Albert G. Simoncelli D.C., CCST
9034 W. Sahara Ave
Las Vegas, NV 89117
702-256-8686 Fax 702-256-2206

Pediatric Auto Accident History

Today's Date _____

Child's Name_____ Sex: M F Date of Birth _____ Age_____

ABOUT THE ACCIDENT

Date of Accident: _____ Time of Day: _____ A.M. / P.M.

Location of Accident: _____

Direction of Impact ( ) Front-end ( ) Rear-end ( ) Left Side ( ) Right Side ( ) Rollover

Did collision involve ( ) Another Vehicle ( ) Other Object _____

Non-Collision Injury ( ) Near-miss ( ) Spin Out ( ) Sudden Stop

Child's position in vehicle ( ) Front-right ( ) Front Left ( ) Front Center
( ) Rear Right ( ) Rear Left ( ) Rear Center

Car Seat Type ( ) Regular Seat ( ) Infant Seat ( ) Booster Seat

Was child wearing Seat Belt ( ) No ( ) Yes ( ) Lap/Sash ( ) Lap Only

At time of accident child was ( ) Facing front ( ) Facing Right ( ) Facing Left ( ) Asleep ( ) Other

Were head rest fitted? ( ) No ( ) Yes Did the air bags inflate? ( ) No ( ) Yes

Was child struck by airbag ( ) No ( ) Yes Did the child strike any object within the vehicle ( ) No ( ) Yes

Speed of your vehicle _____MPH Speed of other vehicle _____MPH

Make and Model of your vehicle _____

Make and Model of other vehicle _____

Was a police report filed ( ) No ( ) Yes

Describe the accident

_____

_____

ABOUT THE CHILD'S INJURIES

Child has no apparent symptoms ( )

Please describe any apparent symptoms _____

Do you have other concerns about your child's condition?_____

Has the child previously been examined or treated since the accident? ( ) No ( ) Yes

Name of hospital or treating doctor _____

Were X-rays taken? ( ) No ( ) Yes

Describe any treatment already received _____

Is the child's condition ( ) Getting better ( ) Getting worse ( ) Constant ( ) Intermittent

When did symptoms start? ( ) Immediately ( ) Later that day ( ) Next day ( ) Days Later

DOES THE CHILD COMPLAIN OF ANY OF THE FOLLOWING:

Pain or Soreness ( ) No ( ) Yes _____

Joint aches or Stiffness ( ) No ( ) Yes_____

Limited or painful motion ( ) No ( ) Yes_____

Headaches ( ) No ( ) Yes_____

Neck pain ( ) No ( ) Yes_____

Dizziness ( ) No ( ) Yes_____

Difficulty sleeping ( ) No ( ) Yes_____

Irritability or fatigue ( ) No ( ) Yes_____

Chest pain ( ) No ( ) Yes_____

Abdominal pain ( ) No ( ) Yes_____

Nausea ( ) No ( ) Yes_____

Back pain or stiffness ( ) No ( ) Yes_____

Leg Pain ( ) No ( ) Yes_____

Arm Pain ( ) No ( ) Yes_____

SIGNATURE OF PARENT OR GAURDIAN _____ **DATE** _____/_____/_____

RELATIONSHIP TO CHILD _____

Personal Injury /Automobile Accident Claim Information Form

Our Personal Injury / automobile Insurance Assignment Program is designed to render you immediate care and keep your out-of-pocket expenses to a minimum. As a courtesy to you, we will bill your insurance carrier on your behalf. Please remember, however, that you are ultimately responsible for payment of all services rendered to you regardless of insurance coverage or settlement status. Our office accepts Attorney Liens, Med-Pay (Your auto insurance policy), and Third Party. Most health insurance companies do not cover for automobile accident injury. We may bill your health insurance if no other coverage is available.

Attorney: We submit all records and financials to your attorney directly and will settle your claim directly with them. Patient authorizes Mountain West Chiropractic to furnish a full report and records regarding case history, examination, diagnosis, treatment and prognosis, X-rays, laboratory reports and the result of all tests to attorney on file. By signing this agreement, patient hereby instructs any attorney-representing patient to honor the lien and assignments and make payment under the lien directly to Albert G. Simoncelli, D.C. Mountain West Chiropractic.

Auto Medical Payments: "Medical Payments" or "Med-Pay" is part of your own auto insurance policy which will immediately cover the costs of your medical expenses given by a licensed health care provider and those of any passengers in your car, up to a certain limit, regardless of fault. This will allow you to get the treatment you need for your injuries without the hassle of dealing with the other party's insurance company. Med-Pay is primary for service rendered to personal injury patients when available. We will submit claims directly to your auto insurance. By signing this policy, you agree to assign your Med-pay benefits to this clinic.

Third Party: This mean the responsible party, or his or her insurance, should cover the cost of medically necessary treatment given by a licensed health care provider. Such claims are considered for payment when all treatment is complete and a settlement is reached with the third party. Upon release of care from the doctor our office will furnish you a copy of all records and financial records for you to settle directly with the third party carrier. Once you have reached a settlement payment will be made directly to you and you will then be responsible to make payment to Mountain West Chiropractic. Our office does collect fees during your treatment to help offset the cost, please ask front desk representative for a copy of third party fees.

Your Auto Insurance Policy

Name of Company: _____

Telephone # : _____

Name on Policy: _____

Claim #: _____

Claims Representative Name and Telephone #: _____

Do you have Medical Payments Benefits on your policy? ( ) Yes, Amount: $_____ ( ) No ( ) I don't know

Third Party Insurance Policy

Third Party's Name: _____

Name of Insurance Company: _____

Name on Policy: _____

Claim #: _____

Claims Representative Name and Telephone #: _____

Patient/ Guardian Signature: _____ Date____/_____/_____

Mountain West Chiropractic

Albert G. Simoncelli D. C., CCST
9034 West Sahara Ave Las Vegas, NV 89117
Office-702-256-8686 Fax-702-256-2206

Medical Lien

I, the undersigned patient (or legal guardian of a minor), grant to Mountain West Chiropractic (hereafter "medical facility") a lien upon the recovery of any and all proceeds from any source obtained through settlement, judgment, for any medical services rendered to me or the minor, for treatment of injuries sustained or the exacerbation of any medical condition(s) (hereafter "treatment") that I or the minor have indicated, believe or did in fact arise out of an incident that occurred on or about the date set forth below (hereafter "incident"). I further authorize the medical facility to furnish my attorney with a full report of the examinations, diagnoses, treatments, prognoses, as well as billings for treatment from this incident. I hereby notify and authorize you, my attorney, to pay directly to the medical facility the unpaid amount due for services rendered.

I understand that apart from this lien, I am directly and fully responsible to the medical facility for all medical bills submitted by it for services rendered, even for bills incurred for the minor (as indicated below) who may reach the age of majority, for which I may be required to make a lump sum or periodic payments, at the election of the medical facility. This lien is made solely for said medical facility's additional protection, and in consideration of its awaiting payment. Except as otherwise provided below, I intend for this lien to continue until all charges have been satisfied. I agree that the statute of limitations of my obligation to pay is tolled and does not begin to run while the medical facility is awaiting payment by way of this lien. I further understand that the payment of services is not contingent upon any settlement, judgment, or verdict that the minor or I may eventually recover.

Except as provided below, I agree never to rescind this lien, and I do not grant any attorney that may represent the minor or me the right to rescind it. However, if my first attorney does not promptly sign, acknowledge and return this lien to the medical facility within 10 (ten) days of receipt of this lien, or if the first attorney for any reason (e.g., withdraws, resigns, is released by me, or substituted by another attorney) no longer represents me or the minor child for injuries arising from this incident, then the Irrevocable Assignment of Proceeds that I have signed with this medical facility supersedes this lien and takes immediate effect. Alternatively, if an attorney modifies this lien in any way, then the Assignment of Proceeds supersedes this lien and takes immediate effect when the modification occurs. I agree to promptly notify medical facility of any change of my address or change or addition of attorney(s)

To my attorney: Please acknowledge this medical lien by signing below and returning it to the medical facility's office.

Date of Incident: _____

_____
Print Name

Date: _____

_____
Signature of Patient or Legal Guardian of Minor

I, the undersigned attorney, state that I am the attorney of record for this this patient; I acknowledge that I am in receipt of this lien; and I agree to observe its terms by withholding the sums from any settlement, judgement or verdict that are owed to the medical facility, for their compensation or benefit. I also agree to promptly (1) notify the medical facility if I discontinue representation of this patient/client, and to (2) provide any subsequent attorney of the patient for this incident a copy of this lien, along with all of the medical facility's records and billings in my or my law firm's possession.

_____
Attorney Signature

Please sign, date and return one copy to medical facility's office within 10 days after receipt. Also keep one for your record

Mountain West Chiropractic

Consent for Treatment of a Minor

I (we) being the parent(s), guardian(s) or custodian(s) of _____ a minor, the age of _____, do hereby authorize request and direct Dr. Albert G. Simoncelli, D.C. to perform in his judgement any necessary examination, x-ray, and chiropractic treatment for the condition.

_____ _____

Parent, Guardian or Custodian Dated

_____ _____

Parent, Guardian or Custodian Dated

_____

Witness

West Office
9034 W. Sahara Ave.
Las Vegas, NV 89117
Ph: 702-256-8686
Fax: 256-2206

East Office
321 N. Pecos
Suite 200
Henderson, NV 89074
Phone: 702-263-4925
Fax: 702-263-6874

Mountain West Chiropractic

Informed consent

Patient Name: _____

To the patient:

Please read this entire document prior to signing it.
It is important that you understand the information contained in this document. Please ask questions before you sign, if there is anything that is unclear.

This office typically performs a very thorough examination utilizing orthopedic and neurological testing. This at times can create some soreness the doctor is looking to elicit regions of pain within your spine or extremities. This typically is temporary.

The primary treatment used within this chiropractic office is the spinal adjustment. It entails the use of adjusting segments of the spine by hand, instrument, or by using a special table with drop mechanisms. Spinal adjustments by hand may cause an audible "pop or click" similar to the sound of popping knuckles. This occurrence is a vacuum release of carbon dioxide within the joint and has been shown to have no detrimental effect to the joint itself.

The first couple of adjustments, may cause soreness around the region. This is typically due to the increased spinal range of motion which can cause muscles to become sore. This is typically temporary. If you experience this, please bring this to the attention of the doctor.

There has been some past concern of cervical spinal manipulation leading to stroke or arterial tearing. Extensive research has shown that chiropractic patients are at no greater risk than patients seeking medical treatment without manipulation, or just within the general public. At Mountain West Chiropractic, we utilize protocols to ensure your safety.

Infrequent side effects that may occur during your treatment, can be increased pain, headaches, bruising, stiffness and muscle spasm, due to the fact that we are working in the region of your pain. Other very infrequent complications can include but are not limited to: disc injuries, dislocations, cervical myelopathy, and costovertebral strains. These typically can be resolved by additional treatment(s). Always bring this to the attention of your doctor.

Some patients that are osteoporotic can experience a rib fracture. This is also infrequent, and we do our best to be gentle to those in this population group. If you have been taking corticosteroid drugs, please inform the doctor.

As a structure based office, and along with the use of therapies to decrease pain and inflammation, we utilize various treatments, such as traction, body weighting, electrical muscle stimulation, heat, ice, low level laser, and exercises utilizing exercise balls or elastic bands. All therapies are utilized at patient tolerance.

A small percentage of patients can experience jaw pain from neck traction. It is important to notify the assistant or the doctor immediately, to seek modification of the traction or an alternative for this treatment.

Ice used over the bare skin can cause superficial burning, and therefore it is not recommended.

There are risks and dangers attendant to remaining untreated; such as the formation of adhesions and reduced mobility, which may lead to a pain reaction further reducing mobility. Over time, this process may complicate treatment, making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE. PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW

I have read [ ] or have had read to me [ ] the above explanation of the chiropractic adjustment and related treatment. I have discussed it with (insert doctor's name) and have had my questions answered to my satisfaction. By signing below, I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Dated: _____

_____
Patient's Name

_____
Signature

_____
Signature of Parent or Guardian (if a minor)

Dated: _____

_____
Doctor's Name

_____
Signature

Mountain West Chiropractic

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XRAY/RECORDS RELEASE FORM

Date: _____

I _____ am requesting that my

_____ X-rays _____ Exam/Findings

from _____ located at

_____

be released to _____.

My date of birth is: _____ and SSN: _____.

I am releasing any and all responsibilities from said Doctor, regarding these X-rays and/or exam/findings.

Patient's Signature

_____

Doctor's/Office Manager

_____

Mountain West Chiropractic
Put Your Health In Our Caring Hands

Dr. Albert G. Simoncelli, DC, PC, CCST, and Associates
9034 W. Sahara Ave.
Las Vegas, NV 89117
702-256-8686

Electronic Health Records Intake Form

This form complies with CMS EHR incentive program requirements

First Name:_____ **Last Name:**_____

Email address: _____@_____

Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail

DOB: __/__/____ **Gender (Circle one):** Male / Female **Preferred Language:** _____

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

Smoking Start Date (Optional): _____

Family Medical History ***(Record one diagnosis in your family history and the affected***				
Diagnosis (Write in below)	Father	Mother	Sibling: (_____)	Offspring: (_____)
Example: Heart Disease		*X*		

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) Native Hawaiian or Pacific Islander / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? *(Include regularly used over the counter medications)*	
Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?			
Medication Name	Reaction	Onset Date	Additional Comments

☐ **I choose to decline receipt of my clinical summary after every visit** *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

Patient Signature: _____ Date: _____

For office use only

Height: _____ Weight:_____ Blood Pressure:_____/_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, (patient's name) acknowledge that I have received, reviewed, understand and agree to the Notice of Privacy Practices of Mountain West Chiropractic, which describes the Practice's policies and procedures regarding the use and disclosure of any of my Protected Health Information created, received or maintained by the Practice.

_____ _____

Date **Signature**

_____

Print Name

FOR OFFICE USE ONLY IF NOTICE NOT PROVIDED TO PATIENT

The Practice has made a good-faith effort to obtain an acknowledgement of _____ (patient's name) receipt of our Notice of Privacy Practices. In spite of these efforts, the Practice has been unable to obtain a signed acknowledgement of receipt for the following reasons (check all that apply):

- □ **Patient Unavailable**
- □ **Patient Physically Unable**
- □ **Patient Unwilling**

In an effort to obtain the patient's acknowledgement, the Practice has attempted to provide patient with a Notice of Privacy Practices in the following manner (check all that apply):

□ **Personally** □ **Mail** □ **Phone Follow-up**

□ **Other:** _____

_____ _____

Date **Signature**

_____

Print Name of Physician

Mountain West Chiropractic
Name of Practice