Patient Information

Thank you for choosing our practice for your chiropractic needs. Please complete the following form(s). If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to assist you.

PATIENT INFORMATION

Date_____/_____/_____

NAME:_____

ADDRESS:_____
Street Address Apt #

_____
City State Zip Code

HOME PHONE:_____

CELL PHONE:_____

WORK NUMBER:_____

SEX: Male or FEMALE (Circle) AGE:_____ Birth Date:_____

Patient SS#:_____/_____/_____

Employer:_____

Occupation (Student?):_____ Part-time / Full-time (Circle)

Spouse's Name:_____ Contact Number:_____

Whom may we thank for referring you?_____

Is this condition due to an accident? YES or NO (Circle) **Date of Injury**:_____

Type of Accident AUTO WORK HOME OTHER_____ (Circle)

To whom have you made a report of your accident?

AUTO INSURANCE EMPLOYER WORKER COMP. OTHER_____ (Circle)

Attorney Name (If applicable)_____

FOR OFFICE USE ONLY

Copies of

- ❑ Driver's License
- ❑ Claim Information

Signatures on

- ❑ Vehicle Accident Information
- ❑ Direct Payment Assignment
- ❑ Informed Consent
- ❑ HIPPA Form
- ❑ Letter Of Protection

DO WE HAVE A LETTER OF PROTECTION ON FILE? YES or NO

VEHICLE ACCIDENT INFORMATION

PATIENT INFORMATION

Patient Name _____ Date _____

Date of Accident _____ Time of Accident _____ ☐ a.m. ☐ p.m.

Please describe the accident in your own words: _____

_____

_____

_____

Were you the: ☐ Driver ☐ Front Passenger ☐ Rear Passenger ☐ Pedestrian

How many people were in the accident vehicle? _____

ACCIDENT SITE

Road/Street Name _____

City/State _____

Nearest intersection with road/street _____

Driving conditions ☐ Dry ☐ Wet ☐ Icy ☐ Other _____

Which direction were you headed? _____

Speed you were traveling? _____

VEHICLE

Make and model of vehicle you were in:

_____

Were you wearing a seatbelt? ☐ Yes ☐ No

If yes, what type? ☐ Lap ☐ Shoulder

Was vehicle equipped with airbags? ☐ Yes ☐ No

If yes, did it/they inflate properly? ☐ Yes ☐ No

Did your seat have a headrest? ☐ Yes ☐ No

If yes, what was the position of the headrest?

☐ Low ☐ Midposition ☐ High

IMPACT

Did your car impact another vehicle? ☐ Yes ☐ No

Did your car impact a structure? ☐ Yes ☐ No

If yes, explain _____

_____

Did any part of your body strike anything in the vehicle?

☐ Yes ☐ No If yes, explain _____

Was impact from :

☐ Front ☐ Rear ☐ Left ☐ Right ☐ Other _____

At the time of impact were you:

☐ Looking straight ahead ☐ Looking to the right

☐ Looking to the left ☐ Looking down

☐ Looking up

Were both hands on the steering wheel? ☐ Yes ☐ No

If no, which hand was on the wheel? ☐ Right ☐ Left

Was your foot on the brake? ☐ Yes ☐ No

If yes, which foot was on the brake? ☐ Right ☐ Left

Were you: ☐ Surprised by impact ☐ Braced for impact

OTHER VEHICLE
(if applicable)

Make and model of other vehicle _____

Which direction was other vehicle headed? _____

Speed other vehicle was traveling _____

POLICE

Did the police come to the accident site? ☐ Yes ☐ No

Were there any witnesses? ☐ Yes ☐ No

Was a police report filed? ☐ Yes ☐ No

Was a traffic violation issued? ☐ Yes ☐ No

If yes, to whom? _____

PATIENT CONDITION

Were you unconscious immediately after the accident? ☐ Yes ☐ No If yes, for how long?_____

Please describe how you felt immediately after the accident:

_____

_____

_____

TREATMENT

Did you go to the hospital? ☐ Yes ☐ No

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

How did you get to the hospital? ☐ Ambulance ☐ Private transportation

Name of hospital_____ Name of doctor_____

Diagnosis_____

_____

Treatment received_____

_____

X-rays taken_____

SYMPTOMS/INJURIES

Have you been able to work since this injury? ☐ Yes ☐ No How many work days have you missed?_____

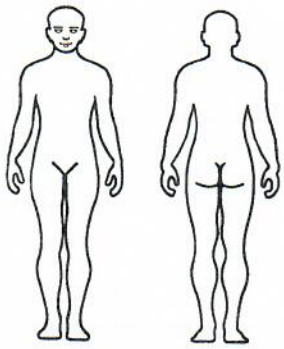
Prior to the injury were you able to work on an equal basis with others your age? ☐ Yes ☐ No

If you have had any of the following symptoms since your injury, please ☑ check:

- ☐ Arm/shoulder pain
- ☐ Back pain
- ☐ Back stiffness
- ☐ Chest pain
- ☐ Dizziness
- ☐ Ear buzzing
- ☐ Ear ringing
- ☐ Fatigue
- ☐ Feet/toe numbness
- ☐ Hand/finger numbness
- ☐ Headaches
- ☐ Irritability
- ☐ Jaw problems
- ☐ Leg pain
- ☐ Memory loss
- ☐ Nausea
- ☐ Neck pain
- ☐ Neck stiff
- ☐ Shortness of breath
- ☐ Sleep difficulty
- ☐ Stomach upset
- ☐ Tension
- ☐ Vision blurred

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.



Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain)_____

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting ☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other_____

How often do you have this pain?_____

Is it constant or does it come and go?_____

Does it interfere with your: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities or movements that are painful to perform: ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

I certify that the above information is correct to the best of my knowledge.

Patient Signature_____ Date_____

Notice of Privacy Practices

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 office may use and disclose medical and financial information related to your care that may be necessary now or in the future to facilitate payment by third parties for services rendered by us, or assist with, aid in or facilitate the collection of data for purpose of utilization review, quality assurance, or medical outcomes for evaluation purposes. Such information may be released to insurance companies, HMO's and PPO's, managed care organizations, IPA's, Medicare/Medicaid, other governmental or third party payers, or any organizations contracting with any of the above or any other physician that is directly or indirectly responsible for your medical care or the payment thereof.

This office will not use or disclose any of your medical and financial information for any purpose not stated above without your specific authorization. You may revoke your authorization at any time.

You may request restrictions on certain uses and disclosures. This office is not required to agree to a requested restriction. You have the right to receive confidential communications of your protected health information. You have the right to inspect, copy and amend your protected health information. You may also request an accounting of disclosures of your protected health information from this office.

We are legally obligated to maintain the privacy of your protected health information and to provide you with this Notice of Privacy Practices and to abide by it terms. We reserve the right to change our privacy practices and apply revised privacy practices to protected health information.

You may register a complaint with this office you suspect that your privacy right have been violated. We will investigate the complaint and inform you of the findings. This office will make no retaliation against you because you registered a complaint. You may also file a complaint with the Secretary of the Department of Health and Human Services.

You may speak with the Office Manager to obtain additional information regarding any questions you may have concerning this Notice or to receive a printed copy of the Notice. This Notice of Privacy Practices is effective immediately.

Patient Signature _____ Date _____

INFORMED CONSENT

I, _____, here by give Dr. Andy Philachack and his office staff permission to care for me in accordance with the assessments, tests, diagnostic impressions, and conclusions. The chiropractic adjustment, as well as other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities, or pathologies may render the patient susceptible to injury. Dr. Andy and his office staff will not render a chiropractic adjustment, or render health care, if he or his staff is aware that such care may be contraindicated. It is the patient's responsibility to make known any pathological defects, illnesses, pregnancies, or deformities that would not otherwise come to the attention of the doctor and his staff.

DIRECT PAYMENT ASSIGNMENT

I, _____, understand and agree, that health and accident insurance policies are an arrangement between the insurance carrier and myself. I understand that Dr. Andy Chiropractic will prepare any necessary reports and forms to assist me in making collections from the insurance company(s), and that any amount authorized for treatment must be paid directly to Dr. Andy Chiropractic. This amount will be credited to my account upon receipt of payment.

However, I also understand that all services rendered to me will be charged directly to me and I am aware that I will be personally held liable for the charges should payment not be made on my behalf by the insurance company(s). I also understand that if I suspend or terminate my care and treatment, all fees for services rendered to me will be due.

_____ _____ _____ _____

SIGNATURE OF PATIENT DATE SIGNATURE OF WITNESS DATE

CONSENT TO TREAT A MINOR

I, _____, hereby authorize, Dr. Andy Philachack and whomever he may designate as an assistant, to administer care as deemed necessary to_____ (Minor).

My relationship to the minor is MOTHER FATHER LEGAL GUARDIAN (Circle One).

_____ _____/_____/_____

Parent/Legal Guardian's Signature Authorizing Care to Minor DATE

AGREEMENT & INSTRUCTION FOR
DIRECT PAYMENT ASSIGNMENT
BY A PRIVATE, GROUP, OR ACCIDENTAL HEALTH INSURANCE COMPANY

PATIENT NAME:_____
INSURED NAME:_____
EMPLOYER:_____ SOCIAL SECURITY:_____/_____/_____
GROUP/CLAIM NUMBER:_____

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

Doctor Andy Chiropractic, P.C.
2645 Arapaho Road Suite 103
Garland, TX 75044

Or, if current policy prohibits direct payment to the provider, then I hereby also instruct and direct you to make out the check to me and mail it as follows;

Doctor Andy Chiropractic, P.C.
2645 Arapaho Road Suite 103
Garland, TX 75044

For the medical expenses and benefits allowable under health insurance or personal injury protection, and otherwise payable to me under current insurance policy as payment toward the total charges for the chiropractic services rendered to me by the above mentioned provider.

THIS IS A DIRECT PAYMENT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.

This payment will not exceed my indebtedness to Dr. Andy Chiropractic. And, I have agreed to pay, in a responsible manner, any balance for chiropractic charges that have not been paid by the above-mentioned insurance company.

A PHOTOCOPY OF THIS ASSIGNMENT SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL.

I also authorize the release of any pertinent information, in regards to my claim, to the insurance company or legal counsel if it has been sought.

Patient Signature _____ Date _____