Auto Accident Questionnaire

Patient Information

Date_____ **Date of Birth**_____

Patient Name_____
First M Last

What do you prefer to be called? _____

Address _____

City _____ **State** _____**Zip** _____

Patient SSN#_____ **Do you?** ☐ **Rent** ☐ **Own**

Sex ☐ **Male** ☐ **Female** **Language** (If other than English)_____

Ethnicity (Mark one) ☐ **Hispanic or Latino** ☐ **Not Hispanic or Latino**

Race Mark one or more) ☐**Native American or Alaska Native** ☐**Asian** ☐**White**

☐ **Black or African American** ☐ **Native Hawaiian or Other Pacific Islander**

Cell Phone_____ **Cell Phone Carrier**_____

Home Phone_____ **E-mail**_____

Occupation _____

Employer/
School_____

Employer/ School Address _____

City _____ **State** _____**Zip** _____

Employer/ School Phone_____

If Minor, Parent/Legal Guardian's Name_____

☐ **Married** ☐ **Single** ☐ **Widowed** ☐ **Divorced** ☐ **Separated**

Spouse's Name_____

Spouse's Cell Phone _____

How did you hear about us?_____

Other Vehicle's Auto Insurance Information

Company_____

Contact_____ **Phone**_____

Policy Holder_____

Policy Holder's Address, City, State, Zip_____

Claim Adjuster_____

Phone_____ **Fax** _____

Your Auto Insurance Information

Company_____

Contact_____ **Phone**_____

Policy Holder_____

Policy Holder's Address, City, State, Zip_____

Claim Adjuster_____

Phone_____ **Fax** _____

Med Pay? ☐ **Yes** ☐ **No** **Amount**_____ **Used** _____

Health Insurance

Do you have a FlexSpending(FSA) or Health Savings(HSA)Account? ☐ **Y** ☐ **N**

Insurance Company_____

Policy # _____**Group #**_____

Relationship to the patient ☐ **Self** ☐ **Spouse** ☐ **Child** ☐ **Other**

* If you selected "self" please stop here and proceed to the next section.

Policy Holder _____
First M Last

Policy Holder's Date of Birth_____ **Sex** ☐ **Male** ☐ **Female**

Policy Holder's Address, City, State, Zip_____

Policy Holder's Employer _____

Employer City _____ **State** _____ **Zip** _____

Employer Phone_____

Secondary Health Insurance

Insurance Company_____

Policy # _____**Group #**_____

Relationship to the patient ☐ **Self** ☐ **Spouse** ☐ **Child** ☐ **Other**

* If you selected "self" please stop here and proceed to the next section.

Policy Holder _____
First M Last

Policy Holder's Date of Birth_____ **Sex** ☐ **Male** ☐ **Female**

Policy Holder's Address, City, State, Zip_____

Policy Holder's Employer _____

Employer City _____ **State** _____ **Zip** _____

Employer Phone_____

Emergency Contact

This must be someone NOT living in your household.

Name:_____**Relationship:**_____**Cell Phone:**_____ **Home :**_____

Address:_____**City, State, Zip:**_____

Designation of Personal Representative

Name:_____**Relationship:**_____**Cell Phone:**_____ **Home Phone:**_____

Address:_____**City, State, Zip:**_____

I hereby designate the above named individual as my personal representative who may act on my behalf for the purpose of: Consenting to use and disclosure of my health information, authorizing use and disclosure of my health information, and receiving information that otherwise would be sent me. If I am incapacitated, my personal representative may also sign any form (such as authorization, revocation of authorization, request for access to information and/or billing inquiries), the uses of which are described in privacy policies and procedures. I understand that a person who is identified in my medical record as having medical power of attorney or other legal authority to act on my behalf is additionally recognized as my personal representative. I understand that I have the right to revoke this authorization at any time. Revoking this authorization must be made in writing, signed, and dated.

Details Regarding the Auto Accident

Date of Accident_____ State ____ Time of Accident _____ am/ pm

Were you admitted to the emergency room? ☐ Yes ☐ No

How did you get to the emergency room? _____

Were you released from the emergency room the same day? ☐ Yes ☐ No*

*If no, how long were you admitted? _____

Did you lose consciousness? ☐ Yes ☐ No

What type of treatment did you receive at the hospital?

☐ X-rays ☐ MRI ☐ CAT scan ☐ Medications _____

Other _____

Have you been treated by another doctor for this accident? ☐ Yes ☐ No

Explain_____

Where were you located in the vehicle?_____

Were you wearing a seatbelt at the time of the accident? ☐ Yes ☐ No

Was your seatbelt a harness type of restraint? ☐ Yes ☐ No

Did the air bag deploy and strike you? ☐ Yes ☐ No

Did your body strike anything in the vehicle? ☐ Yes ☐ No ☐ Unsure

Explain_____

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

How many days of work have you missed?_____

Has this accident restricted your work performance? ☐ Yes ☐ No

Explain_____

Were there other passengers in the car? ☐ Yes ☐ No How many?_____

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

Have you retained an attorney? ☐ Yes ☐ No

Firm Name_____

Phone_____ ____Fax _____

Were the police notified? □ Yes □ No

*If yes, please provide a copy of the accident report.

Who was at fault?_____

Was there a traffic violation issued? □ Yes* □ No

*To whom?_____

What type of vehicle were you struck by?

□ Small □ Mid-Sized □ Large □ Car □ SUV □ Truck

What type of vehicle were you riding or traveling in?

□ Small □ Mid-Sized □ Large □ Car □ SUV □ Truck

Was your car moving or stopped at the time of impact?

□ Stopped □ Moving

What was the approximate speed of YOUR vehicle?_____mph

What was the approximate speed of the OTHER vehicle? _____mph

Were you aware of the accident before impact? □ Yes □ No

During impact were you looking ? □ Right □ Left□ Forward□ Backward

□ Up □ Down □ Other_____

On what side was the impact to YOUR car?

□ Front □ Back □ T-Bone □ Driver Side □ Passenger Side

Did the vehicle □ Flip □ Spin □ Other_____

What was the position of your headrest?_____

Are there any other details from your accident that could impact your treatment?

_____

Have you been in other automobile accidents prior to this one?

□ Yes □ No

If yes, Date_____ Date_____ Date_____

Please indicate symptoms that are a result of this accident.

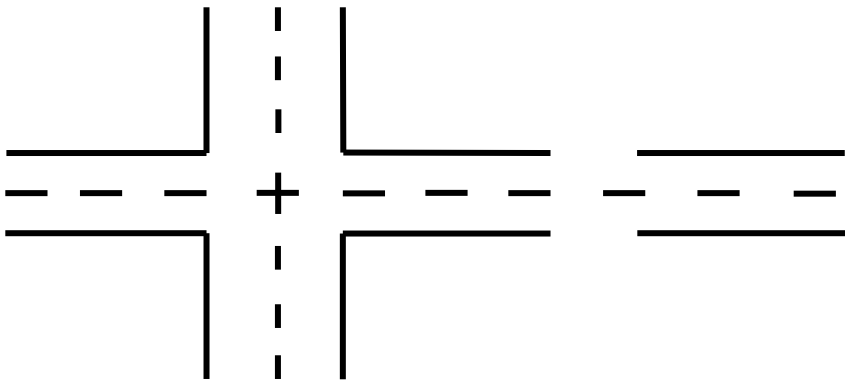
□ Dizziness	□ Memory Loss	□ Numb Hand/ Fingers	□ Headaches
□ Irritability	□ Ears Ringing	□ Difficulty Sleeping	□ Nausea
□ Fatigue	□ Jaw Problems	□ Shortness of Breath	□ Chest Pain
□ Tension	□ Blurred Vision	□ Numb Feet/ Toes	□ Upset Stomach

PLEASE use the diagram below to describe how your auto accident occurred. If there are additional details, list here. Write down street names.

_____

_____

_____



Please indicate: NORTH

Authorization and Medical Release

I affirm that the above information is correct to the best of my knowledge and it is my responsibility to inform this office of any changes in my medical status. I authorize the doctor to treat my condition as he deems appropriate and to grant full disclosure for all previous or concurrent care. I agree to grant full indemnity to Alternative Wellness and Chiropractic Center and it's physicians for complications related to all pre-existing conditions medically diagnosed or otherwise not disclosed.

Patient or Guardian Signature_____ _____Date _____

Print Guardian Name _____ _____Relationship to Patient_____

Name:_____

Height: _____ B/P: _____

Weight: _____ Pulse: _____

Office Use Only

I. HEALTH HISTORY

Do you smoke? ☐ Y ☐ N ☐ Social ☐ Quit

Current Medication:* _____

_____

☐ I will provide a list of my medications.

Allergies:* _____

_____

Medication Intolerance:* _____

_____

Personal Disease/Illness

List any past history of disease/illness *Month/Year*

_____

_____

_____

Family Disease/Illness

List any family history of disease/illness *Relationship* *Month/Year*

_____

_____

_____

Hospitalizations/Surgeries/Injuries

List Past Hospitalizations/Surgeries/Injuries *Month/Year*

_____

_____

_____

_____

Primary Physician(s) _____

_____

Date of Last Exam _____

Date of Last X-ray _____

_____

II. REVIEW OF SYSTEMS

Have you at any time had: *(Check all that apply)*

Head and Neck

☐ Decreased hearing
☐ Ringing in ears
☐ Frequent ear infections
☐ Dizzy spells
☐ Failing vision
☐ Double or blurred vision
☐ Eye pain
☐ Repeated eye infections
☐ Recurrent nose bleeds
☐ Sinus/throat infections

Cardiovascular

☐ High blood pressure
☐ Pain (chest, arms or legs)
☐ Palpitations
☐ Irregular heart beat
☐ Swollen ankles
☐ Fainting spells

Digestive

☐ Difficulty swallowing
☐ Indigestion or heartburn
☐ Nausea/vomiting
☐ Diarrhea
☐ Constipation
☐ Blood in bowel movement
☐ Black bowel movement

Neurological/Physical

☐ Numbness/Tingling
☐ Headache
☐ Nervousness
☐ Memory Loss
☐ Moodiness
☐ Difficulty falling asleep
☐ Difficulty staying awake
☐ Increased irritability
☐ Depression/Anxiety

Endocrine

☐ Chronic fatigue
☐ Weight gain/Weight Loss (recent)
☐ Bruise easily
☐ Cold extremities
☐ Tremors (shaking of hands)
☐ Convulsions
☐ Muscle weakness

Respiratory

☐ Hoarseness
☐ Persistent cough
☐ Blood in spit
☐ Shortness of breath

Skin

☐ Rash
☐ Hives
☐ Moles (cancerous)

Genitourinary

☐ Diabetes*
☐ Painful urination
☐ Blood in urine
☐ Frequent urination
☐ Frequent night time urination
☐ Loss of control of urine
☐ Sexual dysfunction

Musculoskeletal

☐ Neck pain
☐ Joint swelling
☐ Mid back pain
☐ Low back pain
☐ Foot pain
☐ Stiff joints

Other Symptoms

_____

Women Only

Are you pregnant? Y N If Yes, Last Menstrual Period_____ Due Date_____

Are you nursing? Y N Are you planning a pregnancy? Y N

- ☐ Breast tenderness associated with cycle
- ☐ Breast fibroids, benign masses
- ☐ Menstruation Problems
- ☐ Uterine fibroids
- ☐ Endometriosis
- ☐ Vaginal discharge, dryness, itchiness
- ☐ Thyroid Problems
- ☐ Hot flashes
- ☐ Night sweats (in menopausal females)
- ☐ Urinary Tract, bladder, kidney infections
- ☐ Other _____

Men Only Do you experience any of the following? *(Check all that apply)*

- ☐ Prostate problems
- ☐ Difficulty with urination, dribbling
- ☐ Difficult to start and stop urine stream
- ☐ Pain or burning with urination
- ☐ Interruption of stream during urination
- ☐ Pain on inside of thighs, legs or heels
- ☐ Feeling of incomplete bowel evacuation
- ☐ Decreased sexual function
- ☐ Other _____

III. REASONS FOR SEEKING CARE

Present Complaints

1. _____**How long has this been an issue?**_____

Is it: ☐ Dull ☐ Sharp ☐ Ache ☐ Numb/Tingle ☐ Stabbing ☐ Constant ☐ Occasional ☐ Staying the same ☐ Getting worse ☐ Mild ☐ Moderate ☐ Severe ☐ Worse in morning ☐ Worse in evening ☐ Pain radiates to_____

2. _____**How long has this been an issue?**_____

Is it: ☐ Dull ☐ Sharp ☐ Ache ☐ Numb/Tingle ☐ Stabbing ☐ Constant ☐ Occasional ☐ Staying the same ☐ Getting worse ☐ Mild ☐ Moderate ☐ Severe ☐ Worse in morning ☐ Worse in evening ☐ Pain radiates to_____

3. _____**How long has this been an issue?**_____

Is it: ☐ Dull ☐ Sharp ☐ Ache ☐ Numb/Tingle ☐ Stabbing ☐ Constant ☐ Occasional ☐ Staying the same ☐ Getting worse ☐ Mild ☐ Moderate ☐ Severe ☐ Worse in morning ☐ Worse in evening ☐ Pain radiates to_____

4. What makes it better?_____

5. What makes it worse?_____

6. What Doctor's have you seen for this?_____

7. Type of treatment:_____

8. Results:_____

Rate your pain 0 to 10, ten being the worst

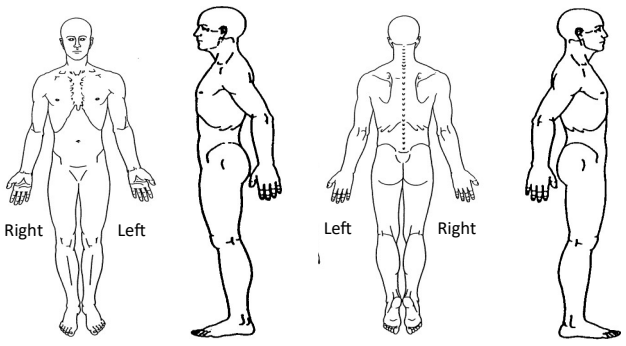
Neck Pain
0 1 2 3 4 5 6 7 8 9 10

Mid Back Pain
0 1 2 3 4 5 6 7 8 9 10

Low Back, Hip Pain
0 1 2 3 4 5 6 7 8 9 10

Other Pain _____
0 1 2 3 4 5 6 7 8 9 10

Mark <u>ALL</u> areas of pain on figures below



IV. CERTIFICATION

I certify that I have read and understand the above information. I acknowledge that I have answered the above questions correctly and to the best of my ability. I will not hold my chiropractor or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Patient/Guardian Signature_____ Date _____

(Office Use Only)

The above health history questionnaire was reviewed by _____(Physician) Date _____

Neck Pain Index

Please read: This questionnaire is designed to enable us to understand how much your **neck pain** has affected your ability to manage everyday activities. Please answer each section by checking the **ONE CHOICE** that most applies to you. We realize that you may feel that more than one statement may relate to you, but please **just check the one choice which closely describes your problem *right now***.

Section 1 PAIN INTENSITY

- ☐ I have no pain at the moment.
- ☐ The pain is mild at the moment.
- ☐ The pain comes and goes and is moderate.
- ☐ The pain is moderate and does not vary much.
- ☐ The pain is severe but comes and goes.
- ☐ The pain is severe and does not vary much.

Section 2 PERSONAL CARE (washing, dressing, etc.)

- ☐ I can look after myself 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 I manage most of my personal care.
- ☐ I need some help in most aspects of self-care.
- ☐ I do not get dressed, I wash with difficulty and I stay in bed.

Section 3 LIFTING

- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights but it causes extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor but I can if they are conveniently positioned, for example, on a table.
- ☐ Pain prevents me from lifting heavy weights 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 with slight pain in my neck.
- ☐ I can read as much as I want with moderate pain in my neck.
- ☐ I cannot read as much as I want because of moderate pain in my neck.
- ☐ I cannot read as much as I want because of severe pain in my neck.
- ☐ I cannot read at all.

Section 5 HEADACHE

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

Section 6 CONCENTRATION

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

Section 8 DRIVING

- ☐ I can drive my car without 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 cannot drive my car as long as I want because of moderate pain in my neck.
- ☐ I can hardly drive my car at all because of severe pain in my neck.
- ☐ I cannot drive at all.

Section 9 SLEEPING

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

Section 10 RECREATION

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

Signature _____

Date _____ File # _____ Disability Index Score: _____ Improvement _____ %

Oswestery Disability Index

ALTERNATIVE WELLNESS
& CHIROPRACTIC CENTER

Low Back Disability Index

Please read: This questionnaire is designed to enable us to understand how much your **low back pain** has affected your ability to manage everyday activities. Please answer each section by checking the **ONE CHOICE** that most applies to you. We realize that you may feel that more than one statement may relate to you, but please **just check the one choice which closely describes your problem *right now***.

Section 1 Pain Intensity
- ☐ The pain comes and goes and is very mild.
- ☐ The pain is mild and does not vary much.
- ☐ The pain comes and goes and is moderate.
- ☐ The pain is moderate and does not vary much.
- ☐ The pain comes and goes and is severe.
- ☐ The pain is severe and does not vary much.

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

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

Section 4 Walking
- ☐ I have no pain on walking.
- ☐ I have some pain on walking but it does not increase with distance.
- ☐ I can not walk more than one mile without increasing pain.
- ☐ I can not walk more than ½ mile without increasing pain.
- ☐ I can not walk more than ¼ mile without increasing pain.
- ☐ I can not walk at all with out increasing pain.

Section 5 Sitting
- ☐ I can sit in a chair as long as I like without pain.
- ☐ I can sit only in my favorite chair as long as I like.
- ☐ Pain prevents me from sitting more than 1 hour.
- ☐ Pain prevents me from sitting more than ½ hour.
- ☐ Pain prevents me from sitting more than 10 minutes.
- ☐ I avoid sitting because it increases pain.

Section 6 Standing
- ☐ I can stand as long as I want without pain.
- ☐ I have some pain on standing, but it does not increase with time.
- ☐ I can not stand for longer than one hour without increasing pain.
- ☐ I can not stand longer than ½ hour without increasing pain.
- ☐ I can not stand longer than 10 minutes without increasing pain.
- ☐ I avoid standing because it increases the pain immediately.

Section 7 Sleeping
- ☐ I get no pain in bed.
- ☐ I get pain in bed but it does not prevent me from sleeping well.
- ☐ Because of my pain, my normal nights sleep is reduced by less than ¼.
- ☐ Because of my pain, my normal nights sleep is reduced by less than ½.
- ☐ Because of my pain, my normal nights sleep is reduced by lees than ¾.
- ☐ Pain prevents me from sleeping at all.

Section 8 Social Life
- ☐ My social life is normal and gives my no pain.
- ☐ My social life is normal but increases the degree of pain.
- ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, ect.
- ☐ Pain has restricted my social life and I do not go out very often.
- ☐ Pain has restricted my social life to my home.
- ☐ I have hardly any social life because of the pain.

Section 9 Traveling
- ☐ I get no pain while traveling.
- ☐ I get some pain while traveling but none of my usual forms of travel make it any worse.
- ☐ I get extra pain while traveling but it does not compel me to seek alternative forms of travel.
- ☐ I get extra pain while traveling which compels me to seek alternate forms of travel.
- ☐ Pain restricts all forms of travel.
- ☐ Pain prevents me from all forms of travel except that dome lying down.

Section 10 Changing Degree of Pain
- ☐ My pain is rapidly getting better.
- ☐ My pain fluctuates but overall it is definitely getting better.
- ☐ My pain seems to be getting better but improvement is slow.
- ☐ My pain is neither getting better nor getting worse.
- ☐ My pain is gradually worsening.
- ☐ My pain is rapidly worsening.

Signature _____

Date _____ File # _____ Disability Index Score: _____ Improvement _____ %

Revised Oswestery Disability

Patient Name:

We would like to take a moment to welcome you to our clinic and assure you that you will receive the very best of care available for your condition. The following are our clinic financial policies please familiarize yourself with our policies, please initial each section. If you have any questions, please contact the front desk. Thank You.

Covered/Non-Covered Services

I understand that the services rendered and/or supplies/aides given to me may not be considered eligible for benefits (eg. Services and/or supplies/aides may be determined to be not medically necessary, non-covered or investigational) by my health insurance company. I understand that my health insurance coverage has certain restrictions and limitations, such as authorization requirements, and non-covered services and/or supplies/aides. Since I have chosen to obtain the services and/or supplies/aides, I agree to be financially responsible for any and all related charges, if they are not covered by my insurance.

Your treatment plan makes it necessary to utilize not only Chiropractic Care codes, but to also utilize what is best described as Physical Rehabilitation codes. Policy benefits for both areas of care vary greatly by insurance policy and we cannot be aware of each person's specific policy benefits. To provide our best level of care, we provide a treatment plan that is specific for you and not based on your insurance policy benefits. Your specific policy benefits will determine what your patient responsibility will be. Our clinic will not quote insurance benefits; therefore, you are encouraged to contact your health plan. **It is ultimately your responsibility to check with your insurance to understand the contract and coverage.**

New Patient Promo: New patients are eligible for a Consultation, Exam, and X-rays, if needed for $_____. Which is paid in full due at time of service. This promo **does not** include a chiropractic adjustment. Promo excludes Medicare and Medicaid.

Illinois Medicaid: This office **does not** accept Illinois Medicaid. I agree that I do not receive Illinois Medicaid health coverage. Initials_____

____PLEASE INITIAL AFTER READING

Billing and Payments

You, the patient or legal guardian, are responsible for all claims made to your insurance. Billing is a courtesy service which we provide to our patients at no extra charge. This clinic will provide any necessary reports or required information to aid in insurance reimbursement of services. In the event of the insurance plan's denial of benefits or claim payments, the patient is responsible for the total balance due to the provider. If the insurance carrier requires the patient to send in more information regarding his/her claim and the patient fails to return the required information to the carrier, the patient will be billed for the entire balance on the claim, as the insurance company requires the provider to do.

All co-pays and known co-insurance amounts are due at the time of service.

In the event you do not have health insurance coverage, we do offer a Time of Service reduction of our fee schedule. This reduced fee must be paid at time of service in order to receive the reduction.

Patient statements mailed out bi-monthly for previous months billing and payment activities. Payments on your account are due by the last day of the month in which the statement was sent. Patients are given 90 days to make payments on account before sent to pre-collections. If at any time a payment cannot be made, please call our clinic to set up a payment plan or inform the clinic of your situation as you may qualify for deferred payments.

All accounts with patient portion balance showing no patient payment activity will be charged a 1.5% monthly late payment fee, for each month no payment is made on the account.

All outstanding unpaid patient account balances over $100 will result in the inability for the patient to schedule future appointments, until the patient portion of the account is paid, or payment arrangements are made.

____PLEASE INITIAL AFTER READING

Patient Name:

Assignment of Benefits

By signing this form you are authorizing payment of medical benefits will be made directly to this clinic. If your insurance carrier sends payment to you for services incurred in this clinic, you agree to send or bring those payments to this clinic upon receipt. However if you pay for your visits in full the assignment will not be reported by this provider and any payment will be send directly to you.

____PLEASE INITIAL AFTER READING

Reminders/Missed Appointments

With the exception of emergencies, it is vital that you keep all your appointments. Reminder cards and text messages are available to help you save the date and time of your appointments.

Our patient's, team and doctor's time is valuable, and we wish to provide every patient with an excellent experience. When you do not show up for a scheduled appointment, it creates an unused appointment slot that could have been used for another patient. Please provide us the courtesy of a **24 hour cancellation** or change notice if you are unable to keep your appointment time.

On your third no-show occurrence, there will be a **$25 charge** to your account. After three consecutive no-show occurrences, the clinic may elect to terminate our relationship with you.

____PLEASE INITIAL AFTER READING

Statement of Privacy

We use and disclose the information we collect from you only as allowed by Health Insurance Portability and Accountability Act and Iowa State. This includes issues relating to your treatment, payment, and care operations. Your personal health information will never be otherwise given to anyone without your written consent. You may give written authorization for us to disclose your information to anyone you choose, for any purpose. Our clinic and systems are secure from unauthorized access and our team is trained to make certain that the confidentiality of your records is always protected. Our privacy policy and practices apply to all former, current, and future patients. We will only request personal information needed to provide our standard of quality chiropractic or massage care, implement payment activates, conduct normal business operations, and comply with the law. This includes name, address, phone numbers, SSN, employment date, medical history, health records, etc. We are obligated to provide information to law enforcement and governmental officials under certain circumstances. We may use and/or disclose your information to communicate reminders about your appointments including text messaging, voicemail messages, and mailings. You have a right to request copies of your healthcare information; all requests must be in writing. We may charge for copies in the amounts allowed by law. If you believe your rights have been violated, we urge you to notify us immediately. You can also notify the US Dept of Health and Human Services. We thank you for being a patient at our clinic.

____PLEASE INITIAL AFTER READING

Release of Information

If we bill your insurance company, and you insurance company requires medical reports or records to document your treatment or progress, your signature below authorizes this clinic to release the medical information necessary to process your claim.

If you pay at the Time of Service and insurance is not billed by our clinic, then your signature below verifies that our clinic will not bill insurance for any services rendered and in turn your health insurance company will not be able to request medical records for services rendered.

____PLEASE INITIAL AFTER READING

Pregnancy Release

I certify that I am not pregnant at this time, and I agree to indemnify Alternative Wellness & Chiropractic Center for any medical complications which may result from radiographic studies performed on myself or unborn fetus.

____PLEASE INITIAL AFTER READING

Patient Name:

Terms of Acceptance

When a patient seeks chiropractic care, it is essential for both patient and clinic to be working towards the same objective. Chiropractic has only one goal. It is important that each patient understand both the objective and the method used to attain it. This will prevent any confusion or disappointment. An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Vertebral Subluxation is a misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential. We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the service of a health care provider who specializes in that area. Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding the treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations. The doctor and/or his staff will not be held responsible for any health conditions or diagnoses which are pre-existing, given by another health care provider, or are not related to the spinal structural conditions diagnosed at this clinic.

____PLEASE INITIAL AFTER READING

Informed Consent to Chiropractic Treatment

As with any healthcare procedure there are certain complications which may arise during chiropractic manipulation and therapy. Doctors of Chiropractic are required to obtain your informed consent before starting treatment. In particular you should note:

1.) Some patients may experience some stiffness or soreness following the first few days of treatment.

2.) Some types of manipulation have been associated with stroke; strokes from chiropractic adjustments are very rare. I am aware that nerve or brain damage including stroke is reported to occur once in one to ten million treatments. Once in a million is about the same chance as getting hit by lightening. Once in ten million is about the same change as a normal dose of aspirin or Tylenol causing death.

3.) I will make every effort to screen for any contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

4.) Other complications may include fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. When osteoporosis, degenerative disc or other abnormality is detected, this clinic will proceed with extra caution.

The probabilities of these complications are rare and generally result from some underlying weakness of the bone or tissue which Dr. Womboldt checks for during the history, examination, and x-ray (when warranted).

I acknowledge I have had the opportunity to discuss the associated risks as well as the nature and purpose of treatment with my chiropractor.

I authorize and agree to allow the doctor and his designated staff to work with my case, my spine and the spine of the charge I represent through the use of spinal adjustments and rehabilitative exercises for the sole purpose of postural and structural restoration of normal bio-mechanical and neurological function.

I intend this consent to apply to all my present and future chiropractic care.

Patient Printed Name: _____ Date: _____

Patient Signature: _____

Doctor Signature:_____ Date:_____

MEDICAL LIEN AGREEMENT

PATIENT NAME:_____ **DATE OF INJURY/INCIDENT:**_____

The named Patient ("Patient") desires medical treatment by the named Provider ("Provider") for injuries sustained in the above-referenced accident/ incident ("Incident"), and has or shall be retaining the named Attorney ("Attorney") to seek compensation from a potentially liable "third party". Provider agrees to establish a creditor-debtor relationship by this Agreement, whereby Provider agrees to treat Patient on a "lien" basis ("Medical Lien") for the Incident-related injuries. The reason for the Medical Lien is because insurance is not being used to cover Provider's full fees, Patient indicates that Patient is unable to pay for the full medical bills until the conclusion of treatment (other than any agreed-upon co-pay), and/or Patient and Attorney are confident in obtaining monies from "third party(ies)" or their insurance carrier(s) to compensate Patient and also be sufficient to pay Provider's Medical Lien.

Provider's Medical Lien is against any and all proceeds arising from the Incident, including, but not limited to, any settlement, judgment, or verdict which may be paid directly to Patient or to Attorney on behalf of Patient. In exchange for Provider agreeing to delay being fully paid, unless a state or federal statute or court order provides otherwise, the Parties to this Medical Lien agree to each of the following:

1. That Provider may release all medical information, billings, treatment notes, etc. concerning Patient's condition and treatment to Patient's insurance company, attorney or insurance adjuster in connection with the incident.
2. That Provider's standard fees and charges are reasonable and customary within the accepted range of similar services in the market where Patient is receiving treatment. Patient and Attorney will promptly advise Provider, upon receipt of any billing statement, of any issue or objection to Provider's fees and charges;
3. That Provider will consider a reduction in Provider's lien in certain cases upon written request; however, no such reduction is agreed to pre-treatment, and any interlineations to this Medical Lien stating otherwise is not effective unless initialed by Provider at each change to this document. No reduction is deemed accepted without Provider's signed written consent specifically agreeing to the amount of any discount, and any discount accepted is good for 30 days only; after 30 days the prior reduction agreement is automatically void and not enforceable;
4. That Provider's lien shall be considered first in priority of repayment among all later-retained medical providers;
5. That Provider's bill regarding Patient shall be paid promptly, and from the first monies received by or for Patient related to the Incident;
6. That any "med pay", PIP or similar insurance payment entitlement related to the Incident, paid or to be paid by any insurer for or related to Provider's bill, is assigned and to be paid directly to Provider, and if sent to Patient or Attorney, that med pay or PIP will be promptly sent to Provider. Patient is still responsible for any invoiced amounts med pay or PIP fails to fully cover.
7. That if Patient's case or lawsuit doesn't result in a recovery that pays Provider's bill in full, Patient agrees to remain fully liable for any remaining balance, and to promptly pay personally all remaining monies due and owing;
8. That if Provider's bill is not promptly paid within ten (10) days of sufficient funds received related to the Incident, then interest on the sums owing Provider shall accrue at the rate of ten percent (10%) per annum, from the date treatment concluded until the outstanding balance is fully paid; and,
9. That if an attorney's involvement is required to recover all or part of Provider's Medical Lien, that the prevailing party in any action arising from this Agreement shall be entitled to their attorney's fees and costs, including, but not limited to, any such fees and costs incurred in pre-filing collection efforts, negotiations or any Interpleader action involving the sums due. Venue for any disputes arising under this Medical Lien shall be in Clinton County, Iowa.

Patient has been advised that if Patient fails to follow the policies of Provider, the recommended treatment plan, or if Attorney does not cooperate in protecting Provider's Medical Lien interest, then Provider is not required to await payment and instead may declare the entire balance due and payable and take all legal action necessary to collect that outstanding balance. Any delay by Provider in the enforcement of this Agreement will not be deemed a waiver of Provider's rights and remedies in any respect.

PATIENT AGREEMENT:

Patient agrees to all the above so that Provider will agree to provide medical treatment on a "lien" basis for the Incident-related injuries sustained. Should Patient retain new counsel, Patient agrees to provide that new counsel a copy of this Medical Lien prior to retention, with the new attorney being bound as is Patient's original attorney.

PATIENT NAME:_____

PATIENT SIGNATURE:_____DATE:_____

ATTORNEY AGREEMENT:

Attorney agrees to honor all terms and conditions of Patient and Provider's Medical Lien agreement as stated above. Attorney agrees to communicate to Provider in a timely fashion the ongoing progress of the lawsuit, prompt written notification of any change in Attorney's representation of Patient, and prompt written notification of the resolution of the lawsuit in whole or in part. If a new attorney is substituted in, this lien will be transmitted to that new attorney prior to formal substitution, with advisement that the new attorney is bound by this lien by virtue of the original attorney's agreement.

LAW FIRM NAME:_____ATTORNEY NAME:_____

ATTORNEY SIGNATURE:_____DATE:_____

PROVIDER AGREEMENT:

Provider, in reliance upon the agreement by both the Patient and Attorney to all the above, agrees to accept and treat, or continue to treat, Patient related to the injuries sustained in this Incident under the conditions stated.

PROVIDER SIGNATURE:_____DATE:_____