLOWING IS REQUIRED BY CALIFORNIA LAW

Doctors and Facilities

You may be referred to one or more of the doctors or-facilities listed below for services. Each of the doctors listed below has a financial interest with or provides services to one or more of the other doctors and/or facilities listed.

Patient's Freedom of Choice

You are free to choose any doctor or organization you wish for obtaining services that may be ordered or requested for you by any of the doctors listed below. This choice, however, may be affected by restrictions imposed by your insurance plan. Your doctor would be happy to discuss alternatives with you.

Potential sources of information concerning alternatives relevant can also be obtained from the Yellow Pages, the internet, or the county medical association.

The following addresses are provided for the filing of any complaints relevant to this notice or the services provided: Medical Board of California, 2005 Evergreen Street, Suite 1200, Sacramento, CA 95834; Board of Chiropractic Examiners, 2525 Natomas Park Drive, Suite 260, Sacramento, CA 95833-2931.

Doctors and Facilities:

Dr. Victor Tomassetti
Chiropractic Director

Patient Signature _____ Date _____

2204 El Camino Real, Suite 201 Oceanside, CA 92054
Tel: 760.757.0222 Fax: 760.757.0224

Victor J. Tomassetti, D.C.

ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO DOCTOR FOR HEALTH INSURANCE, PRIVATE INSURANCE, AND/OR GROUP ACCIDENT

I hereby instruct and direct the_____Insurance Company to pay Dr. Victor J. Tomassetti, D.C. by check made out and mailed directly to:

Dr. Victor Tomassetti
2204 El Camino Real, Suite.201
Oceanside, CA 92054

If my current policy prohibits direct payment to the doctor, then I will make payment directly to the doctor.

The professional or medical expense benefits allowed, and otherwise payable to me under my current insurance policy as payment toward the total charges for professional service rendered. This is a direct assignment of my rights and benefits under this policy. This payment will not exceed my indebtedness, to the above mentioned assignee, and I have agreed to pay any balance of said professional service charges over and above this insurance payment.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

CALIFORNIA STATE LAW, INSURANCE CODE SECTION #10133, MAKES IT MANDATORY, RATHER THAN PERMISSIVE THAT INSURANCE COMPANIES HONOR ASSIGNMENT OF BENEFITS.

_____ _____
Signature of Policyholder Date

_____
Signature of Claimant, if other than Policyholder

2204 El Camino Real, Suite 201 Oceanside, CA
92054 Tel: 760.757.0222 Fax: 760.757.0224

Victor J. Tomassetti, D.C.
Financial Policy

The following is an explanation of our policies and procedures. We will be happy to answer any questions you have regarding our **Policy, your account, and your insurance coverage.**

Payments

Your health care needs are our primary concern. We do not want finances to get in the way of you getting the health care that you need. Policies are in place in an attempt to assist you in meeting your financial obligations without increasing stress in your life.

If you do not have insurance ALL payments are expected at the time of service.
If you have insurance ALL COPAYS AND/OR CO-INSURANCE are due at the time of service. If you have a deductible it must be satisfied before any coinsurance/copay take into effect. There will be a $25.00 charge on all returned checks. There will be a $30.00 charge if any additional forms need to be completed by Dr. Tomassetti, or a massage appointment is missed.

*Initial*___ _

Insurance Coverage/ Verification

Our fees are considered usual, customary and reasonable by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This statement does not apply to companies who reimburse based on an arbitrary schedule bearing no relationship to the current standard of care in this area. If your carrier has not paid a claim within (60) days of submission, you agree to take active part in the recovery of your claim. If your insurance carrier has not paid within (90) days of submission, you accept responsibility for payment in full of any outstanding balance. As a courtesy to our patients, our office will attempt to pre-verify your primary insurance coverage. It is your responsibility to be aware of what service(s) is being provided to you and if it is a covered benefit under your insurance. Please be advised that the information provided by your insurance is not a guarantee of payment.

*Initial*_____

Personal/ Auto Injury

In the nature of a personal/auto injury, payments of medical bills can go months or sometimes years until the case settles and satisfies our charges. We must ask you to provide any/or all of the following benefits that apply:

1. Automobile Insurance- Medical Pay
2. Health Insurance
3. Lien- signed by you and your attorney

*Initial*_____

Appointment/ Treatment

We require that you give us a 24 hour cancellation notice if you need to miss your appointment. For personal/auto injury cases **appointments missed are to be made up within the same week to assist you in reaching your maximum therapeutic benefit.**

*Initial*_____

Patient Health Information Consent

By signing you agree to allow this office to use your Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As a patient you have the right to obtain a copy of your health records at any time. For your security, all staff has been trained in the area of patient record privacy. If you refuse to sign this consent for the purpose of **treatment, payment, and health care Operations our office has the right to refuse to give care.**

_____ _____

Patient/Parent/Guardian Signature **Date**

Victor J. Tomassetti, D.C.
2204 El Camino Real, Suite 201 Oceanside, CA 92054
Tel: 760-757-0222 Fax: 760-757-0224

HIPAA-ACKNOWLEDGEMENT OF RECEIPT
NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have reviewed/received a copy of **HIPAA NOTICE OF PRIVACY PRACTICES documents**.

Patient Name {Please Print)_____

Patient Signature:_____Date:_____

OR

Signature of Personal Representative: _____

Authority of Personal Representative to Sign for Patient {check one)

Parent_____Guardian._____Power of Attorney_____Other:____ _

Please Note: It is your right to refuse to sign this Acknowledgement.

Office Use Only

I tried to obtain written Acknowledgement by the individual noted above of receipt of **HIPAA NOTICE OF PRIVACY PRACTICES, but** it could not be obtained because:

_An emergency prevented us from obtaining acknowledgement.
_A communication barrier prevented us from obtaining acknowledgement.
_The individual was unwilling to sign.
Other_____

Staff Member Signature:_____Date:._____