PERSONAL INJURY QUESTIONNAIRE

NAME:_____PHONE: (____) _____

ADDRESS:_____CITY/STATE/ZIP: _____

AGE:_____BIRTHDATE:_____SEX:_____SS # _____

EMPLOYER'S NAME/ADDRESS: _____

YOUR INSURANCE CO:_____POLICY #: _____

AGENT'S NAME & PHONE: _____

NAME ON POLICY (IF OTHER THAN SELF): _____

RESPONSIBLE PARTY'S NAME/ADDRESS: _____

POLICY HOLDER'S NAME & POLICY #: _____

ATTORNEY:
NAME:_____PHONE: (____) _____

Address_____CITY/STATE/ZIP: _____

Were there any witnesses? ( ) Yes ( ) No Witness(es) Names: _____

NATURE OF ACCIDENT: ( ) AUTO ( ) Work Related ( ) OTHER _____

** If Auto, please bring in a copy of the accident report**

1. Date of Accident: _____ Time of Day: _____
2. Were you: ( ) Driver? ( ) Passenger? ( ) Front Seat? ( ) Back Seat?
3. Number of people in your vehicle? ____ Were you wearing seat belts? _____
4. What direction were you headed: ( ) N ( ) E ( ) S ( ) W
   on (name of street) _____
5. What direction was other vehicle headed? ( ) N ( ) E ( ) S ( ) W
   on (name of street) _____
6. Were you struck from: ( ) Behind ( ) Front ( ) Left Side ( ) Right Side
7. Approximate speed of your car:_____mph Other car's speed:_____mph
8. Were you knocked unconscious? ( ) Yes ( ) No If yes, how long? _____
9. Were police notified? ( ) Yes ( ) No
10. In your own words, please describe accident: _____

_____

11. Did you have any physical complains BEFORE the accident? ( ) Yes ( ) No
    If yes, please describe in detail: _____

_____

12. Please describe how you felt:
    A. DURING the accident: _____
    B. IMMEDIATELY AFTER the accident: _____
    C. LATER THAT DAY: _____
    D. THE NEXT DAY: _____
13. Are you pregnant? ( ) Yes ( ) No

14. Have you ever been to a Chiropractor? ( ) Yes ( ) No

15. What are your PRESENT complains and symptoms? _____

_____

16. Do you have any congenital (from birth) factors which relate to this problem? ( ) Yes ( ) No
If yes, please describe: _____

17. Do you have any previous illnesses which relate to this case? ( ) Yes ( ) No
If yes, please describe: _____

18. Have you ever been involved in an auto accident before? ( ) Yes ( ) No
If yes, please describe and give dates and types of accidents and injuries:

_____

19. Were you given Emergency Medical care at the accident site? ( ) Yes ( ) No
20. Did you go to the hospital? ( ) Yes ( ) No

Hospital Details_____

_____

21. Have you been treated by another doctor since the accident? ( ) Yes ( ) No
If yes, please give doctor's name/address/phone: _____

_____

What type of treatment did you receive? _____
22. Since this injury occurred, are your symptoms:
( ) Improving ( ) Getting Worse ( ) Same

23. Circle the symptoms you have noticed SINCE the accident:

Headache	Irritability	Face Flushed	Cold Feet	Cold hands	Neck pain
Chest Pain	Buzzing in ears	Stomach upset	Constipation	Loss of Smell	Loss of Balance
Diarrhea	Dizziness	Fatigue	Fever	Loss of Taste	Cold Sweats
Back Pain	Nervousness	Fainting	Depression	Memory Loss	Ringing in Ears
Tension	Sleeping problems	Lights bother eyes		Numbness in fingers	Numbness in toes
Pins/Needles in legs	Pins/Needles in arms	Shortness of Breath		Head seems heavy	
Loss of Taste	Other_____				

24. Have you lost time from work as a result of this accident? ( ) Yes ( ) No
If yes, please complete the following:
A. Last day worked? _____
B. Type of employment _____
C. Present Salary: _____
D. Are you being compensated for lost work time? ( ) Yes ( ) No If Yes, what? _____

25. Do you notice any activity restrictions as a result of this injury? ( ) Yes ( ) No
If yes, please describe in detail: _____

_____

26. Please describe any other pertinent information: _____

_____

Printed Name	Patient Signature	Date

Sandy Plains Chiropractic Clinic

2697 Sandy Plains Road
Marietta, GA 30066

OFFICE POLICY

Sandy Plains Chiropractic Clinic is served by a highly dedicated staff. Our objective is enhancing health by providing unique, cost-effective care. Clearly defining our office policies allows both patient and doctor to concentrate on regaining and maintaining optimum health.

Appointments are requested; walk-ins are welcome, but seen after scheduled patients. If late, you may have to wait for the next available opening. We do attempt to honor all appointments at the scheduled time.

X-rays will be part of your examination if existing ones are more than two years old.

Massage therapy/Neuromuscular therapy may be part of the healing process. It is necessary to collect 50% of the neuromuscular therapy fee (massage) at the time of service. Twenty-four hour cancellation is a must or you, the patient, will be charged.

Please – no food or drink in the clinic. Also, please turn off cell phones in the clinic.

FINANCIAL POLICY

Payment is expected when services are rendered, unless previous arrangements are made. We accept cash, checks, Visa, MasterCard, and Discover. There will be a $25 fee for any returned checks. We will file insurance while patients are under reactive care. Wellness care quotes are available upon request. Insurance is filed as a patient courtesy; it is the patient's final responsibility for all charges incurred. Insurance contract discounts are not accepted for neuromuscular therapies.

I consent to Sandy Plains Chiropractic Clinic filing my insurance, and having the insurance company pay this clinic directly for services rendered.

_____ _____

Patient signature Date

Consent to evaluate and adjust a minor child

I, _____, being the parent or legal guardian of _____
have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

_____ _____

Signature of Parent/Guardian Date

Pregnancy release

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

_____ _____

Patient Signature Date

NOTICE OF INSURANCE COMPANY'S LIEN

TO: INSURANCE COMPANY

_____

_____

_____

_____

DOCTOR

Dr. Michael J. Malloy

Sandy Plains Chiropractic Clinic

2697 Sandy Plains Road

Marietta, GA 30066

I, _____, authorize the doctor to furnish you with a full report of his case history, examination, diagnosis, treatment, and prognosis of myself in regard to my accident which occurred on _____.

I hereby give a lien to said doctor on any settlement, claim, judgment, or verdict as a result of said accident, and authorize and direct you to pay directly to said doctor from such sums as may be due.

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

DATE: _____ PATIENT'S SIGNATURE: _____

The undersigned insurance company of record 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.

DATE: _____ ADJUSTER'S SIGNATURE: _____

NOTICE: Please date, sign, and return to doctor's office immediately.

Sandy Plains Chiropractic Clinic, 2697 Sandy Plains Road, Marietta, GA 30066

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I understand and have been provided with a *Notice of Information Practices* (posted next to front desk in hallway), that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent
- The right to object to the use of my health information for directory purposes
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

_____ _____

Patient Signature Date

Informed Consent and terms of acceptance for Chiropractic Care

Chiropractic care, like all forms of health care, while offering considerable benefit, may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include sprain/strain injuries, irritation of a disc condition, and rarely, fractures. One of the rarest complications associated with chiropractic care, occurring at a rate between one instance per one million to one per two million cervical spine (neck) adjustments may be a vertebral artery injury that could lead to stroke.

Prior to receiving chiropractic care this Chiropractic office, a health history and physical examination will be completed. These procedures are performed to assess your specific condition, your overall health and, in particular, your spine health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies are needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan prior to beginning care.

A subluxation is misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function between the brain and tissues of the body. An adjustment is the specific application of forces to the subluxated area to facilitate the body's correction. Our only practice objective is to eliminate a major interference to the expression of the body's innate wisdom we do this by detecting and correcting vertebral subluxations with a chiropractic adjustment.

I understand and accept that there are risks associated with chiropractic care and give my consent to the examinations that the doctor deems necessary, and to the chiropractic care including spinal adjustments, as reported following my assessment.

_____ _____

Patient Name (printed) Relationship to patient

_____ _____

Patient or legal Guardian Signature Date

_____ _____

Witness Signature (office staff) Date

SANDY PLAINS CHIROPRACTIC CLINIC
2697 SANDY PLAINS ROAD
MARIETTA, GA. 30066
770-971-1355

PERSONAL INJURY (PI) FINANCIAL POLICY

We are committed to providing you with the best possible care. If you have medical insurance, we will help you receive your maximum allowable benefits. To achieve these goals we need your assistance, and your understanding of our payment policy.

While the filing of our insurance claims is a courtesy we extend to our patients, all charges are your responsibility from the date the services are rendered. We will gladly discuss your proposed treatment and answer any questions relating to your insurance.

For any PI case that must await settlement:

- We will file your major medical insurance during the interim, with an assignment of benefits signed by you on file.
- We will file your auto insurance med-pay, which is designed for these circumstances.

- If there is no major medical insurance, you are asked to pay ½ on first visit, and 33% of on-going treatment, as provided.

- Another 33% by 30 days after active care is over. Upon settlement, remainder of balance is due.

Signature_____Date_____