Springs Chiropractic

North Office: 1802 Chapel Hills Dr. Suite E P: 719-531-7188 F: 719-531-0880
South Office: 2620 Tenderfoot Hill St. #10 P: 719-527-6747 F: 719-579-9623

AUTOMOBILE ACCIDENT QUESTIONNAIRE

Dear Patient: We need this information because we care enough to want to know, and your answers will help us determine if chiropractic care can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. In order for us to understand your condition properly, please be as neat and accurate as possible. Thank You

Name_____ Today's Date_____ Sex: M or F Marital Status: S M D W

Address_____ City_____ State_____ Zip_____

Home Phone #_____Cell #_____ Work#_____

Date of Birth_____ Age _____SS #_____

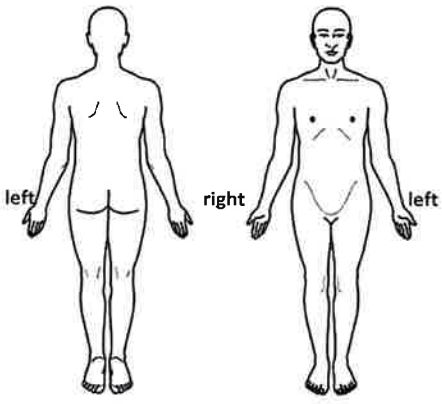
Occupation_____ Employer_____

Email_____ How did you hear about us?_____

ACCIDENT INFORMATION

Driver of Vehicle in which you were injured_____ Relationship_____
The Date of Accident_____ Time of Accident_____
You were heading ( ) North ( ) South ( ) East ( ) West on _____(street or highway)
Other vehicle was heading ( ) North ( ) South ( ) East ( ) West on _____
You were struck from ( ) Behind ( ) Front ( ) Left side ( ) Right Side
You were ( ) Driver ( ) Front Passenger ( ) Rear Passenger Seat Belts Used? ( ) Yes ( ) No
Where did you feel pain immediately after the accident? _____
Where were you taken after the accident? _____
Was any Doctor consulted after the accident? ( ) Yes ( ) No Doctor's Name _____
What treatment was given? _____
What was the diagnosis? _____
Have you had any complaints in the involved area before? ( ) Yes ( ) No
If so, what were the complaints? _____
Are your work activities restricted as a result of this accident? ( ) Yes ( ) No
Since the injury, are symptoms ( ) Improving ( ) Getting Worse ( ) Same

PLEASE MARK YOUR AREAS OF PAIN ON THE FIGURES AT RIGHT >



Name of **Your** Auto Insurance _____ Policy #_____
Do you have Med Pay? ( ) Yes ( ) No If yes claim #_____
Name of Your Insurance Adjustor_____ Phone #_____
Name of Your Health Insurance _____

Name of **Other Driver's** Auto Insurance_____ Policy #_____
Claim #_____ Name of Insurance Adjustor_____ Phone #_____
Have you retained an Attorney? ( ) Yes ( ) No Name and address_____

Please explain how your accident happened _____

_____

_____

HEALTH QUESTIONNAIRE:

Please indicate for each of the questions below your experience by use of the following codes:
1 – Never: 2 – Previously had: 3 – Presently have

Musculo-Skeletal System

( ) Low back problems
( ) Pain between shoulders
( ) Neck problems
( ) Leg problems
( ) Swollen joints
( ) Stiff joints
( ) Sore muscles
( ) Weak Muscles
( ) Walking problems
( ) Ruptures
( ) Broken bones

Genito-Urinary System

( ) Bladder trouble
( ) Excessive urination
( ) Scanty urination
( ) Painful urination
( ) Discolored urine

Female

( ) Abnormal vaginal discharge
( ) Abnormal vaginal bleeding
( ) Abnormal vaginal pain
( ) Breast pain
( ) Lumps on breasts

Are you pregnant?
( ) Yes ( ) No

Gastro-Intestinal

( ) Poor appetite
( ) Excessive hunger
( ) Difficulty swallowing
( ) Difficulty chewing
( ) Excessive thirst
( ) Nausea
( ) Vomiting blood
( ) Abdominal pain
( ) Diarrhea
( ) Constipation
( ) Black stool
( ) Bloody stool
( ) Hemorrhoids
( ) Liver trouble
( ) Gall bladder problems
( ) Weight trouble

Nervous System

( ) Numbness
( ) Loss of feeling
( ) Paralysis
( ) Dizziness
( ) Fainting
( ) Headaches
( ) Muscle jerking
( ) Convulsions
( ) Confusion
( ) Depression

Eye, Ear, Nose & Throat

( ) Eye strain
( ) Eye inflammation
( ) Vision problems
( ) Ear pain
( ) Ear noises
( ) Ear discharge
( ) Hearing loss
( ) Nose pain
( ) Nose bleeding
( ) Sore gums
( ) Dental Problems
( ) Sore mouth
( ) Sore throat
( ) Hoarseness
( ) Difficult speech
( ) Hard to breathe/nose

Cardio-Vascular/Respiratory

( ) Chest pain
( ) Pain over heart
( ) Difficulty breathing
( ) Persistent cough
( ) Coughing phlegm
( ) Coughing blood
( ) Rapid heartbeat
( ) Heart problems
( ) Lung problems
( ) Varicose veins
( ) High blood pressure

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's office will be credited to my account upon receipt. However, I clearly understand and agree that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

I hereby authorize the Doctor to examine me and treat my condition as he/she deems appropriate through the use of Chiropractic Health Care and I give authorization for these procedures to be performed. I also agree that I am responsible for all bills incurred in this office including any balance not paid by Health Insurance for the treatment of the auto accident related injuries. The Doctor will not be held responsible for any pre-existing, medically diagnosed conditions nor for any medical diagnosis.

Patient's/Guardian's Signature_____ Date_____

Auto Injury Form

Date_____

Patient's Name_____

Date of Birth_____

Date of Injury_____

Social Security Number_____

At Fault Driver_____

At Fault Driver Insurance_____

Claim Number_____

Med Pay Yes No

Med Pay Insurance_____

Claim Number_____

Other Comments_____

_____

_____

_____

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MOTOR VEHICLE ACCIDENT BILLING POLICY

In 2002, the Colorado legislature changed the auto insurance laws to eliminate personal injury protection coverage. This created a TORT system where the at-fault party must pay for the medical expenses of anyone injured in the accident. Health insurance plans are not set up to cover injuries sustained in a traumatic situation such as a motor vehicle accident. Their limited coverage does not allow the physician any leeway in treating serious injuries that are not always readily apparent when dealing with this type of trauma.
If you have med pay coverage on your auto insurance policy, whether you are the at-fault driver or the non-fault driver, this coverage is primary and will be billed before any other insurance is billed.

If you are the at-fault driver and you have no med pay coverage through your auto insurance company, then you need to understand that we will bill your health insurance but you will be responsible for fees that exceed the boundaries of a limited insurance plan. No insurance write-off will be made.

If you have any questions or further clarification is needed, please feel free to discuss this or any of our office policies with the doctor.

_____ _____

Patient or Responsible Party Signature Date

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Health Care Provider's Lien

Springs Chiropractic, P.C.
1802 Chapel Hills Dr., Suite E
Colorado Springs, CO 80920
719-531-7188 FAX 719-531-0880

Patient: _____ Date: _____ DOB: _____

I have a cause of action as a result of injuries sustained by me on _____.

I appreciate you treating me, even though I do not have the funds to personally pay for your services at this time.

I understand that I am directly and fully responsible to pay you for all the reasonable and necessary medical bills incurred by me for services provided by you. This agreement is made in consideration of your continued treatment of me, awaiting payment, and foregoing collection efforts.

I give a lien to you on any settlement or jury verdict which I receive as a result of my cause of action. I authorize and direct my attorney to pay directly to you such sum as may be due for services rendered me, and to withhold such sum from my portion of any settlement or jury verdict. In the event my portion of recovery is insufficient to cover all of the protected medical bills in my case, then I will reimburse you from my portion of the recovery on a pro-rata basis with all of my other protected medical bills. I further understand, however, that such pro-rata payment will not be considered payment in full by me, and that I remain fully responsible to pay the balance of my medical bill, and that my personal liability is not contingent on the settlement or jury verdict which I may recover.

Date: _____ **Patient's signature:** _____

As the patient's attorney, I acknowledge the above lien. Upon final settlement or jury verdict in this case, I agree to withhold your medical fees from the client's share of any settlement or jury verdict, and forward full payment to you.

It is expressly understood that in the event the lawyer-client relationship is terminated prior to resolution of the client's case, I will notify you as soon as practical, and I will continue to use my best efforts to ensure that your fees will be protected. I will notify any new attorney, and if there is none, then the insurance company, that the case cannot be concluded without paying your fees in accordance with this agreement.

Date: _____ **Attorney's signature:** _____

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INFORMED CONSENT FOR TREATMENT

Patient: _____ DOB: _____

Phone: _____ Email: _____

Medical doctors, chiropractic doctors, and osteopathic doctors who perform manipulation are required by law to obtain your informed consent before starting treatment.

I, _____ do hereby give my consent to the performance of conservative noninvasive treatment to the joints and soft tissues. I understand that the procedures may consist of manipulations/adjustments involving movement of the joints and soft tissues. Physical therapy and exercises may also be used. Although spinal and extremity manipulation/adjusting is considered to be one of the safest, most effective forms of therapy for musculoskeletal problems, I am aware that there are possible risks and complications associated with these procedures as follows:

Soreness: I am aware, that like exercise, it is common to experience muscle soreness after the first few treatments.

Dizziness: Temporary symptoms like dizziness and nausea can occur, but are relatively rare.

Fractures/Joint Injury: I further understand that in isolated cases, underlying physical defects, deformities, or pathologies like weak bones from osteoporosis may render the patient susceptible to injury. When osteoporosis, degenerative disc disease, or other abnormality is detected, extra caution will be exercised during treatment.

Stroke: Although strokes happen with some frequency in our world, strokes from chiropractic adjustments are rare. I am aware that nerve or brain damage including stroke is reported to occur once in a million to once in ten million treatments. Once in a million is about the same chance as getting hit by lightning. Once in ten million is about the same chance as a normal dose of aspirin or Tylenol causing death.

Tests have been or will be performed on me to minimize the risk of any complication from treatment and I freely assume these risks.

TREATMENT RESULTS

I also understand that there are beneficial effects associated with these treatment procedures including decreased pain, improved mobility and function, and reduced muscle spasm. However, I am aware that there is no certainty that I will achieve these benefits

I have read or had read to me the above explanation of chiropractic treatment. Any questions I have had regarding these procedures have been answered to my satisfaction PRIOR TO MY SIGNING THIS CONSENT FORM. I have made my decision voluntarily and freely. To attest to my consent to these procedures, I hereby affix my signature to this authorization for treatment.

Patient Signature: _____ Date: _____

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THIS NOTICE DESCRIBES HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION (PHI) AND HOW YOU CAN ACCESS THIS INFORMATION. PLEASE REVIEW NOTICE CAREFULLY.

Once you sign Springs Chiropractic's registration & consent form, we may use and disclose your medical information to treat you, to obtain payment, and to operate the practice.

Examples of uses and disclosures for treatment;

If a physician from our practice refers you for outside testing and needs to call that facility for test results, the staff may give your name and reason for testing to that facility.
A physician that you were referred to or from may call to discuss your Personal Health Information (PHI) with our physician.

Example of use and disclosure to obtain payment:

The practice's billing office may submit a claim form that contains your name, address, social security number, diagnoses and procedures performed in our office to your insurance company and discuss this information if necessary with their staff to procure payment of claim.

Examples of use and disclosure to operate the practice:

The practice physicians and staff may audit your medical records.
The practice staff may mail you information and billing statements.
The practice staff may leave messages asking for a return call to discuss medical or financial issues.
This practice may use or disclose your PHI with your written authorization. You may revoke authorization in writing.

This practice may use or disclose PHI for other purposes, and without your consent, if the law requires us to disclose this information to government authorities. Examples of such uses; suspected abuse and infectious diseases.

You have the following rights regarding your Protected Health Information, and the practice must act on your request within 60 days.

You may request a paper copy of this notice.
You may request that your information be amended (must be done in writing).
You may inspect and copy your own Protected Health Information.
You may request restrictions on use of certain PHI, but we are not required by law to agree to a restriction. You may request information to be given to other individuals (must be in and signed and dated).
We are required by law to maintain the privacy of PHI. You may complain to the practice manager if you believe your rights have been violated. This must be in writing, or you may complain to the U.S. Department of Health and Human Services.

It is our responsibility to guard and maintain information about you and your health in a very private manner. This information will be disclosed within the practice on a "Need to Know" basis, and then kept confidential. We will comply with Federal, State, and local laws on "Confidentiality of Medical Information".

I, _____, consent to allow Springs Chiropractic to use and disclose PHI about me for the purpose of treatment, payment, and health care operations in accordance with the above described procedures of health information privacy protection. I further understand my rights under the law as also described above.

_____ _____

Patient Signature (Parent/Guardian if minor) Today's Date

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PATIENT'S NAME: _____ DOB: _____

CELL#: _____ WORK #: _____ HOME #: _____

1. **What is your current smoking status?**

   Everyday Smoker: _____ Occasional Smoker: _____ Never Smoked: _____ Former Smoker: _____

   CURRENT SMOKER: Number of years/months you have SMOKED _____
   FORMER SMOKER: Number of years you smoked_____Number of years since you QUIT _____

2. **Race?**

   Caucasian: _____ Black/African American: _____ Asian: _____ American Indian/Alaska Native: _____ Decline: _____

3. **Ethnicity?**

   Hispanic/Latino: _____ Non-Hispanic/Latino: _____ Decline: _____

4. **Preferred Language?**

   English: ___ Spanish: ___ French: ___ Italian: ___ Japanese: ___ Portugese: ___ Russian: ___ Other: ___ Decline: ___

5. **Do you have any allergies? (Please list)**

_____

_____

6. **Are you currently taking any medicatons/supplements? (Please List)**

_____

_____

7: Height: _____ **Weight:** _____

OFFICE USE

BP: _____ HR: _____