Elevate Chiropractic
8145 East Evans Road, Ste. 3
Scottsdale, AZ 85260
O (480) 588-5111
F (480) 588-8805
Info@elevatechiroaz.com
www.elevatechiroaz.com

# Personal Injury Questionnaire



Full Name: _____ Today's Date: _____ Date of Accident: _____

**Please write a detailed description of the accident:**

_____

_____

_____

_____

Were you: [ ] Driver [ ] Passenger [ ] Front seat [ ] Back seat

Number of people in your vehicle? _____ Were you wearing seat belts? _____

What direction were you headed? [ ] North [ ] East [ ] South [ ] West

On (name of street) _____

Were you struck from: [ ] Behind [ ] Front [ ] Left Side [ ] Right Sight

Approximate Speed of your car: _____ mph Other car: _____ mph

Were you knocked unconscious? [ ] Yes [ ] No If yes, for how long? _____

Were police notified? [ ] Yes [ ] No If yes, do you have a police report? _____

Did you have any physical complaints BEFORE the accident? [ ] Yes [ ] No

If yes, please describe in detail the nature of those complaints: _____

_____

_____

Please describe how you felt

1. DURING the accident: _____
2. IMMEDIATELY AFTER the accident: _____
3. LATER that day: _____
4. The NEXT day: _____

What are your PRESENT complaints and symptoms? _____

_____

_____

Do you have any congenital (from birth) factors which relate to this problem? [ ] Yes [ ] No

If yes, please describe: _____

_____

Do you have any previous illnesses which 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 accidents, as well as injury(ies) received: _____

_____

_____

_____

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# Personal Injury Questionnaire



Have you been treated by another doctor since the accident? [ ] Yes [ ] No

If yes, please list the facility and doctors name: _____

What type of treatment did you receive? _____

Since the injury occurred, are your symptoms: [ ] Improving [ ] Getting worse [ ] Same

**Check any symptoms you have noticed since the accident:**

| | | | | |
|---|---|---|---|---|
| [ ] Headache | [ ] Irritability | [ ] Numbness in Toes | [ ] Face Flushed | [ ] Feet Cold |
| [ ] Neck Pain | [ ] Chest Pain | [ ] Shortness of Breath | [ ] Buzzing in Ears | [ ] Hands Cold |
| [ ] Neck Stiffness | [ ] Dizziness | [ ] Fatigue | [ ] Loss of Balance | [ ] Stomach Upset |
| [ ] Sleeping Problems | [ ] Head Seems Too Heavy | [ ] Depression | [ ] Fainting | [ ] Constipation |
| [ ] Back Pain | [ ] Pins & Needles in Arms | [ ] Lights Bother Eyes | [ ] Loss of Smell | [ ] Cold Sweats |
| [ ] Nervousness | [ ] Pins & Needles in Legs | [ ] Loss of Memory | [ ] Loss of Taste | [ ] Fever |
| [ ] Tension | [ ] Numbness in Fingers | [ ] Ears Ring | [ ] Diarrhea | [ ] _____ |

**Do you notice any activity restrictions as a result of this injury?** [ ] Yes [ ] No

If yes, please describe: _____

_____

Is there any other pertinent information you would like to add? [ ] Yes [ ] No

If yes, please explain: _____

**Patient Auto Insurance:**

Company Name: _____ Company Address: _____

Company Phone #: _____ Policy #: _____

Adjuster's Name: _____ Adjusters Phone #: _____

Claim #: _____

**3rd Party Information:**

Responsible Party's Name: _____

Responsible Party's Address: _____

Auto Ins Company Name: _____ Auto Ins Company Address: _____

Auto Ins Company Phone #: _____ Policy #: _____

Adjuster's Name: _____ Adjusters Phone #: _____

Claim #: _____

**General Health Insurance:**

Ins Co: _____ Subscriber: _____ ID/Group#: _____

**Do you have an attorney involved in this case?** [ ] Yes [ ] No

If so, Attorneys Name: _____ Phone #: _____

**Patient Signature:** _____ **Date:** _____

# ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO DOCTOR
## PRIVATE AND GROUP ACCIDENT AND HEALTH INSURANCE

Re:_____

Patient:_____

Claim/Group #:_____

Insured SS#/ID#_____

I hereby instruct and direct the payment of all professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy to:

**Elevate Chiropractic**
**8145 East Evans Road**
**Suite# 3**
**Scottsdale, AZ 85260**

as payment for 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.

If my current policy prohibits direct payment to doctor, then I hereby also instruct and direct you to make out the check to me and mail it as follows:

**Elevate Chiropractic**
**8145 East Evans Road**
**Suite# 3**
**Scottsdale, AZ 85260**

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.

Dated at _____ this _____ day of _____,_____

_____ _____

Insured Witness

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# DOCTOR'S LIEN

To: _____
_____
_____

Elevate Chiropractic
8145 East Evans Road
Suite# 3
Scottsdale, AZ 85260
(480) 588-5111

Re: Medical Reports and Doctor's Lien

I do hereby authorize the above doctor to furnish you with a report of his examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I was involved.

I hereby authorize and direct you to pay directly to said doctor such sums as may be due and owing him for medical services rendered me both by reason of this accident and by reason of any other bills that are due his office and to withhold such sums from settlement, judgment, or verdict as may be necessary to adequately protect said doctor. And I hereby further give a lien on my case to said doctor against any and all proceeds of any settlement, judgment, or verdict which may be paid to you or myself as the result of the injuries for which I have been treated or injuries in connection herewith.

I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by him for service rendered to me and that this agreement is made solely for said doctor's additional protection and in consideration of his 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.

Dated: _____ Patient's Signature: _____

The undersigned 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 said doctor above named.

This lien does not constitute a request or agreement between the parties for the attorney or law firm to act as a collection agency for the above-named doctor/doctor's office.

Dated: _____ Attorney's Signature: _____

**Elevate Chiropractic**
**8145 East Evans Road**
**Suite# 3**
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For: _____

Claim Number: _____Date of Loss:_____

PLEASE COMPLETE, SIGN AND RETURN THIS FORM AS SOON AS POSSIBLE TO:

**Elevate Chiropractic**
**8145 East Evans Road**
**Suite# 3**
**Scottsdale, AZ 85260**

## MEDICAL AUTHORIZATION FORM

To: Hospital/Doctor Concerned:

Please furnish the bearer with copies of your records, together with any additional information known to you, relative to the diagnosis, treatment and prognosis of my condition, also advise the amount of your bills to date, as well as the probable amount of the final bill for services rendered to and for me, such as the bearer may desire. A photocopy of this authorization shall be considered as effective and valid as the original.

DATE: _____

SIGNATURE:_____

ADDRESS:_____

_____

S.S.#: _____ DATE OF BIRTH:_____

PLEASE IDENTIFY THE NAME, ADDRESS AND THE PHONE NUMBER OF TREATING PHYSICIAN AND/OR FACILITY IN THE SPACE BELOW

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CHIROPRACTIC

# INFORMED CONSENT

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, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future work at the clinic or office listed below or any other office or clinic.

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 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 upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

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) f)or which I seek treatment.

Patient Signature_____ Date _____

Witness Signature _____ Date_____

Elevate
CHIROPRACTIC

Dr. Thomas V. Tuzzolino, D.C., F.I.A.M.A.

# Terms of Acceptance

When a patient seeks chiropractic healthcare and we accept a patient for such care, it is essential for both to be working toward the same objective.

It is important that each patient understand both the objective and the method that will be used to attain improved spinal health. This will prevent any confusion or disappointment.

**Adjustment:** An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxations. Our chiropractic method of correction is by specific, gentle, manual adjustments of the spine. Is some cases an adjusting instrument (an activator) will be used at the discretion of the doctor.

**Health:** A state of optimal physical, mental, and social well-being, not merely the absence of symptoms.

**Vertebral Subluxation:** A misalignment of one or more of the twenty-four vertebra in the spinal column which can cause alteration of nerve function and transmission of nerve impulses resulting in a lessening of the body's ability to perform at it's optimal potential.

We only offer to diagnose either vertebral subluxations or neural-musculoskeletal conditions of the body, however, if during the course of the chiropractic spinal examination we encounter non-chiropractic or unusual findings, we will advise you. We have a list of other professional health care providers for referral purposes if indicated.

I, _____ have read and fully understand the above statements. All questions regarding the doctors' objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis, and understand that all charges incurred are my responsibility.

_____ _____

(patient signature) (date)

****Consent to evaluate and adjust a minor child:**

I, _____ being the parent/legal guardian of _____ have fully read and understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care from Dr. Thomas V. Tuzzolino, D.C., F.I.A.M.A.

_____ _____

(authorized signature) (date)

****Pregnancy Release:**

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his associates have my permission to perform, if needed, an x-ray evaluation. I have been advised that x-rays can be hazardous to an unborn child. *Date of last menstrual period:* _____

_____ _____

(patient signature) (date)

# MEDICAL PAY

## Your car insurance company will only release this information to you, the policy holder. Please call **YOUR** car insurance provider to obtain this information.

Do you have medical pay? YES NO

Is **YOUR** medical pay primary or secondary?_____

If so how much? $1,000 $2,000 $5,000 $10,000

Do you have uninsured motorists policy on your insurance? Yes No

If so what is the limit?_____

PATIENT NAME_____

NAME OF **YOUR** INSURANCE COMPANY_____

YOUR CLAIM #_____

NAME OF PERSON HANDLING YOUR CLAIM_____

HIS/HER TELEPHONE NUMBER_____

DATE OF INJURY_____

*Using your medical pay will **NOT** raise your car insurance rates*