Confidential Patient Information

CHIRO-INJURY & WELLNESS, LLC

NAME _____ HOME PHONE (____)_____
ADDRESS _____
(STREET) (CITY) (STATE) (ZIP)
How long at this address? _____
BIRTH DATE _____ AGE ____ MARITAL STATUS _____ NUMBER OF CHILDREN _____
SS NO _____ DRIVER'S LICENSE NO _____
EMPLOYER _____ OCCUPATION _____
ADDRESS _____ WORK PHONE _____
How long employed? _____
NAME OF SPOUSE _____ EMPLOYER _____
OCCUPATION _____ ADDRESS _____
PHONE NO (____)_____ DRIVER'S LICENSE NO _____ SS NO _____
NAME OF NEAREST RELATIVE _____ PHONE NO (____)_____
(Not living with you)
RELATIONSHIP _____
ADDRESS_____ CITY _____ STATE _____ ZIP _____
NAME OF PERSON RESPONSIBLE FOR PAYMENT: _____ PHONE (____)_____
NOTE: Clinic policy required payment arrangements to be made on the first visit.

GROUP MEDICAL INSURANCE DATE (NOT AUTO OR WORK-COMP):

INSURANCE COMPANY _____ POLICY NO _____
INSURED'S NAME _____ GROUP NO _____
ID NO _____ PHONE NO (____)_____
SPOUSES GROUP INSURANCE DATA:
INSURANCE COMPANY _____ POLICY NO _____
INSURED NAME _____ GROUP NO _____
ID NO _____ PHONE NO (____)_____
Is this visit due to an injury while on the job? _____ YES _____ NO
Is this visit due to an automobile accident? _____ YES _____ NO

ASSIGNMENT OF BENEFITS

I irrevocably assign to CHIRO-INJURY and WELLNESS, LLC, to the extent of any services rendered to me by CHIRO-INJURY and WELLNESS, LLC, the proceeds of any settlement or judgment resulting from the exercise by myself of myself of any rights of recovery I have against any person or organization legally responsible for the bodily injury for which I have been rendered treatment and/ or all rights and benefits of any insurance policy under which such services are covered.

I further authorize and direct you: (a) my insurance company which is potentially liable to me under coverage provisions of an insurance policy I hold with you. (b) an insurance company which is potentially liable to me by virtue of the acts of its insured, and/ or (c) my attorney, to pay CHIRO-INJURY and WELLNESS, LLC, directly, from any insurance benefits for which you are obligated to reimburse me, or from any settlement, judgment or verdict which I may receive against you, or my attorney may receive on my behalf.

I agree that CHIRO-INJURY and WELLNESS, LLC, be given Power of Attorney to endorse, sign my name on any and all checks for payments of my doctor's bill. I also authorize the release of any information pertinent to my case to any insurance company, adjuster or attorney involved in this case. A photocopy of this Assignment shall be considered as effective and valid as is the original.

This assignment is made in consideration of CHIRO-INJURY and WELLNESS, LLC, awaiting payment for services rendered. I understand that this in no way relieves me of my primary personal obligation to pay for such services that the signing of this form does not prohibit customary billing by you. I understand that I will be liable for any balance, which remains unpaid after application of any payment under this assignment.

Date _____ _____
Signature of Patient/Claimant

_____ _____
Witness Signature of Policyholder (If other than patient/claimant)

MEDICAL INFORMATION

CHIRO-INJURY & WELLNESS, LLC

PRESENT COMPLAINT

PLEASE CHECK ANY OF THE FOLLOWING THAT APPLY

- ☐ HEADACHE
- ☐ HEAD SEEMS TOO HEAVY
- ☐ HEAD & SHOULDERS TIRED & HEAVY
- ☐ MENTAL DULLNESS
- ☐ LOSS OF MEMORY
- ☐ EQUILIBRIUM PROBLEMS
- ☐ DIZZINESS
- ☐ FAINTING
- ☐ TREMORS
- ☐ PALPITATION
- ☐ NECK PAIN
- ☐ NECK STIFFNESS
- ☐ NECK MOTION RESTRICTED
- ☐ UPPER BACK PAIN/STIFFNESS
- ☐ MID BACK PAIN/STIFFNESS
- ☐ LOW BACK PAIN/STIFFNESS
- ☐ DIFFICULTY IN EXCESSIVE
  - ☐ STANDING
  - ☐ WALKING
  - ☐ RIDING
  - ☐ BENDING
- ☐ PAIN RADIATING INTO
  - ☐ RIGHT ARM
  - ☐ RIGHT LEG
  - ☐ BOTH
- ☐ LEFT LEG
- ☐ LEFT ARM
- ☐ BOTH
- ☐ DIFFICULTY IN EXCESSIVE
- ☐ LIFTING
  - ☐ LIGHT
  - ☐ MODERATE
  - ☐ HEAVY
  - ☐ REPETITIVE
- ☐ PAIN RADIATING INTO
  - ☐ NECK
  - ☐ BASE OF SKULL
  - ☐ SHOULDER
  - ☐ ARMS
  - ☐ HIPS
  - ☐ LEGS
- ☐ PINS & NEEDLES IN
  - ☐ ARMS
  - ☐ LEGS
- ☐ NUMBNESS IN
  - ☐ FINGERS
  - ☐ ARMS
  - ☐ LEGS
- ☐ CHEST PAIN
- ☐ SHORTNESS OF BREATH
- ☐ EYE STRAIN
- ☐ PAIN BEHIND EYES
- ☐ EYES SENSITIVE TO LIGHT
- ☐ LOSS OF FOCUS
- ☐ DOUBLE VISION
- ☐ EARS BUZZING/ RINGING
- ☐ LOSS OF TASTE
- ☐ LOSS OF SMELL
- ☐ SINUS TROUBLE
- ☐ EXTREME NERVOUSNESS
- ☐ TENSION
- ☐ IRRITABILITY
- ☐ ANXIETY
- ☐ EXTREME FATIGUE
- ☐ INSOMNIA
- ☐ NEURITIS
- ☐ FACE FLUSHED
- ☐ FACE PALE
- ☐ EXCESS PERSPIRATION
- ☐ DIGESTIVE DISORDERS
- ☐ NAUSEA VOMITING
- ☐ DIARRHEA
- ☐ CONSTIPATION
- ☐ DEPRESSION
- ☐ SWOLLEN
- ☐ FEET/HANDS COLD
- ☐ DIFFICULTY IN PROLONGED CAR RIDING

SYMPTOMS OTHER THAN ABOVE _____

_____

DID YOU REQUIRE POST-ACCIDENT HOSPITALIZATION? ☐ YES ☐ NO IF SO, WHERE? _____

HAVE YOU HAD SIMILAR ACCIDENTS OR INJURIES BEFORE? ☐ YES ☐ NO

PAST MEDICAL HISTORY

(IF ANY OF THE FOLLOWING ARE RELEVANT TO YOUR MEDICAL HISTORY, PLEASE CHECK BELOW.)

Myself	Other Family Members		Myself	Other Family Members		Myself	Other Family Member	
☐	☐	CANCER	☐	☐	MUSCULAR DYSTROPHY	☐	☐	RHEUMATIC FEVER
☐	☐	POLIO	☐	☐	MULTIPLE SCLEROSIS	☐	☐	SCARLET FEVER
☐	☐	TUBERCULOSIS	☐	☐	CONVULSIONS	☐	☐	NERVOUSNESS
☐	☐	HIGH BLOOD PRESSURE	☐	☐	EPILEPSY	☐	☐	ASTHMA
☐	☐	HEART TROUBLE	☐	☐	CONCUSSION	☐	☐	DIGESTIVE DISORDERS
☐	☐	DIABETES	☐	☐	DIZZINESS	☐	☐	SINUS TROUBLE
☐	☐	HEPATITIS	☐	☐	ARTHRITIS	☐	☐	BACKACHES
☐	☐	GERMAN MEASLES	☐	☐	NEURITIS	☐	☐	NUMBNESS
☐	☐	VENEREAL DISEASE	☐	☐	RHEUMATISM	☐	☐	ANEMIA

DESCRIBE ANY OPERATIONS YOU'VE HAD. _____

WHEN?_____

HAVE YOU BEEN TREATED BY A PHYSICIAN FOR ANY HEALTH CONDITION IN THE PAST YEAR?___ YES ___ NO

IF SO, DESCRIBE CONDITION. _____

DATE OF LAST PHYSICAL EXAM. _____ ARE YOU ALLERGIC TO ANY MEDICATION? ___ YES ___ NO

IF YES, WHAT KIND? _____

ARE YOU CURRENTLY TAKING ANY MEDICATION? ___ YES ___ NO

IF YES, WHAT KIND? _____

ARE YOU PREGNANT? ___ YES ___ NO. DATE OF LAST MENSTRUAL PERIOD. _____

PATIENT'S NAME _____ DATE _____

ACCIDENTAL INJURY REPORT - TRAFFIC ACCIDENT

Chiro-Injury & Wellness, LLC

If your clinic visit is due to an accident, please describe all events associated with it.

PATIENT'S NAME _____
(Please Print)

DATE OF ACCIDENT _____ TIME OF ACCIDENT _____

What kind of vehicles was involved in accident? Car _____ Truck _____ Motorcycle _____ Other _____

Were you a: Driver _____ Passenger _____ Pedestrian _____

If a passenger, please indicate your location in the car _____

Was the vehicle moving when the accident occurred? Yes _____ No _____ MPH _____?

Did you vehicle hit other vehicle(s)? Yes _____ No _____ Where? _____

Did other vehicle(s) hit your vehicle? Yes _____ No _____ Where _____

Was accident reported to Police Department Yes _____ No _____

Were traffic citations issued? Yes _____ No _____ To whom? _____

Describe accident including cause(s) and surrounding circumstances.

_____

_____

YOUR INSURANCE INFORMATION

INSURANCE COMPANY _____ POLICY NO _____

NAME OF CARRIER _____ PHONE NO (_____) _____

DATE YOU REPORTED ACCIDENT TO YOUR INSURANCE CARRIER _____

CLAIM NO _____

ADJUSTER'S NAME _____ PHONE NO (_____) _____

OTHER PARTIES INSURANCE INFORMATION

INSURANCE COMPANY _____ POLICY NO _____

NAME OF CARRIER _____ PHONE NO (_____) _____

DATE REPORTED ACCIDENT TO THEIR INSURANCE CARRIER _____

CLAIM NO _____

ADJUSTER'S NAME _____ PHONE NO (_____) _____

IF YOU HAVE AN ATTORNEY

PLEASE COMPLETE THE FOLLOWING INFORMATION

ATTORNEY'S NAME _____

ADDRESS _____

Street City State Zip

PHONE NO (____) _____

I do swear that the injuries I suffer from were sustained in an automobile accident on the following date ____/ ____/ ____ I authorize Chiro-Injury and Wellness, LLC or any member of the staff to treat me with whatever means deemed necessary by them for my maximum recovery. I further take full responsibility for any repercussions, either civil or criminal, should any action on my part or statement that I have made be discovered in the future to be false or deceitful.

Patient Signature _____ Date ____/ ____/ ____

PATIENT PROVIDER CONTRACT AND PROMISSORY NOTE

Entered This Day Between Chiro-Injury and Wellness, LLC. (Hereafter "Provider") and _____ (Hereinafter "Patient"). Provider hereby agrees to establish an active account for Patient and to provide essential chiropractic services for the purposes of benefiting and improving Patient's current health condition. Patient hereby agrees to pay Provider in full for services performed by Provider. Patient and Provider acknowledge that Patient retains any and all rights of suit to procure payment for any benefit Patient may be entitled. It is further acknowledged by both parties that this document does not create an express or implied assignment of benefits from any liability insurance carrier, Patient representative, or form Patient to Provider.

In Consideration Of and for Provider rendering essential chiropractic services to Patient and for the temporary suspension of any collection activity by provider by the maintenance of an active account while not receiving payment at the point of service, Patient hereby authorizes and directs the following actions be taken on Patient's behalf:

I. PATIENT AUTHORIZATIONS TO LIABILITY INSURANCE CARRIER: In consideration of the services to be rendered to Patient by Provider, that patient and provider are in privity of contract, and in lieu of provider sending direct billing to liability insurance carrier, Patient authorizes and directs liability insurance company to disclose the settlement status of Patient's claim to Provider upon request, including settlement amounts thereof. After such time that patient has settled the claim with the liability carrier, in consideration that provider has not demanded payment at the point of service. Patient directs the liability carrier to include the name of Provider on any check to Patient after Such Settlement. In the event payment is made to Patient's attorney after settlement of the claim, Patient further authorizes and directs Liability Company to issue a separate check to provider for the full amount owed for chiropractic services rendered to fully satisfy Patient's obligation to provider.

II. PATIENT AUTHORIZATIONS TO ATTORNEY, IF REPRESENTED: If Patient hired an attorney Patient acknowledges that Patient is represented by _____ Attorney-at-Law. Patient and provider stipulates that representation by the above-named attorney shall be a material element to this agreement and further in the event patient terminates the services of the above-agreement and immediately collect from Patient the full amount then owed to Provider Patient directs Attorney to disclose to Provider upon request the settlement status and amount of Patient's claim to include amount of all outstanding medical bills, dollar telephone number and place of employment known to attorney. Patient further directs attorney to honor this agreement and to deduct medical expenses from total settlement prior to contingency fee being deducted and to pay Provider for services rendered after any settlement, judgment or verdict rendered in patient's claim. Patient acknowledges and agrees to remain personally liable to Provider for any unpaid account balance to Provider.

This agreement survives this attorney client relationship and all others that may follow in reference to this claim.

III. BINDING ARBITRATION: In the event liability insurance carrier or Patient's attorney do not honor this agreement both parties agree to submit to binding arbitration prior to the issuance with any funds after settlement is reached. Both parties shall be entitled to legal representation at such hearing, with Patient's attorney the likely representative for Patient.

IV PROMISSORY NOTE: For the consideration stated above, Patient promises to pay Provider the full balance in Patient's account for services rendered to Patient. Payment shall be due an d payable within 120 days of the last date of service or within 3 (three) days of settlement with liability carrier for injuries sustained by Patient and treated by Provider, whichever event occurs first, provided agreement has not been terminated by a Party prior to these events, in which case the account balance will be due in full 3 (three) days after termination. Further, Patient agrees to the following:

IN THE EVENT PATIENTS ACCOUNT IS NOT PAID IN FULL WITHIN 120 DAYS OF THE LAST DATE OF SERVICE OR WITHIN 3 (THREE) DAYS OF SETTLEMENT WITH LIABILITY CARRIER FOR INJURIES SUSTAINED BY PATIENT AND TREATED BY PROVIDER, OR WITHIN 3 (DAYS) OF TERMINATION, WHICHEVER EVENT OCCURS FIRST, PATIENTS ACCOUNT SHALL BECOME DELINQUENT. IF PATIENT'S ACCOUNT BECOMES DELINQUENT, PATIENT AGREES TO PAY INTEREST ON THE ACCOUNT BALANCE AS OF THE LAST DATE OF SERVICE IN THE AMOUNG OF 16% (SIXTEEN PERCENT) PER YEAR. PATIENT FURTHER AGREES TO PAY ALL COURT COSTS AND TO PAY ATTORNEY FEES IN THE AMOUNT OF 15% (FIFTEEN PERCENT) OF THE PRINCIPLE AND INTEREST DUE TO PROVIDER, SHOULD COLLECTION EFFORTS BE UNDERTAKEN BY PROVIDER.

Either party may terminate this agreement at any time, provided Patient's account remains in active status. It is expressly agreed that, in the even Patient terminates this agreement, Patient shall pay the full balance of Patient's account within 3 (three) days of termination or the account shall be *in default. Patient* acknowledges that this document contains the full, final and entire agreement between the parties. There are no other terms to this agreement. Patient has read and fully understands the term of this agreement. In the event any portion of this agreement is rendered null of void, it is expressly agreed by the parties that all remaining provision shall remain in full force.

Date of Agreement: _____ _____

PATIENT SIGNATURE OR GUARDIAN IF A MINOR

_____ _____

NOTARY PUBLIC FOR PROVIDER

MY COMMISSION EXPIRES:

INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

Doctor Patient

Initials

I have been informed that it is not uncommon that patients have some increased discomfort after an adjustment. If that happens I will apply ice to the area and rest it. If I am concerned about this discomfort or develop any new symptoms I can call the number listed below during office hours for emergency attention. If I am out of town or unable to contact the doctor, I can present myself to an emergency room. If any tests were performed outside of this office (laboratory or other diagnostic procedures) I understand that the doctor will notify me of the results at my next scheduled appointment.

Doctor Patient

Initials

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures. including various modes of physical therapy and, if necessary, diagnostic x-rays, on me by the doctor of chiropractic named below and/or in this clinic authorized by the doctor of chiropractic listed below. 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 other procedures. I understand that results are not guaranteed. I further understand and am informed that, as in all health care, in the practice of chiropractic there are some very slight risks to treatment, including, but not limited to, muscle strains and sprains, disc injuries, and strokes. 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.

Doctor Patient

Initials

I have read the above consent, with the doctor, as indicated by our initials. 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 conditions for which I seek treatment.

TO BE COMPLETED BY THE PATIENT

PATIENT'S NAME _____ DATE SIGNED _____

(PRINT)

SIGNATURE OF PATIENT _____

(OR PATIENT/GUARDIAN)

_____

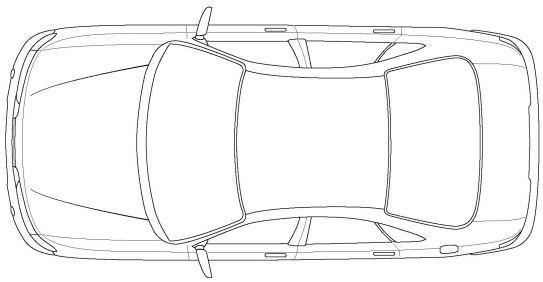
DOCTOR'S SIGNATURE

CHIRO-INJURY & WELLNESS, LLC

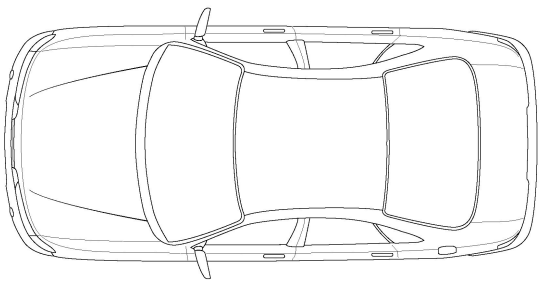
AUTO ACCIDENT DIAGRAM

Show us (X) where you were struck.

Your Car



Other Car



SHOW US WHERE IT HURTS

Please mark area(s) of injury or discomfort using the appropriate symbols.

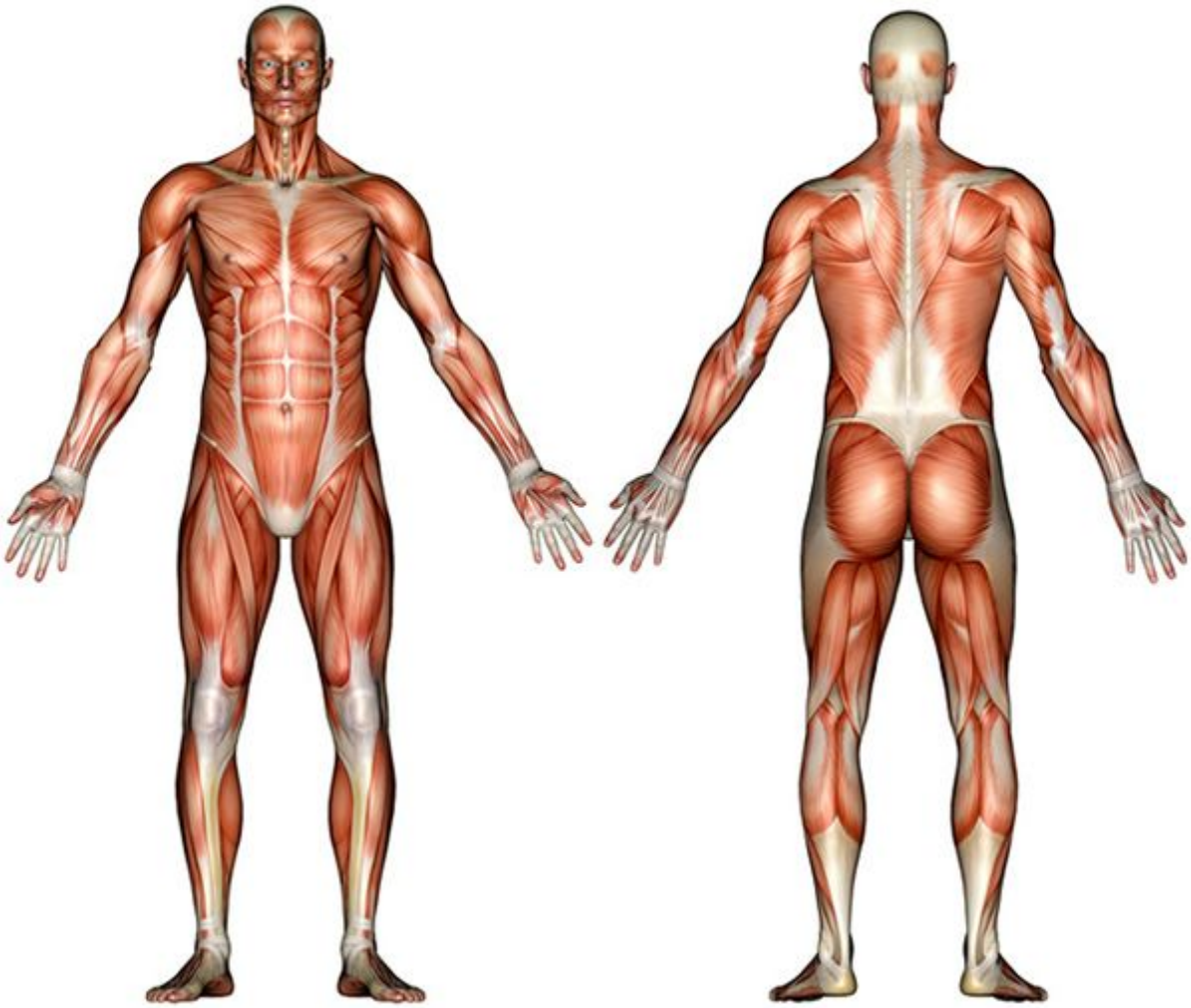
Numbness **X**

Pins & Needled **o**

Burning ●

Aching ✓

Stabbing **>**



SIGNATURE _____ DATE _____

CHIRO-INJURY & WELLNESS, LLC

Please circle "YES" or "NO" to the following questions. This will aid us in completing your medical history.

1.	Do you suffer from headaches or dizziness?	YES	NO
2.	Do you suffer from vertigo or blurred vision?	YES	NO
3.	Do you have difficulty maintaining your balance?	YES	NO
4.	Do you suffer from reduced hearing capacity?	YES	NO
5.	Do you suffer from ringing in your ears?	YES	NO
6.	Do you suffer from neck pain?	YES	NO
7.	Do you suffer with pain in your arms or hands?	YES	NO
8.	Do you have weakness, numbness or burning in either your arms or hands?	YES	NO
9.	Do your hands or arms fall asleep?	YES	NO
10.	Do you have reduced feeling (sensation) in your arms or hands?	YES	NO
11.	Do you suffer a loss of grip strength?	YES	NO
12.	Do you suffer from upper and/or mid back pain?	YES	NO
13.	Do you suffer from low back pain?	YES	NO
14.	Do you suffer with pain in your buttocks, legs or feet?	YES	NO
15.	Do your legs or feet fall asleep?	YES	NO
16.	Do you have weakness, numbness or burning in your buttocks, legs or feet?	YES	NO
17.	Do you have reduced feeling (sensation) in your buttocks, legs or feet?	YES	NO
18.	Do you have bladder or bowel control problems?	YES	NO
19.	Do you suffer from seasonal or chronic allergies or sinusitis?	YES	NO

_____ _____

Patient signature Date

CHIRO-INJURY & WELLNESS, LLC

ACKNOWLEDGEMENT

OF
RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

_____ _____

Patient Name (please print) Date

_____

Parent, Guardian pr Patient's legal representative

_____

Signature

THIS FORM WILL BE PLACED IN THE PATIENT'S CHART AND MAINTAINED FOR SIX YEARS.