PERSONAL INJURY FORM

Name_____ DOB_____ Age _____ Sex M / F
Address _____
City _____ State_____ Zip _____
Home # _____ Work # _____ SS# _____
Employer_____Position/Duties_____

YOUR AUTO INSURANCE INFO:

Your Ins. Co _____ Policy # _____ Agents name _____
Name on policy (if other than self) _____

Claim #: _____ **Name of Adjuster:** _____
Phone #: _____

INSURANCE INFO. ON VEHICLE INVOLVED IN ACCIDENT: (If accident occurred in vehicle other than your own)

Ins. Co. _____ Name of Adjuster: _____
Claim #: _____ Phone #: _____

PERSONAL HEALTH INSURANCE: (Please provide your personal insurance information)

Ins Co. _____ Phone # _____
Name on policy _____ Your Birth date: _____
Ins ID # _____

INFORMATION ABOUT YOUR ATTORNEY: (if applicable)

Name _____ Phone #_____ Fax _____
Address _____City _____ State _____ Zip _____

INFORMATION ABOUT YOUR ACCIDENT:

1. Date of accident _____ Location _____ Time of day _____
2. Name of street _____
3. Were you: ( ) Driver ( ) Passenger ( ) Front seat ( ) Back seat
4. Number of people in your vehicle? _____
5. Were you wearing seat belts? ( ) Yes ( ) No
6. What direction were you headed? ( ) North ( ) South ( ) East ( ) West
7. Direction of other vehicle? ( ) North ( ) South ( ) East ( ) West
8. Were you struck from ( ) Behind ( ) Front ( ) Left side ( ) Right side
9. Approximate speed of your car _____ mph type of vehicle _____
10. Speed of other car _____ mph type of vehicle _____
11. Were you knocked unconscious? ( ) Yes ( ) No If yes, for how long?_____
12. Were police notified? ( ) Yes ( ) No
13. Were there any witnesses? ( ) Yes ( ) No Names_____
14. Describe your body position at time of the accident _____
    _____
15. In your own words, please describe the accident _____
    _____
16. Please describe how you felt:
    a. DURING the accident: _____
    b. IMMEDIATELY AFTER the accident: _____
    c. LATER THAT DAY: _____
    d. THE NEXT DAY: _____
17. Where were you taken after your current accident? _____

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

19. Have you ever been involved in an accident before? ( ) Yes ( ) No
If yes, please describe, including date(s) and type(s) of accidents as well as injuries received:
_____

18. Have you been treated by another doctor(s) since this accident? ( ) Yes ( ) No
If yes, please give name of doctor and type of treatment received:
i. _____ ii. _____

19. Did you have any physical complaints BEFORE THE ACCIDENT? ( ) Yes ( ) No
If yes, please describe _____
_____
_____

20. What are your PRESENT complaints and symptoms? _____
_____
_____
_____

21. Since this injury occurred are your symptoms ( ) Improving ( ) Getting worse ( ) Same

22. **CHECK ALL SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT**

( ) headache	( ) irritability	( ) numbness-toes	( ) face flushed	( ) feet cold
( ) neck pain	( ) chest pain	( ) shortness breath	( ) buzzing in ears	( ) hands cold
( ) neck stiff	( ) dizziness	( ) fatigue	( ) loss of balance	( ) diarrhea
( ) sleep prob.	( ) head heavy	( ) depression	( ) fainting	( ) constipation
( ) back pain	( ) pins/needles-arms	( ) light sensitive eyes	( ) loss of smell	( ) cold sweats
( ) nervousness	( ) pins/needles-legs	( ) loss of memory	( ) loss of taste	( ) fever
( ) tension	( ) numbness-finger	( ) ears ring	( ) stomach upset	

( ) Symptoms other than above _____

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

a. Last day worked: _____
b. Type of employment: _____

24. Do you notice any activity restrictions as a result of this injury? ( ) Yes ( ) No
If yes, please describe _____
_____
_____

23. Other pertinent information:_____
_____

_____ _____
Signature of Patient **Date Signed**

HIPPA and Fee Policy

Welcome to our office. We would like to take a moment to familiarize you with how your medical history and medical bills will be handled in this office.

Health Insurance Portability and Accountability Act (HIPAA)
We are required by state and federal law to maintain the privacy of your patient file and the health protected information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information. You have the right, at any time, to review and receive a copy of our complete HIPAA notice, located at the front desk.

Massage Cancellation Policy
There is a 24 hour cancellation policy for massage therapy. Please notify Mink Chiropractic of a necessary cancellation or reschedule 24 hours prior to your scheduled massage appointment or a $25 fee will be applied to your account.

Financial Policy
We ask to keep your credit card information on file to secure your appointments, service fees and/or product purchases you may make in the future. We will clearly detail any remaining balance approximately 30 days after a date of service. **We will not charge your credit card unless an unpaid balance has gone delinquent over 30 days after a date of service.** We will never charge your card without giving you prior notice. You will always have the option of using a different payment method.

I clearly understand and agree that all services rendered me are charged directly to me and that I am personally and financially responsible for payment whether or not paid by insurance.

Initials_____
Thank you for your cooperation in this matter.

Medical Payments (Med Pay):

- ***If you were involved in an auto accident in your own vehicle***, the med pay portion of your automobile insurance policy will be billed to cover treatment charges incurred.
- ***If you were a passenger in an auto accident in another vehicle***, the med pay portion of the insured's automobile insurance policy will be billed to cover the treatment charges incurred.

3rd Party Payments:

- ***If another vehicle has caused the accident***, your automobile med pay will be billed PRIOR to submitting a claim to the insurance carrier of the party at fault--the 3rd Party.
    - If we rely on a 3rd party settlement for payment, understand that the insurance carrier will pay you directly upon settlement. By signing this form, you agree to pay your balance in full within 3 days of receiving your settlement.

It is to your advantage for our office to bill your own health insurance policy for your medical services providing your policy does not state otherwise. Any amount received above and beyond your total bill in this office will be refunded to you.

Attorney Liens: If you hire an attorney to represent you in a lawsuit, it is our policy to have your attorney sign a Doctor's Lien. This will guarantee direct payment to our office for any unpaid balance upon the settlement of your law suit. We retain the right to first submit all charges to your private health and/or auto insurance policy for payment. Further, 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 gladly submit your charges to your insurance company(ies) and/or your attorney; however, all services rendered by this office are charged directly to you, and, ultimately, you are personally responsible for payment of these charges regardless of any insurance reimbursement or settlement you may or may not receive.

I clearly understand and agree that all services rendered me are charged directly to me and that I am personally and financially responsible for payment whether or not paid by insurance.

Initials_____

I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and me. I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to the provider for services rendered.

Initials_____

Once again, we welcome you to our office and hope that this has answered any questions you might have about financial arrangements. If, at any time, you have further questions about, please do not hesitate to ask.

I have read, or have had read to me, the above statements and by signing below I agree to the above and accept their application. I intend this form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment at Mink Chiropractic.

_____
Patient's Name

_____
Name on credit card (if different)

_____ _____ _____ _____
Billing Street Address City State Zip Code

_____ _____/_____ _____
Credit Card # Exp. Date CCV #

_____ _____
Signature of Patient **Date Signed**

To be completed by patient's representative (if patient is a minor or physically incapacitated)

_____
_____
Print Name of Patient Representative Representative's Relationship to Patient

_____ _____
Signature of Patient's Representative Date Signed

NOTICE OF DOCTOR'S LIEN

Patient: _____ Date of Injury:_____

I do hereby authorize Dr. Julie A. Mink to furnish you, my attorney, with a full report of 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 for medical service rendered me both by reason of this accident and by reason of any other bills that are due to the 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 of my settlement, judgment or verdict which may be paid to you, my attorney, or myself, as the 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 the office for service rendered me and that this agreement is made solely for said doctor's additional protection and in consideration of awaiting payment. And I further understand that such payment is not contingent on 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 connection with this accident, and I instruct my attorney to do the same and to promptly deliver a copy of this lien to any such substituted or added attorney(s).

Please acknowledge this letter by signing below and returning to the doctor's office. I have been 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.

Date:_____ Patient Signature:_____

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 the lien is litigated that the prevailing party will be awarded attorney fees and costs.

Date:_____ Attorney Signature:_____

Please date, sign and return one copy to doctor's office. Also keep one copy for your records.

Thank you,

Dr. Julie A. Mink, DC
Mink Chiropractic
601 South B Street, Suite B, San Mateo, CA 94401
Office: 650-425-7723 Fax: 888-618-8535