***CHIROMEDICA***

*Chiropractic Clinic*

# PERSONAL INJURY QUESTIONNAIRE

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## Information about You

Name _____ Phone_____

Address _____ City _____ State _____ Zip _____

Age _____ Birthdate _____ Sex ( )F ( )M Email: _____

Home Phone _____ Work Phone _____ Cell Phone _____

Auto Ins. Co. _____ Claim # _____

Address _____ City _____ State _____ Zip _____

Adjuster's Name _____ Adjuster's Phone # _____ Ext. _____

Policy Holder's Name (if other than self)_____

## Information about Your Attorney

Name _____ Ph _____ Fx _____

Address _____ City _____ State _____ Zip _____

Were there any witnesses? ( ) Yes ( ) No Names _____

## Information about Your Accident

Date of Accident _____ Time of Day _____

Were you: ( ) Driver ( ) Passenger ( ) Front Seat ( ) Back Seat

Number of people in your vehicle? _____ Were you wearing seatbelts? ( ) Yes ( ) No

What direction was you headed? ( ) North ( ) East ( ) West ( ) South

What direction was the other vehicle headed? ( ) North ( ) East ( ) West ( ) South

On (name of street) _____

Were you struck from: ( ) behind ( ) front ( ) Left Side ( ) Right Side

Approximate speed of your car _____ mph Other car _____ mph

Were you knocked unconscious? ( ) Yes ( ) No If yes, for how long? _____

Were policy notified? ( ) Yes ( ) No

In your own words, please describe the accident: _____

_____

_____

Did you have any physical complaints before the accident? ( ) Yes ( ) No

If yes, please describe: _____

_____

Please describe how you felt:

During the accident: _____

Immediately after the accident: _____

Later that day: _____

The next day: _____

What are your present complaints and symptoms? _____

_____

_____

Where were you taken after the accident? _____

Have you been treated by another doctor since the accident? ( ) Yes ( ) No

If yes, please write down their names: _____

Since the injury occurred, are your symptoms ( ) improving ( ) getting worse ( )Same

CHECK SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT:

| | | | |
|---|---|---|---|
| ( ) Headache | ( ) Irritability | ( ) Numbness in toes | ( ) Flushed face |
| ( ) Neck pain | ( ) Chest pain | ( ) Shortness of breath | ( )Buzzing in ears |
| ( ) Stiff neck | ( ) Dizziness | ( ) Fatigue | ( ) Loss of balance |
| ( ) Difficulty sleeping | ( ) Head is heavy | ( ) Depression | ( ) Fainting |
| ( ) Back pain | ( ) Pin/Needles in arms | ( ) Light sensitive eyes | ( ) Loss of smell |
| ( ) Nervousness | ( ) Pin/Needles in legs | ( ) Loss of memory | ( ) Loss of taste |
| ( ) Tension | ( ) Numbness in fingers | ( ) ringing ears | ( ) Diarrhea |
| ( ) Cold feet | ( ) Cold hands | ( ) Upset stomach | ( ) Constipation |
| ( ) Cold sweats | ( ) Fever | ( ) _____ | ( ) _____ |

Do you have any congenital (from birth) factors which relate to this problem? _____

_____

Do you have any previous illnesses that relate to this case? ( ) Yes ( ) No

If yes, please describe: _____

_____

Have you ever been involved in an accident before? ( ) Yes ( ) No

If yes, please describe, including date(s) and type(s) of accident(s) as well as injuries suffered:

_____

_____

Have you lost time from work as a result of this accident? ( ) Yes ( ) No

Last day worked: _____

Type of Employment: _____

Do you notice any activity restrictions as a result of this injury? ( ) Yes ( ) No

If yes, please describe: _____

_____

Other pertinent information: _____

_____

_____ _____

Date Patient's Signature

***CHIROMEDICA***

*Chiropractic Clinic*

# FINANCIAL AGREEMENT – PERSONAL INJURY

We would like to take this opportunity to welcome you to the office and assure you that you will receive the very best care available for your injury. In order to familiarize you with the financial policy of our office, we would like to explain how your medical bills will be handled.

**Responsibility for Accident**

If you were involved in an auto accident, that you were responsible for, in your own vehicle, we will bill your Med Pay portion of your car insurance policy (if available) for services rendered in our office.

If you were a passenger in another vehicle, the car insurance company that insures that vehicle may be billed for the charges of your medical services.

If another vehicle, other than the vehicle you traveled in, caused the accident, we will first bill your auto insurance Med Pay portion for medical services rendered. If your car insurance policy does not include a Med Pay portion, we will require that you sign a lien and obtain an attorney. By signing the lien we agree, as a courtesy to you, to defer payment of your medical bills until your settlement is received. If care is discontinued before your treatment plan is complete, payment of your account is due immediately. This office does not discount or reduce the amount of your balance based upon the outcome of your settlement.

**Responsibility for Payment**

As a courtesy to you, we will provide your insurance company and attorney with all the information they might need to negotiate and provide payment for any charges you occur in our office. However, all charges for services rendered in our office are charged directly to you and ultimately you are personally responsible for payment of these charges.

**Cancellation & No-show Policy**

Appointments you schedule are reserved especially for you. If you need to reschedule or cancel an appointment, we request and appreciate a minimum of 24-hours notice. For the best customer service, we ask that you make schedule changes during our normal business hours.
Appointments cancelled with less than 24-hours notice will be assessed a fee as follows: $30 for chiropractic office visits and $50 for massages. **This fee is not covered by insurance and is your responsibility to pay at the time of your next visit**. _____ *(initial)*

**Assignment of Insurance Benefits**

I hereby authorize Chiromedica to furnish information to my insurance carrier(s) concerning this treatment and **I hereby assign all payment for services rendered to Chiromedica. If my current policy prohibits direct payment to Chiromedica, I hereby instruct and direct my insurance carrier(s) to make checks payable to me and mail them directly to Chiromedica. _____ *(initial)***

We hope this has answered any questions that you might have about our financial agreement. If at any time you have further questions regarding your financial agreement, please do not hesitate to ask us.

I have read, understand and agree to the above financial agreement.

_____ _____

Patient's Signature Date

_____

Patient's Name

***CHIROMEDICA***

*Chiropractic Clinic*

# MEDICAL LIEN

Patient: _____

Date of Injury: _____

I hereby authorize and direct _____, my attorney, to pay to Dr. _____ such sums as may be due and owing him/her for medical/chiropractic services rendered me by reason of the accident 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 request that payment be made directly to said doctor which would otherwise be paid to myself, as the result of the treatment charges injured for the injuries in connection therewith. This is a direct assignment of my rights and benefits under this claim.

I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by him/her for services rendered me and that this agreement is made solely for said doctor's protection and in consideration of his/her awaiting payment. And I further understand that such payments are not contingent on any settlement, judgment or verdict which I may eventually recover.

Please acknowledge your agreement to this request by signing below and returning to the doctor's office below. I have been advised that if you do 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 by me.

_____ _____

Date Patient's Signature

The undersigned attorney 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 and below named and make payment payable directly to said doctor.

_____ _____

Date Attorney's Signature

***CHIROMEDICA***

*Chiropractic Clinic*

# POWER OF ATTORNEY TO ENDORSE CHECKS

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**KNOW ALL PEOPLE BY THESE PRESENT THAT:** the undersigned has made, constituted and appointed Chiromedica and any of its duly authorized agents and employees as and to be the undersigned's true and lawful Attorney. If fact for and in the undersigned's name, place and stead to endorse any and all checks, drafts and/or money orders which are made payable to the undersigned alone or to the undersigned and Chiromedica to pay for Chiropractic services or the like at the request or within the knowledge and approval of the undersigned and/or maker of the check, draft or money order.

The undersigned by these presents does thus give and grant unto the said office of Chiromedica the full power and authority to do and perform all and every act and thing whatsoever requisite and necessary to be done in and about the premises as fully to all intents and purposes as the undersigned might or could do to personally present insofar as the endorsing and cashing of aid check, draft or money order are concerned.

The undersigned does hereby ratify and confirm any and all actions taken by the office of Chiromedica as Attorney In Fact, in accordance with this special power of attorney and shall do or cause to be done by virtue of these presents.

**IN WITNESS WHEREOF** the undersigned have hereunto set their hands this _____ day of _____, 20_____.

_____ _____

Patient's Full Name (typed) Witness's Full Name

_____ _____

Signature of Patient Signature of Witness

## Notice of Privacy Practices for Protected Health Information
## Health Insurance Portability & Accountability Act of 1996 (HIPAA)

Due to increased awareness of the need for more strict guidelines regarding privacy of your protected health information, the Health Insurance Portability & Accountability Act of 1996 (HIPAA) was legislated, effective April 14, 2003. As part of this law, Chiromedica is required to provide you with the option of receiving a copy of this Notice. You are able to receive this Notice on paper.

**If you wish to receive a paper copy of the Notice, please sign under the Acknowledgement section below. If you decline to receive a paper copy of such Notice at this time, please sign under the Waiver section below, knowing it is available to you in the future should you wish to receive it.**

**Acknowledgement**
I, the undersigned, acknowledge with my signature that I have received a paper copy of the above mentioned Notice. I understand that it is my responsibility to read and be aware of these rights as outlined in the Notice.

Print Name: _____

Signature: _____

Date Signed: _____

# - OR -

**Waiver**
I, the undersigned, am aware of my right to receive a paper copy of the above Notice and I have declined such Notice. I am aware that this Notice is available to me from Chiromedica at any time. I understand that it is my responsibility to read and be aware of these rights as outlined in the Notice.

Print Name: _____

Signature: _____

Date Signed: _____

# CHIROMEDICA

## NOTICE OF PRIVACY PRACTICES

## Disclosure of Your Health Care Information

### Treatment
We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations.

### Payment
We may disclose your health information to our billing service and your insurance provider for the purpose of payment and/or health care operations.

### Workers' Compensation
We may disclose your health information as necessary to comply with State Workers' Compensation Laws.

### Emergencies
We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency.

### Public Health
As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

### Judicial and Administrative Proceedings
We may disclose your health information in the course of any administrative or judicial proceeding.

### Contact
We may contact you for appointment reminders
For Example:

> *"As a courtesy to our patients, it is our policy to call your home on the evening prior to your scheduled appointment to remind you of your appointment time and/or in the event that you miss your appointment we will call to re-schedule. If you are not at home, we leave a reminder message on your answering machine or with the person answering the phone. No personal health information will be disclosed during this recording or message other than the date and time of your scheduled appointment along with a request to call our office if you need to cancel or reschedule your appointment."*

### Change of Ownership
In the event that Chiromedica is sold or merged with another organization, your health information/record will become the property of the new owner.

### Your Health Information Rights

- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised that Chiromedica is not required to agree to the restriction that you requested.

- You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.

- You have the right to inspect and copy your health information.

- You have a right to request that Chiromedica amend your protected health information. Please be advised that Chiromedica is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.

- You have a right to receive an accounting of disclosures of your protected health information made by Chiromedica.

- You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

## Changes to this Notice of Privacy Practices

Chiromedica reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, Chiromedica is required by law to comply with this Notice.

Chiromedica is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information.

If you have any questions and/or complaints regarding this notice or if you want more information about your privacy rights, please contact: Angie Garza, Office Manager by calling the office at 415-567-2225. If Ms. Garza is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

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 Chiromedica 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

. ***CHIROMEDICA***

*Chiropractic Clinic*

# INFORMED CONSENT TO TREAT

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I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic Indicated below and/or other licensed doctors of chiropractic and support staff who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine and like all other health modalities, results are not guaranteed, and there is no promise of cure. I further understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests. I further understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include, but not limited to, self-administered, over-the-counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; physical therapy; steroid injections; bracing; and surgery. I understand and have been informed that I have the right to a second opinion and to secure other opinions if I have concerns as to the nature of my symptoms and treatment options.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

| **CHIROPRACTOR NAME:** |
|---|

| **PATIENT SIGNATURE:** | **DATE:** |
|---|---|

(Or Patient Guardian/Parent/Representative -- provide name and relationship if signing for patient)