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Whom may we thank for referring you to this office → _____?

MOTOR VEHICLE ACCIDENT APPLICATION FOR CARE AT FREEDOM CHIROPRACTIC

Today's Date: _____

Date of Accident: _____

Patient Demographics

Name _____ Birth Date_____-_____-_____ Age _____ ❑ Male ❑ Female

Address _____ City _____ State_____ Zip_____

E-mail Address _____ Home Phone _____ Cell:_____

Marital Status: ❑ Single ❑ Married Do you have Insurance: ❑ Yes ❑ No Work Phone: _____

Social Security # _____ Driver's License # _____

Employer_____ Occupation_____

Spouse's Name _____ Spouse's Employer _____

Number of children and Ages _____

Name & Number of Emergency Contact _____Relationship _____

INSURANCE INFORMATION

Do you have a Medpay rider on your auto insurance policy? (Y / N) If yes, please list limits _____

If yes to Medpay, please list:

Insurance Company_____ Address_____

Phone #_____

Fax #_____ Email_____

Adjuster's Name_____

Adjuster's Billing Address_____ Adjuster's Phone #_____

Fax #_____ Email _____

Claim Number _____

Although we are billing your Medpay, please complete the information for the at fault party's insurance:

Other Party's Insurance Company_____Address_____

Phone #_____ Fax #_____ Email_____

Adjuster's Name_____

Adjuster's Billing Address _____

Adjuster's Phone #_____ Fax #_____

Email _____

Claim Number _____

*Important: This form may be used in the determination of insurance benefits and/or litigation for compensation. It is imperative that this form be filled out completely to protect your rights of compensation.

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Please CIRCLE Correct Responses:

1. Were you the? Driver Front Passenger Back Passenger
2. Were you wearing?
   - Seat Belt with shoulder harness
   - Seat Belt without shoulder harness
   - No seat belt

   2A. Did airbag deploy? YES NO N/A
3. What type of vehicle were you in? _____
4. What type of vehicle was the other driver in? _____
5. How fast were you going at time of impact? _____
6. How fast was the other car going? _____
7. What type of accident did you have? Head-on Rear-ended Broadsided

   Please explain and/or draw a diagram: _____

   _____

   _____

   _____

   _____

   7a. Were you ejected from the car? YES NO
8. How much damage was done to your car?
   1. Totaled
   2. Less than $1,000
   3. Less than $500
   4. None
9. Did you hit your head? YES NO

   If so, on what? _____
10. Did you lose consciousness? YES NO

    If so, how long? _____

    a) When do you remember waking up?

    _____

    _____
11. Were you thrown around inside of the vehicle? YES NO
12. Did you have “whiplash” injury to your neck? YES NO
13. Did you hit your arms, legs, back, face against any object inside the car? YES NO

    If YES, please explain:

    _____

    _____

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14. Did you have any cuts and/or bruises? YES NO

If YES, please explain: _____

_____

15. Were you able to walk at the scene of the accident? YES NO

16. Did you go to the hospital? YES NO

a) If so, when? _____

b) Where? _____

c) How did you get there?

Ambulance Drove myself _____ Drove me

d) Were you kept overnight? YES NO

If yes, how many nights? _____

17. If you didn't go to the hospital, when did you first seek medical attention?

_____

_____

a) By whom? Emergency room DR Family DR Chiropractor

Other:_____

18. Were X-Rays originally taken? YES NO

If so, what areas were X-rayed? Please List:

_____

_____

19. Was anyone else in your car? YES NO

a) Were they injured? YES NO

If yes, please explain:

_____

_____

b) Was anyone in the **other** vehicle seriously injured? YES NO

If yes, please explain:

_____

_____

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20. What were your **ORIGINAL SYMPTOMS** at the time of accident? (You may circle more then one answer.)

1. Headaches	10. Facial Cuts
2. Dizziness	11. Facial Bruising
3. Neck Pain	12. Knee Pain
4. Neck and Arm Pain	13. Loss of Consciousness
5. Low Back Pain	14. Jaw Pain
6. Low Back and Leg Pain	15. Facial Pain
7. Bleeding	16. Numbness: Where_____
8. Light Bothers Eyes	17. Pins and Needles: Where:_____
9. Shortness of breath	18. Other Symptoms (Please List) :_____

21. What are you **SYMPTOMS NOW**? Please order them from ***WORST*** to least:

ON A SCALE OF 0-10 (10=WORST) ***PLEASE CIRCLE*** **SYMPTOMS** (caused by or intensified by accident)

	BEFORE THE ACCIDENT:	**NOW (BECAUSE OF ACCIDENT):**
1. _____	0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10	0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
2. _____	0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10	0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
3. _____	0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10	0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
4. _____	0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10	0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
5. _____	0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10	0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
6. _____	0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10	0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
7. _____	0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10	0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
8. _____	0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10	0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
9. _____	0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10	0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
10. _____	0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10	0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

22. Have you ever had any of these symptoms prior to the accident? YES NO

If YES, please explain:

_____

_____

_____

23. Since this accident have you had:

1. Another MVA YES NO
2. Work related injury YES NO
3. Sports related injury YES NO
4. Any new trauma of any kind YES NO
   a) Did this make your symptoms worse? YES NO
   b) If yes, please explain: _____

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24. How long after your accident did it take for you to return to work?

1. Didn't miss any work
2. One day
3. 2-3 days
4. 1 week
5. 2-3 weeks
6. 1 month
7. 2-3 months
8. 4-5 months
9. 6 months
10. 7-12 months
11. Haven't returned to work
12. Wasn't working at the time of accident
13. Working in the home as a "house person"

25. Did you return to the same job? YES NO

If NO, please explain:

_____

_____

26. You are now working:

1. Not at all
2. Full time, no restrictions
3. Full time, limited duty
4. Part time, no restrictions: _____ hrs/week
5. Part time, limited duty: _____ hrs/week

27. Are there any other factors associated with this accident that you feel have something to do with your current medical condition? YES NO

If YES, please explain:

_____

_____

28. Is there a lawsuit pending as a result of this accident? YES NO

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FREEDOM CHIROPRACTIC POLICIES & CONSENT TO CARE (Page 1)

WELCOME. We are honored to be part of your journey to better health. Please read these policies and consent carefully. We feel it is important that you understand our office policies regarding how patients of this practice are cared for, and the various methods we offer to facilitate payment for that care. If you have questions or anything is unclear, please let a member of our staff know before submitting your ***Application for Care***. It is in everyone's best interest that your decision as to whether you wish to become a patient is informed.

Over time, individuals who are accepted, as patients at this office, gain a greater understanding as to the purpose of chiropractic. Since the majority of patient care occurs in an open bay area, patients have a unique opportunity to observe firsthand the positive results that are achieved and the benefits derived from being under chiropractic care. This knowledge and awareness reaps a positive environment that promotes healing and encourages families to maintain good health. We want your experience with us to be an exceptional one, so help us to help you and together we can make affirmative changes in your life and the lives of those you care about.

FIRST THINGS FIRST: Prior to receiving chiropractic care at this office, a health history and examination will be completed. Imaging studies as well as any other necessary diagnostics may also be ordered, to confirm the true nature of your condition and exact location of subluxations. The results of these procedures will aid in assessing your presenting problem, your overall health and, in particular, the condition of your spine. They will also assist the doctor in determining the type and amount of care you will need. All relevant findings will be reported to you along with care plan recommendations so that you can make the best possible decision regarding your health care needs. Our gold standard for care is to ensure the reduction of subluxation while teaching patients what they need to do in addition to being adjusted to maintain their health for a lifetime.

CHIROPRACTIC CARE: When a patient seeks chiropractic care, it is essential that the patient and doctor are working toward the same objective. Chiropractic is a branch of the healing arts distinct from other branches (e.g. osteopathic or allopathic). Doctors of chiropractic view health as a continuum from optimal health, to hidden imbalances, to disease. Rather than treating disease, chiropractic aims to improve health by eliminating underlying imbalances that interfere with the body's functioning. Such imbalances include subluxation, a major interference to the expression of the body's innate wisdom. Our doctors use specific spinal correction and musculoskeletal techniques to help eliminate subluxation. We also use diagnostic testing and nutritional remedial measures to help achieve homeostasis - a dynamic equilibrium, in which the body continuously changes to maintain optimal internal stability in response to external conditions. As doctors of chiropractic, we do not prescribe drugs or perform surgery and all changes to prescription medications must be made by your prescribing provider. We may, however, recommend homeopathic and botanical medicines, vitamins, minerals, phytonutrients, antioxidants, enzymes, glandular extracts, non-prescription drugs, and medical goods and devices. Although we may screen for the prevention and early detection of cancer, doctors of chiropractic do not treat cancer. We may, however, work with patients who have cancer in conjunction with, but not replacing, drugs, surgery, or chemotherapy. It is important that you understand both the objective and the method(s) so there is no confusion or disappointment. Tremendous progress has been made in the rehabilitating and correction of spinal problems. Where in the past, chronic spinal structural problems could not be reversed or corrected, today they can. Your doctor will outline a course of treatment that will take you beyond simple pain relief, through two distinct phases of care to make a structural correction to your spine that will enable your central nervous system to function optimally, thereby improving you overall health.

RISKS: Chiropractic adjustment involves some risk including, without limit, fractures, disc injury, sprains, dislocation, and vascular injuries/stroke. Hidden conditions, such as tumors and vascular disorders, may increase this risk. Although the nutritional remedial measures we recommend are generally considered safe, they involve some risk including, without limit, changes in blood sugar, allergic reaction, and gastrointestinal upset. They may also may be inappropriate during pregnancy, toxic in large doses, and may interact with certain drugs. You agree to consult with your prescribing physician/provider about any prescription drugs you are taking and the impact of supplements, vitamins, minerals, food grade herbs, and other nutrients on such drugs. You also agree to immediately report suspected pregnancy or any potential interactions to us and your prescribing providers.

ALTERNATIVES: I understand that the alternatives include doing nothing and/or relying solely on care from providers in other branches of the healing arts. We always encourage you to communicate with your other health providers about your care.

NO GUARANTEE: Every individual responds to care differently and no guarantee or assurance is made as to the results of care in any specific case, as care may not improve your condition.

PAYMENT, INSURANCE, AND REFUNDS: Payment for services is not conditional on response to care. There is no guarantee of insurance coverage. Any insurance you have is an agreement between you and your insurance carrier and you are responsible for payment of services, whether or not they are covered by insurance. Prorated fees for unused, prepaid services will be refunded if you wish to cancel; however, no refunds are available for products purchased or services rendered.

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FREEDOM CHIROPRACTIC POLICIES & CONSENT TO CARE (Page 2)

PATIENT PRIVACY: The majority of care takes place in an open bay area. Accordingly, conversations you have with the doctor may be overheard by others. To maintain privacy, if you have a confidential matter you wish to discuss please let us know and we will schedule time for you to speak to the doctor in a private consultation room. These consultations must be scheduled in advance.

REPORT OF FINDINGS: To enhance understanding of our approach, you will be scheduled for a "Report of Findings" following your first appointment. Attendance is required for individuals who wish to become patients of this practice. Because the results of your examinations and care recommendations will be discussed at that time, we strongly urge you to invite your spouse or a significant other to attend. We know that when a patient's family understands the goals of care and how restoring and maintaining health can affect their lives as well, they become supportive in making important treatment decisions.

QUESTIONS AND ANSWERS: I have read and fully understand this consent, and understand that I should not sign this form if any of my questions have not been explained to my satisfaction or if I do not understand any of the terms or words. Knowing the risks of chiropractic care, I consent to chiropractic care and recommendations.

EMAILS: I understand that by providing my email address, I authorize Freedom Chiropractic to send me emails.

DO NOT SIGN UNLESS YOU HAVE READ AND FULLY UNDERSTAND!
Patient or Person with Authority to Consent Date

I hereby acknowledge receiving a copy of the practices 'Office Policies' a two page document, the first page of which I have read and retained. This second page is recognized by me as the signature page and will be retained by the practice as evidence of my receiving and understanding this 'Notice'. I further acknowledge that any concerns regarding these 'Policies 'as well as all my questions have been answered by a qualified member of the staff to my complete satisfaction.

_____ _____

Patient's Name (Print) DOB

_____ _____

Patient signature Date

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FREEDOM CHIROPRACTIC NOTICE OF PRIVACY PRACTICE (Page 1)
This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your Personal Health Information. In addition we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as dictated by our office policy, we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. In addition, you will find we have placed several copies in report folders labeled 'HIPAA' on tables in the reception. Once you have read this notice, please sign the last page, and return only the signature page (page 2) to our front desk receptionist. Keep this page for your records.

PERMITTED DISCLOSURES: 1. Treatment purposes- discussion with other health care providers involved in your care 2. Inadvertent disclosures- open treating area mean open discussion. If you need to speak privately to the doctor, please let our staff know so we can place you in a private consultation room. 3. For payment purposes - to obtain payment from your insurance company or any other collateral source. 4. For workers compensation purposes- to process a claim or aid in investigation 5. Emergency- in the event of a medical emergency we may notify a family member 6. For Public health and safety - in order to prevent or lessen a serious or eminent threat to the health or safety of a person or general public. 7. To Government agencies or Law enforcement – to identify or locate a suspect, fugitive, material witness or missing person. 8. For military, national security, prisoner and government benefits purposes. 9. Deceased persons –discussion with coroners and medical examiners in the event of a patient's death. 10. Telephone calls or emails and appointment reminders -we may call your home and leave messages regarding a missed appointment or apprize you of changes in practice hours or upcoming events. 11. Change of ownership- in the event this practice is sold, the new owners would have access to your PHI.

YOUR RIGHTS: 1. To receive an accounting of disclosures 2. To receive a paper copy of the comprehensive "Detail" Privacy Notice 3. To request mailings to an address different than residence 4. To request Restrictions on certain uses and disclosures and with whom we release information to, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction. 5. To inspect your records and receive one copy of your records at no charge, with notice in advance 6. To request amendments to information. However, like restrictions, we are not required to agree to them. 7. To obtain one copy of your records at no charge, when timely notice is provided (72 hours). X-rays are original records and you are therefore not entitled to them. If you would like us to outsource them to an imaging center, to have copies made, we will be happy to accommodate you. However, you will be responsible for this cost.

COMPLAINTS: If you wish to make a formal complaint about how we handle your health information, please call Dr.Jason Cahill,DC at (719) 533- 0303. If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to:

DHHS, Office of Civil Rights 200 Independence Ave. SW Room 509F HHH Building Washington DC 20201

Patient initials:* _____*-retaining page 1 of 2

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Freedom Chiropractic's NOTICE REGARDING YOUR RIGHT TO PRIVACY (Page 2)

I have received a copy of Freedom Chiropractic's Patient Privacy Notice. I understand my rights as well as the practices duty to protect my health information, and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this 'Notice of Privacy Practice" at a time in the future and will make the new provisions effective for all information that it maintains past and present.

I am aware that a more comprehensive version of this "Notice" is available to me and several copies kept in the reception area. At this time, I do not have any questions regarding my rights or any of the information I have received.

_____ _____

Patient's Name (Print) DOB

_____ _____

Patient signature Date

Freedom Chiropractic is committed to insuring the privacy and confidentiality for your medical records. We comply with the Health Insurance Portability and Accessibility Act of 1996 (HIPAA).

To whom may we speak with other than yourself regarding your medical care? (If more than one, please list all)

□ Spouse □ Child □ Sibling □ Care Giver □ Friend □ Other Name:

_____

□ Spouse □ Child □ Sibling □ Care Giver □ Friend □ Other Name:

_____

□ Spouse □ Child □ Sibling □ Care Giver □ Friend □ Other Name:

_____

May we leave a voicemail on your primary phone number? □ Yes □ No

May we leave a voicemail on your work phone number? □ Yes □ No

May we leave a voicemail on your alternate phone number? □ Yes □ No

May we mail medical information to your home? □ Yes □ No

I have been made aware of the privacy policies of Freedom Chiropractic, and have received (or made available to me) a copy of the Notice of Privacy Practices of Freedom Chiropractic.

_____ _____

Patient signature Date