

COMEAU HEALTH CARE ASSOCIATES, PC

Wayne A. Comeau, DC, DACBOH

Parry N. Comeau, P.T., D.C.

194 NORTH STREET

DANVERS, MA 01923-1242

Patient Case History

A thorough case history is an important part of evaluating your condition and arriving at a diagnosis. Please fill out this form in as much detail as possible. The doctor will review the history with you and answer any questions you might have.

Personal Data

Today's Date: _____

First Name: _____ Middle Initial: _____

Last Name: _____

Nickname: _____ Marital Status: M S D W

Date of Birth: _____ Age: _____ S.S. # ____ - ____ - ____

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

Home Phone: _____ Cell Phone: _____

E-Mail address: _____

Occupation: _____ Employer: _____

Work Phone: _____ Number of hours a week you work? _____

Are you currently able to work? ____ Yes ____ No If no, list dates out of work: _____

Date of Your Last Physical Examination: _____

In case of emergency please contact _____ Phone: _____

Are you: __right handed __left handed __ambidextrous

Who referred you to our office? _____

Have you seen our advertising? _____

**COMEAU HEALTH CARE ASSOCIATES, PC
COMEAU REHAB THERAPIES**

Wayne A. Comeau, DC, DACBOH
Parry N. Comeau, PT, DC
194 NORTH STREET
DANVERS, MA 01923-1219

CONSENT TO PHYSICAL THERAPY SERVICES

1. I, _____,
authorize the performance upon myself of examinations and/or treatments performed by
or under the direction of doctors, associates or assistants employed by Comeau Health
Care Associates, PC and or Comeau Rehab Therapies.

2. I also consent to the performance of other diagnostic and therapeutic procedures
in addition to, or different from those stated above, whether or not arising from presently
unforeseen conditions that the doctors, associates or assistants employed by Comeau
Health Care Associates, PC and or Comeau Rehab Therapies may consider necessary or
advisable in the course of my health care.

3. The nature and purpose of the procedures, the possible alternatives, the risks
involved, the possible consequences, and the possibility of complication have been
explained to me by the doctors, associates or assistants employed by Comeau Health Care
Associates, PC and or Comeau Rehab Therapies.

4. I acknowledge that no guarantee or assurance as to the results that may be
obtained from the procedure has been given by the doctors, associates or assistants
employed by Comeau Health Care Associates, PC and or Comeau Rehab Therapies.

Date: _____ Signed: _____

Witness: _____ Relationship: _____

Comeau Health Care Associates

Wayne A. Comeau, D.C. DACBOH
Parry N. Comeau, P.T., D.C.
194 North Street
Danvers, MA 01923-1219
978-774-5600 Fax – 978-774-5601

To help us with total quality health care for our patients we would like to increase communication between our office and your medical doctor. If you would be interested in our new policy, please complete the authorization form, and we will periodically send an updated report to:

Primary Care Medical Doctor: _____

Address: _____

City/State: _____

Other Medical Doctors that need to be informed: _____

Address: _____

City/State: _____

Patient Please Initial: _____

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194 NORTH STREET

DANVERS, MA 01923-1219

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize the above named Physician to release any information acquired in the course of my examination or treatment as necessary to process any claims.

Signed: _____ Date _____

HEALTH INSURANCE CLAIM FORM

Name of insurance company: _____

Insured's Name: _____
(first name, middle initial, last name)

Insured's I.D. No. or MEDICARE No. _____
(Include any letters)

Insured's Group No. _____
(Or Group Name)

Insured's Address _____
Street city state zip code

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN

I hereby authorize payment directly to the above named Physician attending me, of the medical benefits otherwise payable to me.

Signed: _____ Date _____

I understand and agree that the health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the doctor's office will prepare any necessary report and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the doctors office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered 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 me will be due and payable.

It is understood and agreed the amount paid the Doctor, for x-rays, is for examination only and the x-ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient of this office. The patient agrees that he/she is responsible for all bills incurred at this office including supplies or services not paid for by insurance. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions, nor for any medical diagnosis.

Signed: _____ Date _____

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201

This notice is effective as of ____/____/____

I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide Comeau Health Care Associates with my authorization and consent to use and disclosed my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice

Patient's Name (print)

Patient's Signature

Date

Authorized Facility Signature

Date