Chiropractic Wellness Center
It's more than feeling better... it's being healthier.

MVA Welcome Packet

Patient Information

Name: _____
Last First MI Prefer to be called

Phone: _____ Email address: _____
Cell Work

Mailing Address: _____ City: _____ State: _____ Zip: _____

Whom may we thank for referring you? _____

How would you like to receive appointment reminders? ☐ Phone ☐ Email ☐ Text

If choosing "Text" please tell us you Phone Provider (Verizon, AT&T, etc.): _____

May we send you our e-newsletter to inform you of special offers and health information? ☐ Yes ☐ No

Date of Birth: _____ Sex: ☐ Male ☐ Female Age: _____ SS#: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Minor

Occupation: _____ Employer: _____

Employer Address: _____ Phone: _____

Emergency contact: _____ Relation: _____ Phone: _____

Insurance *(Let us make a copy of your insurance card and you can skip this section)*

Company Name: _____ Phone: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Insured's Name: _____ ID #: _____ Group #: _____

Insured is: ☐ Self ☐ Other *(relationship)*: _____

Insured's D.O.B.: _____ Insured's Employer: _____

Account Information *(Person ultimately responsible for account)* ☐ **Check here if you are responsible**

Name: _____
Last First MI

Phone: _____ Email address: _____
Cell Work

Mailing Address: _____ City: _____ State: _____ Zip: _____

Health History

What is your current weight: _____ lbs., and height: _____ ft. _____ in.

Who is your primary care physician? (doctor and/or practice) _____

Do you exercise: ☐ Frequently ☐ Moderately ☐ Occasionally ☐ None

Do your work activities mostly involve: ☐ Sitting ☐ Standing ☐ Light Labor ☐ Heavy Labor

Do you sleep on your: ☐ Back ☐ Side ☐ Stomach Do you use a cervical pillow? ☐ Yes ☐ No

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Please check to indicate if you are currently experiencing any of the following conditions:

☐ Neck Pain/Stiffness	☐ Pins/Needles in Arms	☐ Light Bothers Eyes	☐ Sudden Weight Loss	☐ Nausea
☐ Back Pain/Stiffness	☐ Pins/Needles in Legs	☐ Depression	☐ Loss of Taste	☐ Cold Feet
☐ Arm/Hand Pain	☐ Fatigue	☐ Nervousness	☐ Loss of Memory	☐ Chest Pain
☐ Leg/Knee Pain	☐ Sleeping Difficulties	☐ Tension	☐ Jaw Problems	☐ Fever
☐ Headaches	☐ Loss of Smell	☐ Cold Sweats	☐ Constipation	☐ Fainting
☐ Dizziness	☐ Allergies	☐ Stomach Problems	☐ Shortness of Breath	
☐ Asthma	☐ Blurred Vision	☐ Night Pain	☐ Bowel/Bladder Changes	

Please check to indicate if you have ever had any of the following:

☐ Aids/HIV	☐ Cancer	☐ Hepatitis	☐ Osteoporosis	☐ Scarlet Fever
☐ Alcoholism	☐ Cataracts	☐ Hernia	☐ Pacemaker	☐ Stroke
☐ Allergy Shots	☐ Chemical Dependency	☐ Herniated Disc	☐ Parkinson's Disease	☐ Suicide Attempt
☐ Anemia	☐ Chicken Pox	☐ Herpes	☐ Pinched Nerve	☐ Thyroid Problems
☐ Anorexia	☐ Diabetes	☐ High Cholesterol	☐ Pneumonia	☐ Tonsillitis
☐ Appendicitis	☐ Emphysema	☐ Kidney Disease	☐ Polio	☐ Tuberculosis
☐ Arthritis	☐ Epilepsy	☐ Liver Disease	☐ Prostate Problems	☐ Tumors/Growths
☐ Asthma	☐ Fractures	☐ Measles	☐ Prosthesis	☐ Typhoid Fever
☐ Bleeding Disorders	☐ Glaucoma	☐ Migraines	☐ Psychiatric Care	☐ Ulcers
☐ Breast Lump	☐ Goiter	☐ Miscarriage	☐ Rheumatoid Arthritis	☐ Bronchitis
☐ Gonorrhea	☐ Mononucleosis	☐ Rheumatic Fever	☐ Venereal Disease	☐ Bulimia
☐ Gout	☐ Multiple Sclerosis	☐ Whooping Cough	☐ Heart Disease	☐ Mumps
☐ Severe allergy to chicken		☐ Other _____		

Are you currently under drug and/or medical care? ☐ Yes ☐ No If yes, explain _____

List Medications/Supplements Below:

Name	Dosage	Frequency	Reason for medication
1.			
2.			
3.			

Please list any surgeries and/or hospitalizations you have had (type & date):

1._____
2._____
3._____

Allergies? (circle) If so, please list below:

Drug Allergies	Food Allergies	Seasonal Allergies
1.		
2.		
3.		

What is your intake of: Caffeine _____ cups/day Alcohol _____ drinks/week Cigarettes _____ packs/day

About Your Accident

Time and Date of Accident: _____ am / pm _____ / _____ / _____

Where were you seated? ☐ Driver ☐ Front passenger ☐ Rear passenger

Did your vehicle impact another vehicle or structure? ☐ Yes ☐ No

Did any part of your body strike anything in the car? ☐ Yes ☐ No, Describe: _____

Your Vehicle Information

What is the make and model of the vehicle you were driving? _____

Name of the street/intersection you were traveling on? _____

In what direction were you heading? ☐ North ☐ South ☐ East ☐ West

What was your approximate speed? _____ m.p.h.

Other Vehicle Information

What is the make and model of the other vehicle? _____

Name of the street/intersection the other vehicle was traveling on? _____

In what direction was the other vehicle heading? ☐ North ☐ South ☐ East ☐ West

What was their approximate speed? _____ m.p.h.

What direction did the impact to your vehicle come from? ☐ Front ☐ Rear ☐ Right ☐ Left ☐ Other

Was a Police Report Filed? ☐ Yes ☐ No (If no, skip this section)

Did police come to the scene? ☐ Yes ☐ No

Ticket was issued to: ☐ You ☐ Other Driver ☐ No One

Auto Safety Devices

Seat belt was: ☐ On ☐ Off

Headrest was: ☐ Above ☐ Below ☐ At base of skull

Does your vehicle have airbags? ☐ Yes ☐ No

Did it/they inflate? ☐ Yes ☐ No

After Your Accident

Any loss of consciousness during the accident? ☐ Yes ☐ No, if yes, how long? _____

Please describe how you felt immediately after the accident: _____

Have you gone to a Hospital or seen any other Doctors? ☐ Yes ☐ No (If no, skip this section)

When did you go? ☐ Just after the accident ☐ Next day ☐ 2 or more days later

How did you get there? ☐ Ambulance ☐ Private transportation

Was he/she a: ☐ MD ☐ DO ☐ DC ☐ Other

Did you receive any of the following treatments/diagnostic testing? ☐ Yes ☐ No If Yes, any of the following?

☐ X-Ray ☐ MRI ☐ Physical Therapy ☐ CT Scan ☐ Medication

What symptoms are you experiencing as a result of this accident?

☐ Dizziness	☐ Difficulty sleeping	☐ Jaw/TMJ problems	☐ Nausea
☐ Memory loss	☐ Irritability	☐ Arm/shoulder pain	☐ Back pain
☐ Headache(s)	☐ Neck stiffness	☐ Numb hands/fingers	☐ Lower back pain
☐ Blurred vision	☐ Fatigue	☐ Chest pain	☐ Back stiffness
☐ Buzzing in the ear	☐ Tension	☐ Short of breath	☐ Leg pain
☐ Ringing in the ear	☐ Neck pain	☐ Stomach upset	☐ Numb feet/toes

Work Related Questions

Have you been able to work since this injury? ☐ Yes ☐ No

Have your work activities been restricted as a result of this injury? ☐ Yes ☐ No

If yes, what activities are you unable to perform normally? _____

_____

What positions can you work in with minimum physical effort and for how long? _____

_____

Prior to your accident, were you able to work on an equal basis with others your age? ☐ Yes ☐ No ☐ N/A

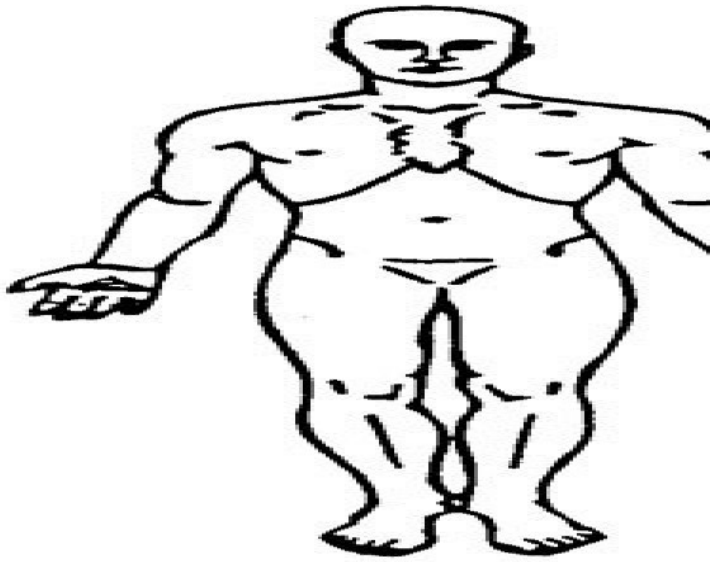
Do you work with others that can assist you with heavy lifting? ☐ Yes ☐ No ☐ N/A

While recovering from your injuries, can you request light duty work? ☐ Yes ☐ No ☐ N/A

Do you have an attorney? ☐ Yes ☐ No, if yes, whom? _____ Phone: _____

Pain Chart

Please mark the figure below with: **Muscle Spasm = M Burning = B Ache = A Numbness = N Pins & Needles = P**



Please describe your condition: _____

X-ray Questionnaire: For women only

Our consultation and examination may indicate x-rays are necessary. If so, please confirm that you are not pregnant at this time.

☐ **There is a possibility that I may be pregnant at this time.**
☐ **No, I am definitely not pregnant at this time.**
Date of last Menstrual Period: _____

☐ **Yes, I am definitely pregnant.**
☐ **I request that films not be taken because:**
_____

I certify that the above questions were answered accurately. I understand that providing incorrect information can be dangerous to my health.

Patient Signature: _____ Date:_____

Consent to Care

I hereby authorize the providers to treat my case as they deem appropriate through the use of physical therapy, rehabilitation, manual therapy, chiropractic manipulation of the spine, nutritional support, trigger point injections and diagnostic testing. I realize the goal of integrated healthcare is to strengthen the patient's body in order to heal themselves.

A patient coming to the doctor gives him/ her permission and authority to care for them in accordance with appropriate testing, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare if he/ she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health care procedures from whatever he/ she is suffering from: latent pathological defects, illnesses, or deformities, which would otherwise not come to the attention of the physician.

It is understood and agreed the amount paid the clinic for x-rays is for interpretation and only the x-ray negatives will remain the property of this office, being on file. The patient also agrees to that he/she is responsible for all bills incurred at this office.

I agree to settle any claim or dispute I may have against or with any of these persons or entities. Whether related to the prescribed care or otherwise it will be resolved by binding arbitration under the current malpractice terms which can be obtained by written request.

"National Supplier Clearinghouse Medicare DMEPOS Supplier Statement"

DMEPOS suppliers have the option to disclose the following statement in order to satisfy the requirement outlined in Supplier Standard 16 in lieu of providing a copy of the standards to the beneficiary.

The products and/or services provided to you by supplier legal business name or DBA are subject to the supplier standards contained in the Federal regulations shown at 42 Code of Federal Regulations Section 424.57(c). These standards concern business professional and operational matters (e.g., honoring warranties and hours of operation). The full text of these standards can be obtained at http://ecfr.gpoaccess.gov. Upon request we will furnish you a written copy of the standards.

Patient Signature: _____ Date:_____

HIPAA Notice of Privacy Practices *6 / 8*

This Notice Describes How Medical Information About You May be Used and Disclosed and How You Can Get Access to This Information. Please Review it Carefully.

This notice of privacy practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. Fore example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose and treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to that health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support that business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of students, licensing, and conducting or engaging for other business activities. For example, we may disclose your protected health information to a chiropractic student that sees patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your doctor. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

Use or disclose your protected health information in the following situation without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight, Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers Compensation: Inmates: Required Users and Disclosures: Under the law, we may make disclosures to you and when required by the Secretary and the Department of Heath and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other permitted and required uses and disclosures will be made only with your consent, authorization or opportunity to object unless required by law. You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights
Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes: information compiled in reasonable anticipation of or use is a civil criminal or administrative action or proceeding, and protected health information that is subject to law may protect access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us normal use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that nay part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in the Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If your physician believes it is not in your best interest to permit use and disclosure of your protected health information; your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively. I.e. electronically.

You have the right to have your physician amend your protected health information. If we deny your request to amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of such rebuttal.

You have the right to review an accounting of certain disclosures we have made, if any, of your protected health information. We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints
You may complain to us or to the Secretary of Heath and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint. This document was published and becomes effective on/or before June 1st 2007.

Patient Name: _____ Date: _____
(printed)

Patient Signature: _____ Witness: _____
Adult Patient, Parent/Guardian, or Spouse

Patient Acknowledgment of Receipt of Notice of Privacy Practices

I acknowledge that I have reviewed the Notice of Privacy Practices of Chiropractic Wellness Center.

Please initial <u>one</u> of the following options and sign below:

_____ I wish to receive a paper copy of Privacy Notice.

_____ I wish to receive an electronic copy of Privacy Notice.

Email: _____ @_____

_____ I **do not** request a copy of the Privacy Notice at this time. I acknowledge that I can request a copy at any time and the Privacy Notice is posted in the office.

Please initial below:

_____ I acknowledge that it is the policy of Chiropractic Wellness Center to leave reminder messages on my answering machine or with another person in my home. I may make a request of an alternative means of communication (within reason) in writing.

_____ I acknowledge that if I should have a problem or question in regard to my rights, I may speak with the Privacy Officer, Tammy Giles, about my concerns.

Patient Name: _____ Date: _____
(printed)

Patient Signature: _____ Witness: _____
Adult Patient, Parent/Guardian, or Spouse

Medical Reports and Doctor's Lien

I hereby authorize Chiropractic Wellness Center, to furnish you, my attorney, with a full 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, my attorney, to pay directly to said doctor such sums as may be due and owing him for medical service rendered me both by reason of this accident and by reason of any other bills, including interest on the unpaid balance of my account, that are due his office and to withhold such sums from any settlement, judgment, or verdict as may be necessary to adequately protect said doctor. 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 by you, my attorney, or myself as the result of the injuries for which I have been treated or injuries in connection therewith.

I hereby authorize and direct the responsible insurance company to pay directly to Integrative Health and Rehabilitation such sums as may be due and owing for treatment rendered me by reason of this accident on _____, 20____, if an attorney has not been retained.

I fully understand that I am directly responsible to said doctor for all medical bills submitted by him for service rendered me and that this agreement is made solely for said doctor's additional protection and in consideration of his awaiting payment. I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

Patient Signature: _____ Date: _____

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 said doctor above named.

Attorney's Signature: _____ Date: _____

I hereby state and agree that a photocopy of this document will be deemed as valid and binding on all parties involved in the original copy. **Patient's Initials: _____**

Acknowledgment and Understanding

I hereby acknowledge that I am receiving (or about to receive) health care services from Chiropractic Wellness Center. I have been advised that the doctor providing the services is willing to wait for payment for these services, provided that there continues to be a reasonable chance that payment will be made either by insurance proceeds or out of the settlement of a liability claim.

I understand that if it is determined either:

1. That there is no insurance company obligated to pay for these services, or if the insurance company involved refuses to acknowledge an assignment to the doctor or make other provisions for the protection of the interest of the doctor; or
2. If a liability claim exists, and my attorney refuses to agree to protect the interest of the doctors, or if I have not engaged the services of an attorney; then **I agree to pay for services rendered on a current basis**. My bill will be paid in full as soon as my liability claim is settled, or within three months of the date of my last treatment, whichever occurs first.

Patient Name: _____ **Date:** _____
(printed)

Patient Signature: _____ **Witness:** _____
Adult Patient, Parent/Guardian, or Spouse