Chiropractic, Acupuncture & Massage Center

Dr. Amir Ahmadiyar, D.C.

Your Back to Health Choice for All Ages

Authorization to Pay Physician

I hereby authorize _____ Insurance Company to pay by check and mail directly to:

Greater Falls Church Chiropractic Center
6521 Arlington Boulevard, Suite 100
Falls Church, VA 22042

Ashburn Chiropractic Center
44121 Harry Byrd., Suite 145
Ashburn, VA 20147

If my current policy prohibits direct payment to the doctor, I hereby also instruct and direct you to make out the check to me and mail it to the above named address for the professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services 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, in a current manner, any balance of said professional service charges over and above the insurance payment.

A photocopy of this assignment shall be considered as effective and valid as the original. I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

I authorize the doctor to initiate a complaint to the insurance commissioner for any reason on my behalf.

_____ _____

Print Name **Date**

_____

Signature

CHIROPRACTIC, ACUPUNCTURE & MASSAGE CENTER

DR. AMIR AHMADIYAR, D.C.

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Confidential Health History

Last Name: _____ First Name: _____
Address: _____

City:_____ State:_____ ZIP: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Email Address: _____

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

SS#: _____ Driver's License #: _____

Employer:_____ Type of Work: _____

Employment Status: _____Full Time _____ Part Time _____ Not Employed _____Retired_____

Marital Status: _____ Single _____ Married _____Widowed: _____Divorced _____ Separated: _____

Name of Spouse:_____Spouse SS#: _____

Spouse Employer:_____ Work Phone:_____

Emergency Contact Name:_____ Phone:_____

******Referred to this office by:_____**

PLEASE CIRCLE TYPE OF PATIENT:

SELF PAY INSURANCE AUTO ACCIDENT WORKER'S COMP

HEALTH INSURANCE INFORMATION

Primary Insurance: _____
Policy Holder: Self Spouse Other _____

ID#: _____
Group #: _____

Policy Holder's Name: _____

Date of Birth: _____

SS #: _____

Sex: _____ Male _____ Female

Secondary Insurance: _____
Policy Holder: Self Spouse Other_____

ID#:_____
Group #: _____

Policy Holder's Name:_____

Date of Birth: _____

SS #: _____

Sex: _____ Male _____ Female

****

I understand and agree that health and accident insurance policies are an arrangement between insurance carriers and my self. Furthermore, I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized should be paid directly to the Doctor's Office will be credited to me account on receipt. However, I clearly understand and agree that services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable. In the event my account is past due for 60 days from the date of service, and is turned over to an attorney for collection, I will also be liable for attorney's fees in the amount 1/3 of the principal balance, plus court costs.

PATIENT'S SIGNATURE:_____ DATE: _____

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Designation of Authorized Representative

I _____, do hereby designate Dr. Amir Ahmadiyar/ Dr. James Geer of Greater Falls Church Chiropractic Center to full extent permissible under the Employee Retirement Income Security Act of 1974 ("ERISA") and as provided in 29 CFR 2560-503-1(b)4 to otherwise act on my behalf to pursue claims and exercise all rights connected with my employee health care benefit plan, with respect to any medical or other healthcare expense(s) incurred as a result of the services I receive from the above named doctor. These rights include the right to act on my behalf with respect to initial determinations of claims, to pursue appeals of benefit determinations under the plan, to obtain records, and to claim on my behalf such medical plan reimbursement and to pursue any other applicable remedies.

_____
Patient's Name

_____
Patient's Signature

_____
Date

CHIROPRACTIC, ACUPUNCTURE & MASSAGE CENTER
Dr. Amir Ahmadiyar, D.C.

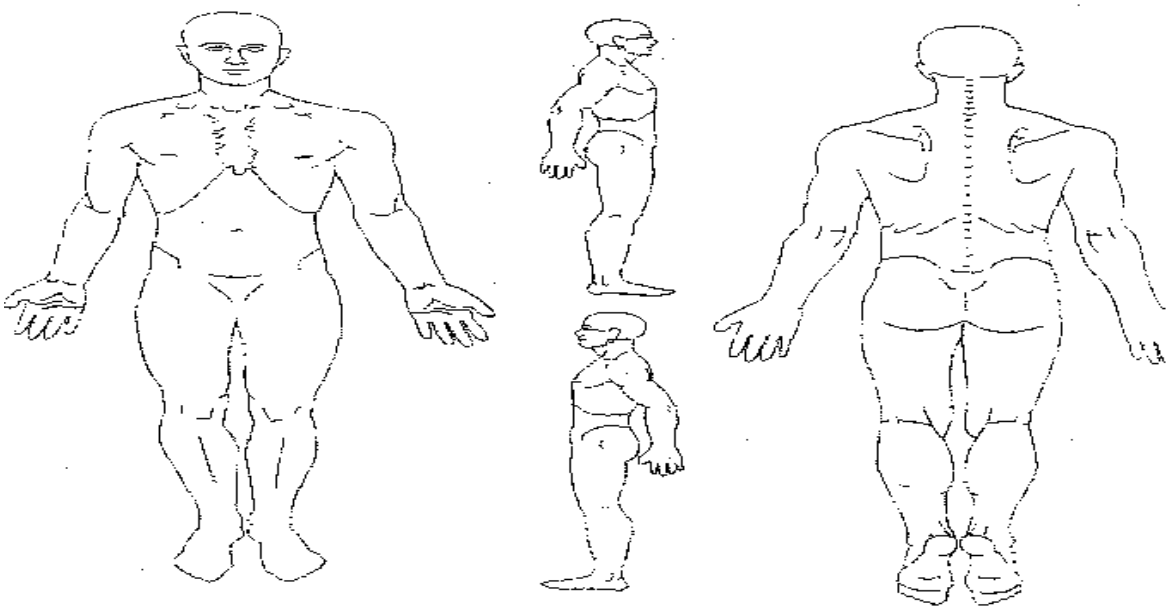
Health History Form

1. Reason for seeking chiropractic care
   a. PRIMARY REASON _____
   b. SECONDARY REASON _____
2. How long have you had this problem? _____ Years _____ Months _____ Weeks
3. Is this your first episode of this pain? _____ YES _____ NO
4. Does anything make the complaint better? _____
5. Does anything aggravate the complaint? _____
6. Have you seen another doctor for this problem? _____ YES _____ NO
7. Please circle the quality of pain: Dull Aching Sharp Shooting Burning Throbbing Deep Nagging Other _____
8. Grade intensity/severity (0-No pain. 10 Worst pain) 0 1 2 3 4 5 6 7 8 9 10
9. Rate Frequency: Occasional (20% awake time) Intermittent (26-50% of awake time) Frequent (51-75% of awake time) Constant (76-100% of awake time)

****

Please mark the location of your pain or discomfort on the images below.
Use symbols shown to represent type (s) of pain.

D – DULL
S – STABBING
B – BURNING
T – TINGLING (PINS & NEEDLES)
N – NUMB
C – CRAMPING



Name: _____ Date: _____

Signature: _____

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FOR DOCTOR USE ONLY

DIAGNOSIS: ___.__ ___.__ ___.__ TREATMENT PLAN: _____

CHIROPRACTIC, ACUPUNCTURE & MASSAGE CENTER

Dr. Amir Ahmadiyar, D.C.

Notice of Practices Acknowledgement

I understand that, under the Health insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information will be used to:

*Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
*Obtain payment from third party payers.
*Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more description of the uses and disclosures of my health information. I understand that this organization has the right to charge its Notice of Privacy Practices from time to time and that I may contact the organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment and health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

I attempted to obtain the patient's signature in acknowledgement on the Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below.

Date: _____ Initials: _____ Reason: _____

CHIROPRACTIC, ACUPUNCTURE & MASSAGE CENTER

Dr. Amir Ahmadiyar, D.C.

Your Back to Health Choices for All Ages

Notice of Doctor's Lien

PATIENT: _____ DATE OF ACCIDENT: _____

I do hereby authorize DR. AMIR H. AHMADIYAR AT GREATER FALLS CHURCH CHIROPRACTIC CENTER to furnish you, my attorney, with a full report of his examination, diagnosis, treatment, prognosis, etc. of myself in regard to the accident in which I was recently 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 his office and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect and fully compensate said doctor. And I hereby further give a Lien on my case to said doctor against any and all proceeds from my settlement, judgment, or verdict which may be paid to you, my attorney, or myself, as a 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 me and this agreement is made solely for said doctor's additional protection and in consideration of his awaiting payment. And I further understand that such payment is not contingent upon any settlement, judgment, or verdict by which I may eventually recover said fee.

I agree to promptly notify said doctor of any change or addition of attorney(s) used by me in advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment but may declare the entire balance due and payable.

_____ _____

PATIENT SIGNATURE DATE

The undersigned being attorney of record for the above patient does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment, or verdict, as may be necessary to adequately protect and fully compensate said doctor above-named. Attorney further agrees that in the event this lien is litigated, that the prevailing party will be awarded attorney fees and costs.

_____ _____

ATTORNEY SIGNATURE DATE

Please date, sign, and return one copy to doctor's office. Also keep one copy for your records.

Dr. Amir H. Ahmadiyar, Clinic Director

6521 Arlington Boulevard, Suite 100, Falls Church, Virginia 22042 Tel. (703) 538-6666 Fax (703) 538-6675

CHIROPRACTIC, ACUPUNCTURE & MASSAGE CENTER

Dr. Amir Ahmadiyar, D.C.

WORKER'S COMP INJURY INFORMATION

PART1

Injuries involving <u>LIFTING</u>:

1. From where were you lifting the object?

_____ Ground level _____ Below ground level _____ A surface about 1 to 2 feet off the ground
_____ A surface about 2 to 3 feet off the ground _____ A surface about 3 to 5 feet off the ground
_____ A surface above 5 feet off the ground _____ Other _____

2. How many pounds was the object you were lifting?

_____ 1 to 5 pounds _____ 5 to 10 pounds _____ 10 to 20 pounds _____ 20 to 40 pounds
_____ 40 to 60 pounds _____ 60 to 80 pounds _____ 80 to 100 pounds _____ over 100 pounds
_____ Other _____

3. What position were you in while lifting the object?

_____ Back was in an upright/straight position _____ Position was bent over at the waist
_____ Position was twisted to the left side _____ Position was twisted to the right side
_____ Other _____

4. What type of pain did you feel immediately after the injury?

_____ A gripping pain _____ A sharp pain _____ A dull pain _____ An achy pain
_____ A popping feeling _____ Other

Injuries involving <u>FALLING</u>:

1. Where at work did you fall?

_____ Onto the ground while walking _____ Onto the ground while running
_____ From a surface 1 to 3 fee off the ground _____ From a surface 3 to 6 feet off the ground
_____ From a surface 6 to 9 feet off the ground _____ From a surface higher than 9 feet off the ground
_____ Other _____

2. What part of your body did you land on?

A. Head	B. Neck	C. Right Shoulder	D. Right Arm	E. Right Hand
F. Right Buttock	G. Tail Bone	H. Left Shoulder	I. Left Shoulder	J. Left Arm
K. Left Hand	L. Back	M. Left Hip	N. Left Leg	O. Right Leg
P. Right Knee	Q. Right Foot	R. Left Knee	S. Left Buttock	T. Left Foot

3. What other areas were injured as a result of your fall?

A. Head	B. Neck	C. Right Shoulder	D. Right Arm	E. Right Hand
F. Right Buttock	G. Tail Bone	H. Left Shoulder	I. Left Shoulder	J. Left Arm
K. Left Hand	L. Back	M. Left Hip	N. Left Leg	O. Right Leg
P. Right Knee	Q. Right Foot	R. Left Knee	S. Left Buttock	T. Left Foot

Other Work Related Injuries

Other type of accident (if not caused by lifting or a fall)

_____ Raised up from bending over _____ Twisted at the waist
_____ Suffered a wrist injury from repetitive use _____ Suffered a wrist injury from pulling
_____ Other _____

PART 2

JOB ANALYSIS:

What regular activities do you perform at your job?

_____ Bending and stooping _____ Crawling _____ Reaching above the shoulders _____ Squatting
_____ Climbing _____ Crouching _____ Kneeling _____ Maintaining an awkward posture
_____ Pushing and pulling

How much do you regularly lift at your job?

_____ 1 to 10 pounds _____ 10 to 20 pounds ____ 20 to 40 pounds _____ 60 to 80 pounds
_____ 80 to 100 pounds _____ over 100 pounds _____ Other

Are your required to regularly bend over while lifting at your job? _____ YES _____ NO

Are your hands subject to repetitive movements such as?

_____ Light grasping with the left hand _____ Firm grasping with the right hand
_____ Light grasping with both hands _____ Firm grasping with the left hand
_____ Light grasping with the right hand _____ Firm grasping with both hands
_____ Typing _____ Using a computer mouse

How many hours are you required to regularly perform each of the following activities at your job?

Sitting _____hrs
Standing _____ hrs
Walking _____ hrs
Lifting _____ hrs

Check if applicable:

_____ Did you report this injury in writing a work?

_____ Have you seen another health care provider since the accident?