PERSONAL INJURY QUESTIONNAIRE

Name _____ Phone ( ) _____

Address _____ City _____ State _____ Zip _____

Age _____ Birthdate _____ Sex _____ S/S # _____

Employer's Name _____ Employer's Address _____

Your Ins. Co. _____ Policy # _____ Agent's Name _____

Name on Policy (If other than self) _____ Policy # _____

Responsible Party's Name _____

Address _____ City _____ State _____ Zip _____

Policy Holder's Name _____ Policy # _____

ATTORNEY

Name _____ Phone ( ) _____

Address _____ City _____ State _____ Zip _____

Were there any witnesses? ( ) Yes ( ) No Name(s) _____

NATURE OF ACCIDENT:

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? ( ) North ( ) East ( ) South ( ) West
   on (name of street) _____
5. What direction was other vehicle headed? ( ) North ( ) East ( ) South ( ) West
   on (name of street) _____
6. Were you struck from: ( ) Behind ( ) Front ( ) Left side ( ) Right side
7. Approximate speed of your car _____ mph Other car _____ mph
8. Were you knocked unconscious? ( ) Yes ( ) No If yes, for how long? _____
9. Were police notified? ( ) Yes ( ) No
10. In your own words, please describe accident: _____

    _____

    _____

    _____

11. Did you have any physical complaints 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. What are your PRESENT complaints and symptoms? _____

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

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

16. Have you ever been involved in an accident before? ( ) Yes ( ) No If yes, please describe, including date(s) and type(s) of accidents, as well as injury(ies) received. _____

17. Where were you taken after the accident? _____

18. Have you been treated by another doctor since the accident? ( ) Yes ( ) No If yes, please list doctor's name and address: _____

What type of treatment did you receive? _____

19. Since this injury occurred, are your symptoms: ( ) Improving ( ) Getting Worse ( ) Same

20. CHECK SYMPTOMS YOU HAVE NOTICED SINCE ACCIDENT:

☐ Headache	☐ Irritablity	☐ Numbness in Toes	☐ Face Flushed	☐ Feet Cold
☐ Neck Pain	☐ Chest Pain	☐ Shortness of Breath	☐ Buzzing in Ears	☐ Hands Cold
☐ Neck Stiff	☐ Dizziness	☐ Fatigue	☐ Loss of Balance	☐ Stomach Upset
☐ Sleeping Problems	☐ Head Seems Too Heavy	☐ Depression	☐ Fainting	☐ Constipation
☐ Back Pain	☐ Pins & Needles in Arms	☐ Lights Bother Eyes	☐ Loss of Smell	☐ Cold Sweats
☐ Nervousness	☐ Pins & Needles in Legs	☐ Loss of Memory	☐ Loss of Taste	☐ Fever
☐ Tension	☐ Numbness in Fingers	☐ Ears Ring	☐ Diarrhea	☐ _____

Symptoms Other Than Above _____

21. Have you lost time from work as a result of this accident? ( ) Yes ( ) No If yes, please complete this question.

a. Last Day Worked: _____

b. Type of Employment: _____

c. Present Salary: _____

d. Are you being compensated for time lost from work? ( ) Yes ( ) No If yes, please state type of compensation you are receiving: _____

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

23. Other pertinent information: _____

_____ DATE

_____ PATIENT'S SIGNATURE

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

SECURITY AGREEMENT & ASSIGNMENT OF AN INTEREST IN A PERSONAL INJURY CLAIM

TO: Attorney/Insurance Carrier Doctor

_____ _____

_____ _____

RE: Patient's records and Security Agreement & Assignment of an Interest in a Personal Injury Claim.

I do hereby authorize the above doctor to furnish you, my attorney/insurance carrier, with a full report of his case history, examination, diagnosis, treatment and prognosis of myself in regard to my accident/illness which occurred / began on_____.

I hereby give a lien to said doctor on any settlement and direct you, my attorney/insurance carrier, to pay directly to said doctor such sums as may be due and owing him for service rendered to me, and to withhold such sums from such settlement, claim, judgment or verdict as may be necessary to protect said doctor adequately. Prior to dispersing any such fees, it is the responsibility of the payor to verify with this office all outstanding balances.

I fully understand that I am directly and fully responsible to said doctor for all chiropractic 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. And I further understand that such payment is not contingent on any settlement, claim, judgment or verdict by which I may eventually recover said fee. I also understand and agree that I am responsible for any reasonable collections fees required to secure the doctor's payment.

I further understand that there is likely to be an outstanding balance at the end of my treatments. This balance may be due to uncovered expenses such as orthopedic supplies and/or any medically necessary treatment beyond that authorized by my health insurance coverage. I agree to make any/all co-payments as per my health insurance contract.

Dated: _____Patient's Signature: _____

The undersigned being attorney of record or authorized representative of insurance carrier for the above patient does hereby acknowledge receipt of the above lien, and does agree to honor the same to protect adequately said above named doctor.

Dated: _____Authorized Signature: _____

Attorney/Insurance Carrier:

Please date, sign and return to doctor's office at once.

Keep a copy for your records.

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

DIRECT ASSIGNMENT OF BENEFITS & RIGHTS

PROVIDER: **PATIENT:** **Date:**

In consideration of your undertaking to render care, I agree to the following:

1. RELEASE OF INFORMATION: You are authorized to release any information you deem appropriate concerning my physical condition to any Insurance company, attorney or adjuster In order to process any claim for reimbursement of charges incurred by me at your treatment facility.
2. RIGHT TO RECEIVE INFORMATION: I authorize my chiropractic provider the authority to affix my necessary signature as noted below to obtain medical information from any hospital, medical provider, etc. as It relates to the care being provided by my chiropractic doctor.
3. RIGHT TO RECEIVE PAYMENT: I irrevocably authorize and assign to you, the chiropractic provider, the right to receive direct payment from my attorney or any Insurance company which may become obligated to pay me any sums. I further authorize the endorsement of my name to any draft containing my name to which you are legally entitled.
4. ASSIGNMENT OF RIGHT TO SUE: In the event any insurance company or attorney obligated by contractual agreement to make payment to me for your service charges refuses to make such payment upon demand by you, I irrevocably hereby assign and transfer to you the cause of action that exists in my favor against any such company or attorney and authorize you to prosecute said action either in my name or your name as you otherwise resolve said claim as you see fit. I understand that whatever amounts you do not collect from said insurance proceeds (whether it be all or part of what is due) shall be paid by me.
5. RIGHT TO LIEN: I also irrevocably assign to you, the chiropractic provider, and grant the right of lien against any and all claims against any third party whose negligence may have caused my Injury, Including their insurance, up to the amount of the bill for treatment, as it relates to my healthcare as provided by you.
6. RIGHT FOR INFORMATION: I irrevocably authorize my attorney, legal representative, insurer or any other party regarding my care or case to release financial information about proposed settlement, settlement/verdict payments or amounts owed included, but not limited to other providers or legal representatives, liens, billing amounts, and balances. I also instruct all representatives to include all financial information from all facets of my case including, but not limited to third party, uninsured motorist and underinsured motorists.
7. I irrevocably waive the Statute of Limitations regarding my doctor's right to recover from me directly.
8. I hereby acknowledge that I am receiving (or about to receive) health care services and I am advised that they are willing to wait for payment for these services, provided 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 (a) there Is no insurance company obligated to pay for the services, or if the insurance company Involved refuses to acknowledge an assignment to the Doctor(s) or make other provisions for the protection of the interest of the Doctor(s); or (b) if a liability claim exists and my attorney refuses to agree to protect the interest of the Doctor(s) or If I have not engaged the services of an attorney, payment for services rendered by the above-named Doctor(s) will be made on a current basis and my account paid In full immediately. In any event, I hereby promise to pay my bill in full within (10) days from the date my liability claim Is settled or after the passage of three (3) months from the date of my last treatment, whichever comes first.
9. If any payment for any services rendered under this agreement becomes delinquent, the patient or patient's guardian shall be responsible for payment of any and all court costs, attorney's fees, service of process fees and any additional reasonable costs incurred in order to collect or that are associated with collecting monies due on the patient's· account.

Dated Signature ___ day of _____ 20 __ Patient Signature_____

Witness Signature _____

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_____