Move • Feel • Live BETTER

Dr. Amy M. O'Donnell

Chiropractic Physician

PATIENT REGISTRATION

PATIENT INFORMATION

MR MRS MS MISS DR Name_____
(Circle) (First) (Middle) (Last)

Mailing Address_____
(Street) (City) (State) (Zip)

Date of Birth _____Sex Prefer not to say Marital Status _____

Phone: Home ( ) _____Work ( ) _____Cell ( ) _____

Email _____

Fax: Home ( ) _____Office ( ) _____

May we leave a message? Yes_____ No_____

IN CASE OF EMERGENCY, PLEASE NOTIFY:

Name _____ Relationship_____

Emergency Contact Telephone: Home ( ) _____ Work ( ) _____

Cell ( ) _____ Other ( ) _____

Primary Care Physician _____ Telephone ( ) _____

Address _____
(Street) (City) (State) (Zip)

RESPONSIBLE PARTY INFORMATION (if different from patient information)

MR MRS MS MISS DR Name_____
(Circle) (First) (Middle) (Last)

Mailing Address_____
(Street) (City) (State) (Zip)

Relationship to Patient: Spouse_____ Parent/Guardian_____ Other _____

Phone: Home ( ) _____ Work ( ) _____Cell ( ) _____

PATIENT HISTORY

Name _____ Date _____

What are your chief symptoms or medical problems at this time? _____

_____

How long have you had this condition? _____ Have you had this condition in the past? _____

Previous treatment? _____

What increases pain? _____

What alleviates pain? _____

Is this condition interfering with your sleep, work or daily routine?_____

MEDICAL HISTORY

Please list any significant medical illnesses or diagnoses given to you by a physician. Check box if hospitalized for this condition.

_____ ☐

_____ ☐

_____ ☐

Age of mattress _____ Comfortable Uncomfortable

Are you wearing heel lifts ☐ sole lifts ☐ inner soles (orthotics) ☐

Were you in a motor vehicle accident? _____ Personal injury? _____ Work related? _____

Describe_____

_____

Date of injury _____

SURGICAL HISTORY

Operation _____ Date _____ Reason_____

Operation _____ Date _____ Reason_____

EXERCISE

Type _____ hours/day _____ Days/week _____

SITTING

Computer – hours/day _____ TV – hours/day _____ Stress level (0 – 10) _____

CURRENT MEDICATIONS

Medication	Dosage	Frequency

CURRENT SUPPLEMENTS

Supplement	Dosage	Frequency

FAMILY HISTORY

	Check if deceased	Current age (or age at death)	Health problems or cause of death
Father			
Mother			
Siblings			
Children			

Has anyone in your family had:

Diabetes? Yes _____ No _____ Relationship _____

Thyroid Disease? Yes _____ No _____ Relationship _____

Cancer? Yes _____ No _____ Relationship _____

History of back pain? Yes _____ No _____ Relationship _____

Arthritis? Yes _____ No _____ Relationship _____

GENERAL

Are you frequently ill? ☐ Yes ☐ No

Are you having: fever _____chills _____sweats_____ at night? _____

Have you lost ___ gained ___ weight recently?

Loss of appetite? _____ Fatigue? _____

Lyme Disease? _____

NOSE AND THROAT

Sinus trouble? _____ Hay fever? _____ Allergies _____ Nasal polyps? _____

Hoarseness or change in voice? _____

Significant alteration in taste or smell? _____

Thyroid disease? _____

CHEST

Last chest X-ray? _____ Was it normal? _____

Asthma or wheezing? _____ Shortness of breath at rest ____ with exertion ____ at night? _____

Frequent cough? _____ Coughed up blood? _____

HEART

Last electrocardiogram? _____ Was it normal? _____

Heart problems? _____ High blood pressure? _____

Elevated cholesterol? _____ Suffered a heart attack? _____ If yes, when? _____

Chest pain or discomfort? _____ Leg or ankle swelling? _____

Thumping, racing or skipping of the heart? _____ Heart murmur? _____

GASTROINTESTINAL

Trouble swallowing? _____ Heartburn? _____

Nausea or vomiting? _____ Abdominal pain? _____

Ulcer? _____ Gallbladder disease? _____

Last sigmoidoscopic exam? _____ Colon polyps? _____

GENITOURINARY

Frequent urination? ____ Burning pain? _____ Blood in urine? _____

History of bladder or kidney infection? _____ Trouble starting or stopping urine flow? _____

Sometimes lose control of your bladder? _____

BONES AND JOINTS

Joint pain or stiffness? _____ Red/swollen? ___ Gout? ____

Osteoporosis? _____ Osteopenia? _____

Muscle weakness? _____ Tenderness? _____

Muscle cramps with walking? ___ At night? ___

NEUORLOGICAL

Frequent or severe headaches? _____

Fainting or loss of consciousness? _____

Seizure or convulsion? _____

Bothered by a spinning sensation or vertigo? _____ Lightheadedness?_____

Balance problem? _____ Difficulty walking? _____

Numbness ___ Tingling ___ In your arms or legs?

Weakness in your arms or legs? _____

Changes in bowel/bladder? ___ Loss of control? ___

LYME SYMPTOMS

Fever? ____ Chills? ____ Sweats? ____ Muscle Aches? ____ Fatigue? ____ Depression? ____

Nausea? ____ Joint Pain? ____ Rash? ____ Facial Drooping? ____ Brain Fog? ____

SOCIAL HISTORY

Birthplace _____

Marital status: Single ___ Married ___ Widowed ___ Divorced ___ Separated ____ How long _____

Number of children _____ With whom do you live? _____

Occupation (s) past and present _____

HOW DID YOU LEARN OF OUR OFFICE?

_____ Newspaper, magazine article, advertisement

_____ Friend/Family

_____ Lecture

_____ Website

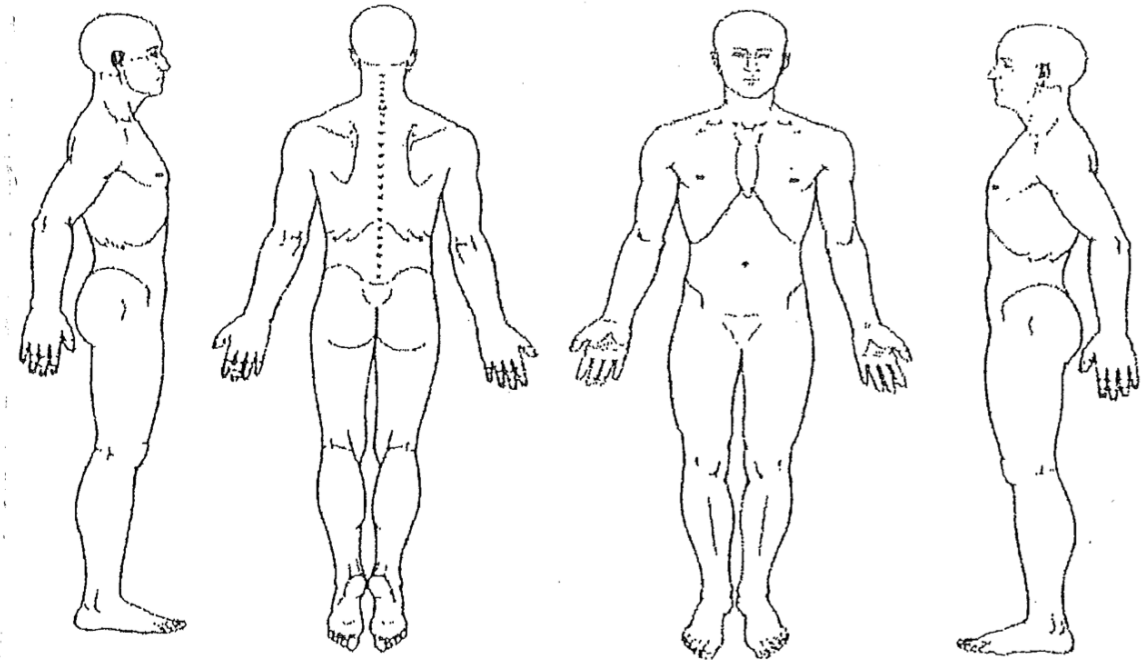
_____ Other _____

_____ Physician Referral

Physician's Full Name _____ Telephone ( ) _____Fax ( ) _____

Referring Physician's Address_____

(Street) (City) (State) (Zip)



1 2 3 4 5 6 7 8 9 10

Indicate where you have pain or other symptoms.
Indicate the intensity of your symptoms
1= none
10= unbearable

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FINANCIAL AND CANCELLATION POLICY

It is our office policy to collect full payment for services rendered at the time of each visit. We accept VISA and Master Card as well as checks or cash. Returned checks are charged a $25 fee for processing.

Appointments must be canceled at least 24 hours in advance of the appointment.

ASSIGNMENT

I hereby instruct and direct my insurance company to pay by check, made out and mailed directly to Dr. Amy O'Donnell, the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered by Dr. Amy O'Donnell. A photocopy of this assignment shall be considered as effective and valid as the original.

RELEASE OF INFORMATION

I authorize Dr. O'Donnell to release any information pertinent to my case to any insurance company, adjustor and attorney involved in this care; and hereby release Dr. O'Donnell of any consequence thereof.

FINANCIAL REPONSIBILITY

I agree to be financially responsible for all charges incurred with Dr. O'Donnell including my insurance deductible, co-payment and any services rejected by my insurance company.

_____ _____

Patient Signature Date

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INFORMED CONSENT FOR CHIROPRACTIC TREATMENT

The nature of chiropractic treatment: The doctor will use her hands in order to move or release your joints. You may feel a "click" or a "popping sound," such as the noise when a knuckle is "cracked," and you may feel movement of the joint. Various ancillary procedures, such as the use of hot or cold packs, electric muscle stimulation, therapeutic ultrasound, Graston Technique, myofascial release, or MLS Laser may also be used.

Possible Risks: As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bones, muscular strain, ligamentous sprain, dislocation of joint, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury of arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or minor complications.

Probability of risks occurring: The risks of complications due to chiropractic treatment have been described as "rare," about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke has been estimated at one in one million to one in twenty million, and can be even further reduced by screening procedures. The possibility of adverse reaction due to ancillary procedures is also considered "rare."

Graston Technique is an instrument assisted variation of traditional cross fiber or transverse friction massage. The Graston Technique instruments consist of six stainless steel instruments of various sizes and shapes. Graston Technique is a form of treatment used to "break up" or "soften" scar tissue or adhesions in muscle, tendon or ligaments, thus allowing for the return of normal function in the area being treated.

Graston Technique may produce the following:

1. Local discomfort during the treatment
2. Reddening of the skin
3. Superficial tissue bruising
4. Post treatment soreness

Graston Technique is designed to minimize discomfort; however the above reactions are normal, and in some instances unavoidable. These reactions will subside after 24-48 hours.

Other treatment options which could be considered may include the following:

- Over the counter analgesics. The risks of these medications include irritation to the stomach, liver and kidneys, and other side effects in a significant number of cases.
- Medical care, typical anti-inflammatory drugs, tranquilizers and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.
- Hospitalization in conjunction with medical care adds risk of exposure to virulent communicable diseases in a significant number of cases.
- Surgery in conjunction with medical care adds the risk of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

MLS Laser Therapy Consent: In some cases, Dr. O'Donnell may recommend using a state of the art Class IV, FDA approved MLS Therapy laser, which produces a painless invisible beam of light that stimulates the tissue to kick start the healing process. This can reduce recovery time, even post-operative, leading to a quicker return to work or other activities.

I understand that MLS Laser Therapy is an option and I have been advised of the advantages the MLS Therapy will offer me. I also understand that MLS Laser Therapy is not effective in 100% of the patients. There are no known side effects to this treatment.

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

I have read the explanation and have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and hereby give my full consent to treatment.

TRIGGER POINT DRY NEEDLING ® CONSENT AND REQUEST FOR PROCEDURE

Trigger Point Dry Needling ® (TrP DN) involves inserting a tiny monofilament needle in a muscle or muscles in order to release shortened bands of muscles and decrease trigger point activity. This can help resolve pain and muscle tension as well as promote healing. This is **not** traditional Chinese Acupuncture, but is instead a treatment that relies on a diagnosis to be effective. Dr. O'Donnell's training was in accordance with requirements dictated by the State of CT licensure.

TrP DN is a valuable and effective treatment for musculoskeletal pain. Like any treatment, there are possible complications. While complications are rare in occurrence, they are real and must be considered prior to giving consent for treatment.

Risks: The most serious risk with TrP DN is accidental puncture of a lung (pneumothorax). If this were to occur, it may likely require a chest x-ray and no further treatment. The symptoms of shortness of breath may last for several days to weeks. A more severe puncture can require hospitalization and re-inflation of the lung. This is a rare complication, and in skilled hands, it should not be a major concern. Other risks include injury to a blood vessel causing a bruise, infection, and/or nerve injury. Bruising is a common occurrence and should not be a concern.

Patient's Consent: I understand that no guarantee or assurance has been made as to the results of this procedure and that it may not cure my condition. Dr. O'Donnell has also discussed with the probability of success of this procedure, as well as the probability of serious side effects. Multiple treatment sessions may be required/needed, thus this consent will cover this treatment as well as consecutive treatments. I have read and fully understand this consent form and understand that I should not sign this form until all items, including my questions, have been explained or answered to my satisfaction. With my signature, I hereby consent to the performance of this procedure. I also consent to any measures necessary to correct complications which may result.

Procedure: I, _____, authorize Dr. Amy O'Donnell to perform Trigger Point Dry Needling ® for my diagnosis of: _____.

Please answer the following questions:

Are you pregnant? Yes _____ No _____ **Are you immunocompromised?** Yes _____ No _____

Are you taking blood thinners? Yes _____ No _____

DO NOT SIGN UNLESS YOU HAVE READ AND THOROUGHLY UNDERSTAND THIS FORM
You have the right to withdraw consent for this procedure at any time before it is performed.

_____ _____
Patient or Authorized Representative Date

_____ _____
Relationship to Patient (if other than patient) Print Patient Name

I have explained the procedure indicated above and its attendant risks and consequences to the patient who indicated understanding, thereof, and has consented to its performance.

_____ _____
Dr. Amy O'Donnell Date

Patient was offered copy of consent and refused _____

Patient was given copy of consent _____

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MEDICAL RELEASE FORM

Please fill in the name of the physician, hospital or clinic from which you are requesting information:

_____

_____

Please forward copies of my:

Laboratory work _____ Diagnostic studies _____ Operative reports _____

Pertinent report(s) related to the following medical problem(s):

_____

_____

Patient name _____

Date of birth _____ Phone: _____

Signature _____ Date: _____

Please send medical records to:

Amy O'Donnell, DC, DABCO
2001 West Main Street, Suite 255
Stamford, CT 06902
203-388-8735
Fax: 475-619-9014

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PRIVACY STATEMENT ACKNOWLEDGEMENT

Our office is committed to maintaining our patients' trust and confidence. That is why we have made it our priority to keep the information you provide us safe and confidential. Our employees are educated on the importance of maintaining the confidentiality of your health information.

The Practice's Privacy Notice has been provided to me prior to my signing this form. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information (PHI) necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out health care operations. The Practice explained to me that the Privacy Notice is available to me now, or in the future at my request.

The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.

I understand that, and consent to, the following appointment reminders that may be used by the Practice: a) a postcard mailed to me at the address provided by me, b) telephoning my home or office and leaving a message on my answering machine or with the individual answering the phone.

I understand that I have a right to request an accounting of the disclosure of my PHI other than for treatment, payment and/or health care operations. I understand I may restrict access or disclosure of my PHI. However, the Practice is not required to agree to any restrictions that I have requested. If the Practice agrees to a requested restriction, then the restriction is binding on the Practice.

I understand the Practice may share my PHI with the Connecticut Chiropractic Association in the event advocacy is needed for insurance claims or utilization disputes.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

_____ _____

Name of Individual (Printed) Signature

_____ _____

Signature of Legal Representative
(e.g., Guardian, parent if minor, attorney) Relationship

_____ _____

Date Signed Witness

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ASSIGNMENT OF BENEFITS/ERISA AUTHORIZATION FORM

Financial Responsibility

I have requested professional services from [Amy M. O'Donnell, D.C., DABCO] ("Provider") on behalf of myself and/or my dependents, and understand that by making this request, I am responsible for all charges incurred during the course of said services. I understand that all fees for said services are due and payable on the date services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement unless other arrangements have been made in advance.

Assignment of Insurance Benefits

I hereby assign all applicable health insurance benefits to which I and/or my dependents are entitled to Provider. I certify that the health insurance information that I provided to Provider is accurate as of the date set forth below and that I am responsible for keeping it updated.

I hereby authorize Provider to submit claims, on my and/or my dependent's behalf, to the benefit plan (or its administrator) listed on the current insurance card I provided to Provider, in good faith. I also hereby instruct my benefit plan (or its administrator) to pay Provider directly for services rendered to me or my dependents. To the extent that my current policy prohibits direct payment to Provider, I hereby instruct and direct my benefit plan (or its administrator) to provide documentation stating such non-assignment to myself and Provider upon request. Upon proof of such non-assignment, I instruct my benefit plan (or its administrator) to make out the check to me and mail it directly to Provider.

I am fully aware that having health insurance does not absolve me of my responsibility to ensure that my bills for professional services from Provider are paid in full. I also understand that I am responsible for all amounts not covered by my health insurance, including co-payments, co-insurance, and deductibles.

Authorization to Release Information

I hereby authorize Provider to: (1) release any information necessary to my health benefit plan (or its administrator) regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims. This order will remain in effect until revoked by me in writing.

ERISA Authorization

I hereby designate the Provider as my Authorized Representative with respect to insurance coverage for health care services, and thereby authorize, and convey to Provider to the full extent permissible under law and under any applicable insurance policy and/or employee health care benefit plan: (1) the right and ability to act on my behalf in connection with any claim, right, or cause in action that I may have under such insurance policy and/or benefit plan; and (2) the right and ability to act on my behalf to pursue such claim, right, or cause of action in connection with said insurance policy and/or benefit plan (including but not limited to, the right to act on my behalf in respect to a benefit plan governed by the provisions of ERISA as provided in 29 C.F.R. S2560.5031(b)(4)) with respect to any healthcare expense incurred as a result of the services I received from Provider and, to the extent permissible under the law, to claim on my behalf, such benefits, claims, or reimbursement, and any other applicable remedy, including fines.

A photocopy of this Assignment/Authorization shall be as effective and valid as the original.

_____ _____

Patient Date

_____ _____

Policyholder/Insured Date