PERSONAL INJURY INFORMATION FORM

Patient Name: _____ Date of Initial Visit: _____/_____/_____

Attorney Name: _____Paralegal Name:_____

Attorney Address: _____ City: _____ State:_____

Primary Phone: (_____)_____-_____ Fax Number: (_____)_____-_____

Motor Vehicle Collision Information

Date of Accident: _____/_____/_____ Location: _____

Car Insurance Company: _____

Name of Contact: _____ Phone Number: (_____)_____-_____

Auto Policy #: _____ Claim Number: _____

Office Use Only

Claim Adjustor: _____

Phone Number: (_____)_____-_____ Fax Number: (_____)_____-_____

Claims Address: _____

_____

Comments: _____

_____

PERSONAL INJURY QUESTIONNAIRE

Patient Name: _____ Date of Birth: _____/_____/_____

Today's Date: _____/_____/_____ Date of Motor Vehicle Collision: _____/_____/_____

1. Any previous accidents / injuries or surgeries? _____ YES _____ NO

If yes, please explain: _____

_____

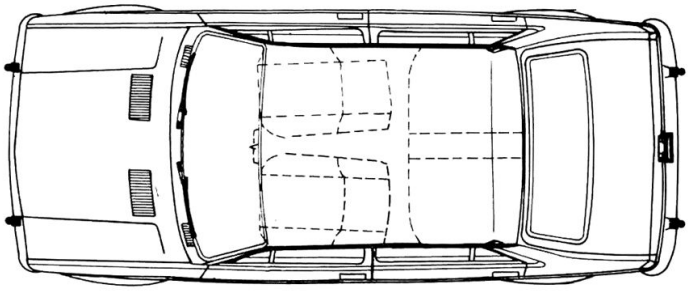
2. In your own words, please explain what happened and where it happened: _____

_____

_____

3. Put an **X** on the drawing where the car was hit.

4. Put a **O** on the drawing where you were sitting.



5. What's the make and model of the car you were in?

Make: _____ Model: _____

6. What's the make and model of the other car involved? Make: _____ Model: _____

7. Was there anyone else in the car? _____ YES _____ NO. If yes, How many people? _____

8. Seat belts worn: _____ YES _____ NO 9. Airbags deployed: _____ YES _____ NO

10. Did any part of your body hit anything in the car during the initial impact? _____ YES _____ NO

If Yes, please explain: _____

_____

11. Were you knocked unconscious during the impact? _____ YES _____ NO

12. What hospital / clinic did you go to? _____

13. When? _____ Same Day _____ Next Day _____ Date: _____/_____/_____

14. Ambulance? _____ YES _____ NO

If you weren't seen in a hospital or clinic, skip to question 18.

15. What was the diagnosis? _____

16. Care received / Imaging (X-rays, MRI, CAT Scan, Etc): _____

_____

17. Prescribed medication: _____ Ibuprofen _____ Tylenol _____ Naproxen _____ Flexeril

_____ Valium _____ Percocet _____ Vicodin _____ Other: _____

18. Are you currently being treated for this injuries by another doctor? _____ YES _____ NO

If Yes, by whom: Doctor Name: _____

Address: _____ City: _____ State: _____

19. Have you been able to work since this injury? _____ YES _____ NO

20. How many work days have you missed? _____

21. If you have had any of the following symptoms since your injury, please check all that apply:

___ Arm/shoulder pain
___ Back pain
___ Back stiffness
___ Chest pain
___ Dizziness
___ Fatigue
___ Tension
___ Neck pain
___ Hip / leg pain
___ Knee pain
___ Ankle pain
___ Hand/finger numbness
___ Foot/toe numbness
___ Blurred vision
___ Headaches
___ Jaw problems
___ Memory Loss
___ Nausea
___ Shortness of breath
___ Difficulty Sleeping
___ Confused / Disoriented

22. This condition is progressively getting: _____ Worse _____ Better _____ Unknown

23. Is the pain constant or does it come and go? _____

24. Does the pain interfere with your: ___ Work ___ Sleep ___ Daily Routine ___ Recreation

25. Activities or movements that are painful to perform: ___ Sitting ___ Bending ___ Standing
___ Laying down ___ Walking ___ Other

Please describe any activities that you have difficulty performing due to the injury: _____

_____

_____

Patient Information

Last Name: _____ First Name: _____ MI _____

Mailing Address: _____ City/State/Zip: _____

Primary Phone: (_____)_____-_____ Alternate Phone: (_____)_____-_____

Email: _____ @_____ Date of Birth _____/_____/_____

Primary Care Physician: _____ Referring Physician: _____

How did you hear about iMed Centers? _____

Responsible Party Information (Parent Information if Patient is a Minor)

Name: _____

Address: _____ City/State/Zip: _____

Primary Phone: (_____)_____-_____ Alternate Phone: (_____)_____-_____

Insurance Information

Primary Insurance Company Name: ___ Anthem ___ Cigna ___ Aetna ___ Other: _____

Patient Relationship to Insurance Subscriber: ___ Self ___ Spouse ___ Child ___ Other: _____

Name of Subscriber: _____ Date of Birth _____/_____/_____

Insurance ID #: _____ Group #: _____ Effective Date: _____

Emergency Contact Information

Name: _____ Relationship: _____

Primary Phone: (_____)_____-_____ Alternate Phone: (_____)_____-_____

Name: _____ Age: _____ Date: _____/_____/_____

HEALTH HISTORY

What is your overall goal(s) in coming to Norwalk iMed Center? Check all that apply.

___ Pain Relief ___ Posture Correction ___ Balance Training
___ Ergonomic Training ___ Strengthening ___ Wellness
___ Post Surgical Rehab ___ Pre Surgical Training ___ Weight Loss
___ Other (please specify): _____

Medical History

Do you have any of the following symptoms?

General
__ Chills
__ Depression
__ Dizziness
__ Fainting
__ Fever
__ Forgetfulness
__ Headaches
__ Loss of Sleep
__ Loss of Weight
__ Nervousness
__ Numbness
__ Sweats

Muscle/Joint/Bone
Pain, Weakness, numbness in:
__ Arms __ Hips
__ Back __ Legs
__ Feet __ Neck
__ Hands __ Shoulders

Genito-Urinary
__ Blood in urine
__ Frequent urination
__ Lack of bladder control
__ Painful urination

Men Only
__ Breast hump
__ Erection difficulties
__ Lump in testicles
__ Penis discharge
__ Sore on penis
__ Other: _____

Gastrointestinal
__ Appetite poor
__ Bloating
__ Bowel changes
__ Constipation
__ Diarrhea
__ Excessive hunger
__ Excessive thirst
__ Gas
__ Hemorrhoids
__ Indigestion
__ Nausea
__ Rectal bleeding
__ Stomach pain
__ Vomiting
__ Vomiting blood

Cardiovascular
__ Chest pain
__ High blood pressure
__ Irregular heartbeat
__ Low blood pressure
__ Poor circulation
__ Rapid heartbeat
__ Swelling of ankles
__ Varicose veins

Women Only
__ Abnormal pap smear
__ Bleeding between periods
__ Breast lump
__ Extreme menstrual pain
__ Hot flashes
__ Nipple discharge

Eye, Ear, Nose, Throat
__ Bleeding gums
__ Blurred vision
__ Crossed eyes
__ Difficulty swallowing
__ Double vision
__ Earache
__ Ear discharge
__ Hay fever
__ Hoarseness
__ Loss of hearing
__ Nosebleeds
__ Persistent cough
__ Ringing in ears
__ Sinus problems
__ Vision-flashes
__ Vision-halos

Skin
__ Bruise easily
__ Hives
__ Itching
__ Change in moles
__ Rash
__ Scars
__ Sore that won't heal

__ Painful intercourse
__ Vaginal discharge
__ Other: _____

DO YOU HAVE any other medical conditions?

_____

Past Surgeries/Hospitalizations?

1)_____Estimated date:_____ **3)**_____Estimated date:_____

2)_____Estimated date:_____ **4)**_____Estimated date:_____

Current list of medicines (medications, vitamins, herbs, and/or supplements with dosages and frequencies):

1)_____Dosage:_____Frequency:_____

2)_____Dosage:_____Frequency:_____

3)_____Dosage:_____Frequency:_____

4)_____Dosage:_____Frequency:_____

5)_____Dosage:_____Frequency:_____

Allergies:

_____

_____

Preferred Pharmacy for Electronic Prescriptions (e-Rx):

Pharmacy: ___ CVS ___ Walgreens ___ Stop & Shop ___ Walmart ___ Other: _____

Address:_____City/State_____

Family History:

__ Heart disease
__ Cancer
__ Kidney disease
__ Stroke
__ Diabetes
__ Arthritis
__ Tuberculosis
__ Asthma
__ Kidney disease
__ High blood pressure
__ History of alcohol / drug addiction
__ Hay fever
__ Gout
__ Other: _____

Social History:

Marital Status: _____

Smoke: Y / N Frequency: _____

Exercise: Y / N Frequency: _____

Employer: _____

Women: Are you or might you be pregnant? Y N Number of Pregnancies: _____ Live Births: _____

Living Children/ gender/ ages: 1) M / F _____ 2) M / F _____ 3) M / F _____ 4) M / F _____ 5) M / F _____

Complications during pregnancy or delivery? _____

Name: _____ Age: _____ Date: _____/_____/_____

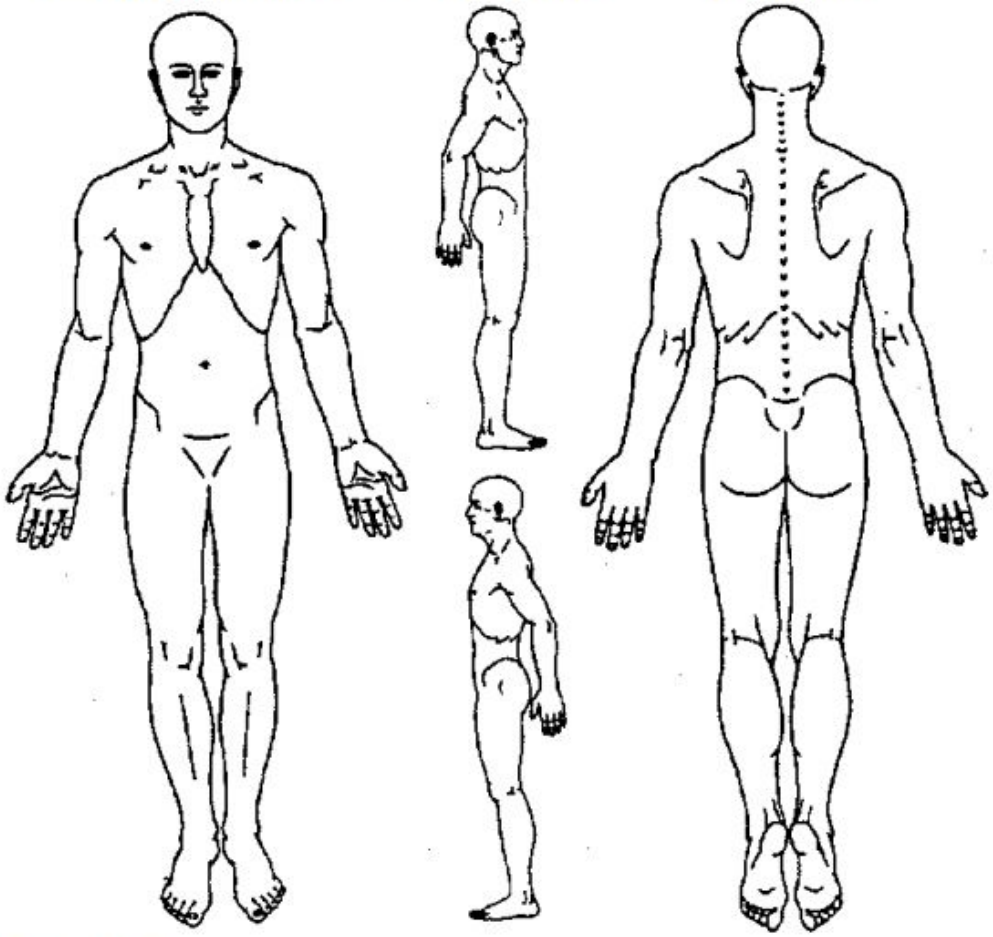
Please review the list below:

Previous Treatment	*Have used in the past*	*Worked well for me*	*Would like to try*
Chiropractic	_____	_____	_____
Physical Therapy	_____	_____	_____
Massage	_____	_____	_____
Acupuncture	_____	_____	_____

PAIN DIAGRAM

On the diagram below, mark where you are experiencing pain, right now. Use the letters below to indicate the type and location of your sensations.

Key: **A** – ACHE **B** – BURNING **N** – NUMBNESS
P – PINS & NEEDLES **S** – STABBING **O** - OTHER



PAIN SCALE

Rate the severity of your pain by checking one box on the following scale.

No Pain — Worst Possible Pain

0	1	2	3	4	5	6	7	8	9	10

CONSENT FOR TREATMENT

I have been informed of the nature of my disorder(s) and of the nature and purpose of physical therapy, chiropractic care, massage therapy and physical medicine as treatment. I have also been informed of the possible consequences and risks inherent in such treatments. The availability of these treatment options have been explained to me. I have also been advised of the possible consequences if I decide not to receive care. I understand there is no guarantee or warranty for any specific cure or result.

Consent for the following treatments:

- Physical Medicine
- Chiropractic Care
- Physical Therapy
- Massage Therapy

I HAVE READ THE ABOVE PARAGRAPH AND I UNDERSTAND THE INFORMATION PROVIDED. THIS INFORMATION HAS BEEN EXPLAINED TO ME, AND ALL QUESTIONS WHICH I HAVE ASKED HAVE BEEN ANSWERED TO MY SATISFACTION.

Patient Signature: _____ Date: _____/_____/_____

HIPAA PRIVACY STATEMENT

The HIPAA Privacy Rule provides federal protections for personal health information held by covered entities and give patients an array of rights with respect to that information. At the same time, the Privacy Rule is balanced so that it permits the disclosure of personal health information needed for patient care and other important purposes.

This Notice describes how medical information about you may be used and disclosed, and how you can get access to this information.

Please review it carefully.

This Notice will tell you about the ways we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding such medical information. We are required by law to make sure that medical information which identifies is kept private; give you this Notice of our legal duties and privacy practices with respect to your information; and follow the terms of the Notice that is currently in effect.

This Notices covers the physician practices of iMed Centers, including its employed physicians and other personnel.

Changes to this notice
We reserve the right to change this Notice. We reserve the right to make the revised or changed Notice effective for medical information about you we already have as well as any information we received in the future. The current Notice in effect at any time will be posted on our website address listed below and will be available from the Privacy Office as well as at any of our practice locations.

www.imedcenters.com

Using and Disclosing Medical Information
How we may use and disclose medical information about you.

Treatment.
We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, or other iMed Centers personnel.

We may use and disclose medical information about you, so that we may bill for treatment and services that you received at iMed Centers, and collect payment from you, and insurance company or another party.

We may also use and disclose medical information about you for hospitalization, appointment reminders, treatment alternatives, and health-related benefits and services.

We may use and disclose medical information about you to contact you and remind you that you have an appointment for treatment or medical care, or to contact you to tell you about possible treatment options and health-related benefits and services that may be of interest to you.

PAIN MANAGEMENT AGREEMENT

The purpose of this agreement is to prevent misunderstandings about certain medicines you will be taking for pain management. This is to help both you and your doctor to comply with the law regarding controlled pharmaceuticals.

I understand that this agreement is essential to the trust and confidence necessary in the doctor/patient relationship and that my doctor undertakes to treat me based on this agreement.

I understand that if we break this agreement, my doctor will stop prescribing these pain-control medicines.

In this case, my doctor will taper off the medicine over a period of several days, as necessary, to avoid withdrawal symptoms. Also, a drug-dependence treatment program may be recommended.

I will communicated fully with my doctor about the character and intensity of my pain, the effect of the pain on my daily life, and how well the medicine is helping to relieve the pain.

I will not use any illegal controlled substance, including marijuana, cocaine, etc.

I will not share, sell or trade my medications with anyone.

I will not attempt to obtain any controlled medicines, including opioid pain medicines, controlled stimulants, or anxiety medicines from any other doctor.

I will safeguard my pain medicine from loss or theft. Lost or stolen medicines will not be replaced.

I agree that refills of my prescription for pain medicine will be made only at the time of an office visit or during regular office hours. No refills will be available during evenings or on weekends.

I agree to use the preferred pharmacy mentioned in my intake packet. for filling prescriptions for all of my pain medicine.

I authorize the doctor and my pharmacy to cooperate fully with any city, state or federal law enforcement agency, including this state's Board of Pharmacy, in the investigation of any possible misuse, sale, or other diversion of my pain medicine.

FINANCIAL POLICY

The following is a statement of our financial policy. We hope this gives you a better understanding of our billing process.

Patients have many different types of insurance and payment options for services rendered. Also, not all physicians in the practice accept the same type of insurance. The three most common scenarios are outlined below. Please read the following and if you have questions or concerns, please call the office of the physician you are seeing.

Participating Plans
In this scenario, the physician you will see participates in your insurance plan. It is you responsibility to ensure your physician is in fact currently a provider in that plan. If your insurance plan requires an authorization, please be sure to obtain one before arriving to your appointment. Your provider's plan can assist you in obtaining authorization or notification to your insurance. If your plan requires a referral, please present the referral at check-in time. If you do not have a referral you might have to reschedule your appointment.

At the time of service, you will be responsible for all co-payments as outlined by your plan coverage. The co-payment is typically listed on your insurance card. iMed Centers Billing Department will then forward a bill to your insurance carrier who will inform our office if any deductible or percentage of payment is due from you. You will receive written notification of such decision and may ultimately be responsible for such payments as determined by your insurance company.

Non-Participating Plans
In this scenario, the physician you will see does not participate in your insurance plan. Payment for services is due at the time of the visit. We can submit the claim directly to your carrier or a claim can be mailed directly to you. Our staff will provide you with additional financial agreements to assist you in reviewing the fees.

Medicare
Most of our physicians in the practice do not accept Medicare. In the event that your physician does not participate in Medicare, you will be responsible for payment at the time of service.

Payment
Cash, check, Mastercard, Visa, Discover and American Express are recognized forms of payment.

By submitting this form, I acknowledge that the information I have provided is true and accurate. I acknowledge that I have read the iMed Centers terms and conditions, and indicate my agreement by checking the respective line below:

___ Consent for Treatment (Physical Medicine, Chiropractic Care, Physical Therapy, Massage Therapy)
___ HIPAA Privacy Statement
___ Pain Management Agreement
___ Financial Policy
___ Patient Registration
___ Health History

Patient Signature: _____ Date: _____

LIEN ON PERSONAL INJURY RECOVERY

_____(The Patient) Does hereby authorize Norwalk Integrated Medical Center (The Doctor) To furnish patient's attorney of record with a dull report of The Doctor's examination, diagnosis, treatment, prognosis, etc. of The Patient in regard to the accident in which The Patient was involved on _____, 20_____.

The Patient hereby authorizes and directs Attorney to pay directly to The Doctor such sums as may be due and owing The Doctor for medical services rendered to The Patient as a result of the above-referenced accident and/or owing The Doctor by reason of any other bills that are due by The Patient to The Doctor and to withhold such sums from any settlement, judgement or verdict as may necessary to adequately protect and fully compensate The Doctor. The Patient further gives a lien on The Patient's lawsuit arising from the above-referenced accident to The Doctor against any and all proceeds of any settlement, judgement or verdict which may be paid to Attorney or to The Patient in connection with that lawsuit.

The Patient understands and acknowledges that The Patient is directly and fully responsible to The Doctor for all bills submitted by The Doctor for health care services rendered to The Patient and that this agreement is solely for The Doctor's additional protection and in consideration of The Doctor's agreement to postpone demand for payment. The Patient further understands and acknowledges that such payment is not contingent on any settlement, judgement or verdict by which The Patient may eventually recover all or any portions of the sums owed by The Patient to The Doctor.

The Patient directs that Attorney shall not withhold any portion of the amount due to The Doctor under this lien to offset Attorney fees which Attorney now or hereafter may claim to be owing by The Doctor to Attorney in connection with this lien.

The Patient agrees to promptly notify The Doctor of any change or addition of Attorney(s) used by the patient in connection with the lawsuit described above, and instructs Attorney to do the same and to also promptly deliver a copy of this lien to any substituted or added Attorney(s).

DATED: _____, 20_____

PATIENT'S SIGNATURE: _____

Attorney shall promptly notify The Doctor if an when Attorney ceases to represent The Patient in the lawsuit described above or when The Patient retains addition attorney(s) to represent The Patient in that lawsuit. Attorney shall also promptly deliver a copy of this lien to any additional or substitute attorney(s) retained by The Patient in connection with that lawsuit.

Attorney does hereby agree to observe all the term of this lien stated above and agrees to withhold, without deduction for any Attorney's fees such sums from any settlement, judgement or verdict as may be necessary to adequately protect and fully compensate The Doctor.

DATED: _____, 20_____

ATTORNEY'S SIGNATURE: _____

Patient Name _____Date of Birth _____/_____/_____

I authorize the custodian of records of (check all that applicable):

_____ All records
_____ Laboratory/pathology records
_____ X-rays/radiology reports and images
_____ Billing and coding records
_____ History and physical/progress notes/summary /discharges/consultations
_____ Pharmacy prescription records
_____ Other (Describe specifically) _____

*Note: If these records contain any information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, or sexually transmitted disease, you are hereby authorizing disclosure of this information.

Please send the records listed above to:

Integrated Medical Center
365 Westport Ave, Suite 3
Norwalk, CT 06851
Fax: (203) 845-0005

The information may be used /disclosed for each of the following purposes:

_____ At my request (only the patient can check this box)
_____ For review by Integrated Medical Center
_____ For payment / Insurance / Managed Care query
_____ Other: _____

By signing below, I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

_____ _____/_____/_____
Signature of patient (or guardian / health care proxy / conservator) Date

_____
Printed Name

Integrated Medical Center
365 Westport Ave, Suite 3
Norwalk, CT 06851
Phone: (203) 845 - 0400
Fax: (203) 845 - 0005