

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.

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 change 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.

CHIROPRACTIC, ACUPUNCTURE & MASSAGE CENTER

Dr. Amir Ahmadiyar, D.C.

WORKER'S COMP INJURY INFORMATION

PART 1

Injuries involving LIFTING:

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 FALLING:

1. Where at work did you fall?

Onto the ground while walking Onto the ground while running
 From a surface 1 to 3 feet 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 you 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 at work?

Have you seen another health care provider since the accident?