Chiropractic Intake — Auto — 1

Patient Name: _____ Date: _____

PATIENT INFORMATION

Address _____

City, State, Zip _____

Phone (H) _____

Phone (C) _____

Email _____

q Male q Female Age _____ Birthday _____

q Married q Widowed q Single q Minor

q Separated q Divorced q Partnered

Employer/School _____

Occupation _____

Spouse's Name _____

Spouse's Occupation _____

IN CASE OF EMERGENCY, CONTACT

Name _____

Relationship _____

Who may we thank for referring you? _____

ACCIDENT/DRIVER(S) INFORMATION

Please give a brief description of the crash. _____

_____

_____

_____

_____

Your car insurance company: _____

Adjuster: _____ Phone: _____

Policy #: _____ Claim #: _____

Medical payments coverage amount: _____ Uninsured motorist coverage amount: _____

Third party insurance: _____

Name of other driver involved: _____

What law firm represents you? _____

Address _____ City, State, Zip _____

Your lawyer's name _____ Phone: _____

Have you had any other medical care since the crash? If so, describe. _____

Have you lost any work time since the crash? q No q Yes, on these dates _____

Your personal MD's name _____ Phone: _____

HABITS

Smoke q No q Yes ____ pk/day _____ years **Alcohol** q Never q Social q Light q Moderate q Heavy

EMPLOYMENT

Occupation/job at time of crash _____

Employer _____ q Unemployed

Occupation/job currently _____

Current employer _____ q Unemployed due to crash? q No q Yes

Type of work q Office/clerical q Light labor q Moderate labor q Heavy labor

Chiropractic Intake — Auto — 2

MEDICAL HISTORY—PRIOR TO CRASH

Surgeries (dates and residuals) _____

Fractures (dates and residuals)_____

Serious illness (dates and residuals)_____

Workers' comp. injuries (date, TX, awards, residuals) _____

Personal injuries (date, TX, awards, residuals) _____

Sports or other injuries to head, neck or back _____

Any prior episodes of current complaints _____

1. _____

2. _____

3. _____

INJURY HISTORY

Date of crash injury / injuries _____ Were you aware of the impending crash? q Yes q No

Were you the q Driver q Passenger-front q Passenger-rear **L/R**

q Motorcyle operator q Motorcycle passenger q Other _____

Name of vehicle driver _____

YOUR vehicle (year, make, model) _____

Does it have a trailer hitch? q Yes q No q Not sure

Your estimated speed at moment of crash _____ q Stopped q Slowing q Accelerating

OTHER vehicle (year, make, model) _____

Estimated speed of other vehicle at moment of crash _____ q Stopped q Slowing q Accelerating

Road conditions q Dry q Damp q Wet q Snow q Icy q Other _____

Your head restraint q None q Integral q Adjustable: up / down q Don't know

Was your seat back position altered by the crash? q Yes q No

Was the seat broken? q Yes q No

Were you wearing a lap belt? q Yes q No Shoulder belt? q Yes q No

Did air bag deploy? q Yes q No If yes, were you struck by it? q Yes q No

Body position q Straight forward q Leaning forward q Twisted q Other _____

Head position q Forward q Left _____° q Right _____° q Up _____° q Down _____°

Hands q One (q Left or q Right) on wheel q Two on wheel q Not sure q Not driving

DURING THE CRASH

Location of the crash (street, intersection, city, state) _____

_____

Damage to your vehicle q Front q Rear q Driver side q Passenger side q Roof q Other _____

Estimated damage to your vehicle: $ _____ q Not yet estimated.

Did your body strike any parts of the vehicle? q No q Yes, describe. _____

_____

Were police on scene? q No q Yes If yes, was a report made? q No q Yes

Chiropractic Intake — Auto — 3

AFTER THE CRASH

Symptoms of: q Headache q Dizziness q Nausea q Confusion / disorientation q Neck pain q Back pain

q Numbness / tingling / paresthesia(s) If yes, where? _____

q Arm and / or leg pain. If yes, where? _____

q Other symptoms? _____

Where did you go after the crash?

q Home q Work q Hospital _____ q Private doctor _____

Mode of transportation q Drove self q Other drove q Emergency transport

TREATMENT HISTORY

Prior to this office, have you been evaluated / treated for these injuries? q No q Yes (list below)

Date _____ Doctor / Provider _____

Specialty _____

Treatment _____

Date _____ Doctor / Provider _____

Specialty _____

Treatment _____

Date _____ Doctor / Provider _____

Specialty _____

Treatment _____

Date _____ Doctor / Provider _____

Specialty _____

Treatment _____

MEDICAL HISTORY — *office use only*

Request records:

q Request radiographs from _____

q Request records from _____

q Request copy of police report.

Doctor notes: _____

_____

_____

_____

_____

Signed _____ Date _____

Oswestry Low Back Pain Scale

Please rate the severity of your pain by circling a number below:

No pain | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | ***Unbearable pain***

Name _____ **Date** _____

Instructions: Please circle the **ONE NUMBER** in each section which most closely describes your problem.

Section 1 – Pain Intensity
0. The pain comes and goes and is very mild.
1. The pain is mild and does not vary much.
2. The pain comes and goes and is moderate.
3. The pain is moderate and does not vary much.
4. The pain comes and goes and is severe.
5. The pain is severe and does not vary much.

Section 2 – Personal Care (Washing, Dressing, etc.)
0. I would not have to change my way of washing or dressing in order to avoid pain.
1. I do not normally change my way of washing or dressing even though it causes some pain.
2. Washing and dressing increase the pain but I manage not to change my way of doing it.
3. Washing and dressing increase the pain and I find it necessary to change my way of doing it.
4. Because of the pain I am unable to do some washing and dressing without help.
5. Because of the pain I am unable to do any washing and dressing without help.

Section 3 – Lifting
0. I can lift heavy weights without extra pain.
1. I can lift heavy weights but it gives extra pain.
2. Pain prevents me lifting heavy weights off the floor.
3. Pain prevents me lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g., on a table.
4. Pain prevents me lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
5. I can only lift very light weights at most.

Section 4 – Walking
0. I have no pain on walking.
1. I have some pain on walking but it does not increase with distance.
2. I cannot walk more than 1 mile without increasing pain.
3. I cannot walk more than ½ mile without increasing pain.
4. I cannot walk more than ¼ mile without increasing pain.
5. I cannot walk at all without increasing pain.

Section 5 – Sitting
0. I can sit in any chair as long as I like.
1. I can sit only in my favorite chair as long as I like.
2. Pain prevents me from sitting more than 1 hour.
3. Pain prevents me from sitting more than ½ hour.
4. Pain prevents me from sitting more than 10 minutes.
5. I avoid sitting because it increases pain immediately.

Section 6 – Standing
0. I can stand as long as I want without pain.
1. I have some pain on standing but it does not increase with time.
2. I cannot stand for longer than 1 hour without increasing pain.
3. I cannot stand for longer than ½ hour without increasing pain.
4. I cannot stand for longer than 10 minutes without increasing pain.
5. I avoid standing because it increases the pain immediately.

Section 7 – Sleeping
0. I get no pain in bed.
1. I get pain in bed but it does not prevent me from sleeping well.
2. Because of pain my normal nights sleep is reduced by less than one-quarter.
3. Because of pain my normal nights sleep is reduced by less than one-half.
4. Because of pain my normal nights sleep is reduced by less than three-quarters.
5. Pain prevents me from sleeping at all.

Section 8 – Social Life
0. My social life is normal and gives me no pain.
1. My social life is normal but it increases the degree of pain.
2. Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.
3. Pain has restricted my social life and I do not go out very often.
4. Pain has restricted my social life to my home.
5. I have hardly any social life because of the pain.

Section 9 – Traveling
0. I get no pain when traveling.
1. I get some pain when traveling but none of my usual forms of travel make it any worse.
2. I get extra pain while traveling but it does not compel me to seek alternate forms of travel.
3. I get extra pain while traveling which compels to seek alternative forms of travel.
4. Pain restricts me to short necessary journeys under ½ hour.
5. Pain restricts all forms of travel.

Section 10 – Changing Degree of Pain
0. My pain is rapidly getting better.
1. My pain fluctuates but is definitely getting better.
2. My pain seems to be getting better but improvement is slow.
3. My pain is neither getting better or worse.
4. My pain is gradually worsening.
5. My pain is rapidly worsening.

TOTAL _____

The Neck Disability Index

Name: Date:

Please read instructions:

This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage everyday life. Please answer every section and mark in each section only the ONE box that applies to you. We realize that you may consider that two of the statements in any one section relate to you, but please just mark the box that most closely describes your problem.

SECTION 1-PAIN INTENSITY

- ☐ I have no pain at the moment.
- ☐ The pain is very mild at the moment.
- ☐ The pain is moderate at the moment.
- ☐ The pain is fairly severe at the moment.
- ☐ The pain is very severe at the moment.
- ☐ The pain is the worst imaginable at the moment.

SECTION 2-PERSONAL CARE (Washing, Dressing, etc.)

- ☐ I can look after myself normally, without causing extra pain.
- ☐ I can look after myself normally, but it causes extra pain.
- ☐ It is painful to look after myself and I am slow and careful.
- ☐ I need some help, but manage most of my personal care.
- ☐ I need help every day in most aspects of self care.
- ☐ I do not get dressed; I wash with difficulty and stay in bed.

SECTION 3-LIFTING

- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights, but it gives extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example, on a table.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can lift very light weights.
- ☐ I cannot lift or carry anything at all.

SECTION 4-READING

- ☐ I can read as much as I want to, with no pain in my neck.
- ☐ I can read as much as I want to, with slight pain in my neck.
- ☐ I can read as much as I want to, with moderate pain in my neck.
- ☐ I can't read as much as I want, because of moderate pain in my neck.
- ☐ I can hardly read at all, because of severe pain in my neck.
- ☐ I cannot read at all.

SECTION 5-HEADACHES

- ☐ I have no headaches at all.
- ☐ I have slight headaches that come infrequently.
- ☐ I have moderate headaches that come infrequently.
- ☐ I have moderate headaches that come frequently.
- ☐ I have severe headaches that come frequently.
- ☐ I have headaches almost all the time.

SECTION 6-CONCENTRATION

- ☐ I can concentrate fully when I want to, with no difficulty.
- ☐ I can concentrate fully when I want to, with slight difficulty.
- ☐ I have a fair degree of difficulty in concentrating when I want to.
- ☐ I have a lot of difficulty in concentrating when I want to.
- ☐ I have a great deal of difficulty in concentrating when I want to.
- ☐ I cannot concentrate at all.

SECTION 7-WORK

- ☐ I can do as much work as I want to.
- ☐ I can do my usual work, but no more.
- ☐ I can do most of my usual work, but no more.
- ☐ I cannot do my usual work.
- ☐ I can hardly do any work at all.
- ☐ I can't do any work at all.

SECTION 8-DRIVING

- ☐ I can drive my car without any neck pain.
- ☐ I can drive my car as long as I want, with slight pain in my neck.
- ☐ I can drive my car as long as I want, with moderate pain in my neck.
- ☐ I can't drive my car as long as I want, because of moderate pain in my neck.
- ☐ I can hardly drive at all, because of severe pain in my neck.
- ☐ I can't drive my car at all.

SECTION 9-SLEEPING

- ☐ I have no trouble sleeping.
- ☐ My sleep is slightly disturbed (less than 1 hr sleepless).
- ☐ My sleep is mildly disturbed (1-2 hrs sleepless).
- ☐ My sleep is moderately disturbed (2-3 hrs sleepless).
- ☐ My sleep is greatly disturbed (3-5 hrs sleepless).
- ☐ My sleep is completely disturbed (5-7 hrs sleepless).

SECTION 10-RECREATION

- ☐ I am able to engage in all my recreation activities, with no neck pain at all.
- ☐ I am able to engage in all my recreation activities, with some neck pain at all.
- ☐ I am able to engage in most, but not all, of my usual recreation activities, because of pain in my neck.
- ☐ I am able to engage in few of my recreation activities, because of pain in my neck.
- ☐ I can hardly do any recreation activities, because of pain in my neck.
- ☐ I can't do any recreation activities at all.

Instructions:

1. The NDI is scored in the same way as the Oswestry Disability Index.

2. Using this system, a score of 10-28% (i.e., 5-14 points) is considered by the authors to constitute mild disability; 30-48% is moderate; 50-68% is severe; 72% or more is complete.

PERSONAL INJURY FINANCIAL AGREEMENT

Welcome to our office. We assure you that you will receive our very best care for your injury. It's important to familiarize you with our financial policies and we would like to explain the 3 options to handle the cost of your personal injury care.

Option 1: Med Pay
Medical Payments (Med Pay) is a coverage option available with auto insurance policies that covers medical expenses for the policyholder, passengers, and family members traveling in the insured vehicle at the time of an accident. This coverage will pay up to policy limits and regardless of fault. Use of Med Pay does not affect policy premiums. We will bill the Med Pay portion of the auto insurance policy covering the vehicle you were injured in. If the Med Pay benefit is exhausted, you are responsible for payment at that point ***unless*** an attorney is representing you.

Option 2: Attorney Liens
If you have hired an attorney to represent you during your personal injury case, it is our policy to have you and your attorney sign a Chiropractic Lien. This will guarantee direct payment to our office for any unpaid balance upon the settlement of your case in exchange for delaying required payment. Please note that we retain the right to first submit and receive payment from available Med Pay coverage. The amount not covered by Med Pay will be held on the Chiropractic Lien until the case is settled. Further, this office does not discount or reduce the amount of your balance based upon the outcome of your settlement.

Option 3: Self Pay - Third Party Recovery
If you are solely relying on the "at fault" vehicles insurance to pay your medical expenses, this is termed a "Third-Party" claim. The Third-Party insurance is not obligated to pay our office directly and typically will only reimburse the claimant (you) directly for your medical expenses. Therefore, we **do not** bill Third Party insurers. In these cases, if you do not have legal representation, you will need to pay for your services (care) and be reimbursed by the at-fault third party. We will provide you with any needed records and receipts. The third party should make any appropriate payment directly to you.

Responsibility for Payment
We will gladly submit records and charges, with your approval and direction, to insurance companies and/or attorneys to help settle your case. However, understand that all services rendered by this office are charged ultimately to you. You are personally responsible for the cost of all services rendered, regardless of any insurance reimbursement or settlement you may or may not receive. Personal health insurance is not billed in personal injury claims, it is not a responsible payer in personal injury claims. We will not bill your personal health insurance.

Voluntary Termination of Care
If you suspend or terminate your care at any time, your portion of all charges for professional services provided becomes immediately due and payable to this office.

I have read and understand the above.

Patient (or Legal Guardian) Signature	Date
Patient's Name Printed	Witness

Date: _____

Patient Name: _____

Date of Accident: _____

FAMILY FIRST CHIROPRACTIC
...We Care

I do hereby authorize **Family First Chiropractic** and associated Doctors, to furnish you, my attorney, with a full report of the Doctor 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/facility such sums as may be due and owing him/them for medical services rendered me both by reason of this accident and by reason of any other bills that are due his office/facility 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/facility 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 and facility for all medical bills submitted by him/them for service rendered me and that this agreement is made solely for said doctor's/facilities additional protection and in consideration of his/their 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/facility 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/facilities interest, the doctor/facility 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 terms of the above and agrees to withhold such sums for any settlement, judgment, or verdict, as may be necessary to adequately protect Family First Chiropractic in consideration for one copy of records at no expense.

Date: _____ Attorney Signature: _____

Please date, sign and return to Family First Chiropractic.

2155 Green Vista Drive, Suite 202
Sparks, NV 89434
775-337-0184 – fax 337-2395

www.FFCWeCare.com

9476 Double R Boulevard, Suite A
Reno, NV 89521
775-284-3333 – fax 284-3395

FAMILY FIRST CHIROPRACTIC
...We Care

Electronic Health Records Intake Form

In compliance with requirements for the government EHR incentive program

First Name: _____Last Name: _____

Preferred Language: _____ D.O.B.___/____/_____ Sex: _____

Sex at Birth:_____

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked CMS requires providers to report both race and ethnicity If yes, start date:_____

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

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

☐ I choose to decline receipt of my clinical summary after every visit.

Patient Signature:_____ Date:_____

For office use only

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

Consent for Purposes of Treatment, Payment and Healthcare Operations

In this document, "I" and "my" refer to the patient, and "Chiropractor" refers to Clifford J. Fisher or Rick F.J. Swecker or Jack Nolle or Steve Perry or Rachel Whitman or Harry Heeder.

I consent to the use or disclosure of my protected health information by Chiropractor for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Chiropractor. I understand that analysis, diagnosis or treatment of me by Chiropractor may be conditioned upon my consent as evidenced by my signature below.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Chiropractor is not required to agree to the restrictions that I may request. However, if Chiropractor agrees to a restriction that I request, the restriction is binding on Chiropractor.

I have the right to revoke this consent, in writing, at any time, except to the extent that Chiropractor has taken action in reliance on this Consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I have a right to be provided with a copy of the Notice of Privacy Practices of Chiropractors and understand that I have a right to review the Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Chiropractor. The Notice of Privacy Practices for Chiropractor is available at 2155 Green Vista Drive Suite 202, Sparks, NV 89431 and at 9476 Double R Boulevard Suite A, Reno, NV 89521 and at our website at FFCwecare.com. This Notice of Privacy Practices also describes my rights and duties of the Chiropractor with respect to my protected health information.

Chiropractor reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office of Chiropractor and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment. A revised copy will also be available on our web site at RenoSparksChiro.com.

Signature of Patient or Personal Representative	Printed Name of Patient
Date of Signing	Witness

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www.FFCwecare.com

Insurance Information

Policy Holder Name: _____

Patient Name: _____ Date Today: _____

Employer: _____ Insurance ID #: _____

Health Insurance Co. _____ Policy# _____

Address _____

City, State, Zip _____

Adjuster _____ Phone _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse co-issued remittances for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. It is my understanding that my credit may be checked if Family First Chiropractic extends credit to me and I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable unless prior arrangements are made. I hereby authorize the doctors at Family First Chiropractic and whomever they may designate as their assistants to administer treatment as they so deem necessary and I also authorize the release of any information acquired in the course of my examination or treatment, I certify that the following information is true and correct.

I hereby instruct and direct _____ Insurance Company to pay by check issued to and mailed to:

- ☐ Family First Chiropractic, 2155 Green Vista Dr. #202, Sparks NV 89431
- ☐ Family First Chiropractic, 9476 Double R Blvd. Suite A, Reno, NV 89521

or if my current policy prohibits direct payment to doctor, I hereby also instruct and direct my insurance company to issue the check to me and mail it to the address as follows:

- ☐ Family First Chiropractic, 2155 Green Vista Dr. #202, Sparks NV 89431
- ☐ Family First Chiropractic, 9476 Double R Blvd. Suite A, Reno, NV 89521

for the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered.

THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

A photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case. I also authorize the request of medical records, reports and imaging which are pertinent to the delivery of my care by this office.

I authorize doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

_____ Date

_____ Witness

_____ Signature of Policyholder

_____ Signature of Claimant, if other that Policyholder

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