

FINANCIAL AGREEMENT PERSONAL INJURY

We would like to take a moment to welcome you to our office and assure you that you will receive the very best of care available for your injury. In order to familiarize you with the financial policy of this office we would like to explain how your medical bills will be handled.

Party Responsibility

If you were involved in an auto accident in your own vehicle, we will bill the medical payments portion or Personal Injury Protection portion of your automobile insurance policy to cover the treatment charges incurred in our office.

Med Pay: If you were a passenger in another vehicle, the insurance company which insures the automobile may be billed for your medical services incurred.

PIP: If you were a passenger in another vehicle, and you own a car which has PIP coverage, the insurance company which carries your policy will be responsible to pay your medical bills.

3rd Party: If another vehicle has caused the accident, we will first bill your automobile Med Pay or PIP policy for coverage PRIOR to submitting a claim to the insurance carrier of the party at fault. If we rely solely on a 3rd party settlement for payment, please understand that the insurance carrier will pay you directly upon settlement. **By signing this form, you are agreeing to pay your balance in full within 3 days of receiving your settlement.** x _____ (Patient's Initials)

It is also to your advantage for our office to bill your own health insurance policy for your medical services, providing your policy does not state otherwise. Any amount received above and beyond your total bill in this office will be refunded to you.

Attorney Liens

If you hire an attorney to represent you in a law suit, it is our policy to have your attorney sign a Doctor's Lien. This will guarantee direct payment to our office for any unpaid balance upon the settlement of your law suit. We retain the right to first submit all charges to your private and/or auto insurance policy for payment. Further, this office does not discount or reduce the amount of your balance based upon the outcome of your settlement.

Responsibility for Payment

As a courtesy to you, we will gladly submit your charges to your insurance company(ies) and/or your attorney; however, all services rendered by this office are charged directly to you, and, ultimately, you are personally responsible for payment of these charges regardless of any insurance reimbursement or settlement you may or may not receive.

Voluntary Termination of Care

If you suspend or terminate your care at any time, your portion of all charges for professional services is immediately due and payable to this office.

We hope this answers any questions you might have concerning the financial policy of this office. Once again we welcome you to our office, and will be glad to answer any further questions that you might have.

I have read and agree to the above.

Patient's Signature

Date

Patient's Name Printed

Witness' Signature

PERSONAL INJURY QUESTIONNAIRE

Patient Information:

Name _____ Phone () _____
Address _____ City _____ State _____ Zip _____
Age _____ Birthdate _____ Sex _____ SSN # _____

Health Insurance Information:

Insurance Co. _____ Member ID # _____
Policy Holder's Name _____ Group # _____

Your Auto Ins. Information:

Insurance Co. _____ Policy # _____
Adjustor's Name _____ Claim # _____

Other Party's Auto Insurance Information:

Name _____ Policy # _____
Insurance Co. _____ Claim # _____

ATTORNEY Name _____ Phone () _____
Address _____ City _____ State _____ Zip _____

ACCIDENT INFORMATION:

Date of Accident _____ Time of Day _____
Were you: Driver Passenger Front Seat Back Seat Pedestrian
Were there any witnesses? YES NO Name(s) _____
Were you struck from: Behind Front Left Right
What did your vehicle impact? Another vehicle Other _____
Approximate speed of your car _____ mph. Other car _____ mph
Were you knocked unconscious? YES NO If yes, for how long? _____
Were police notified? YES NO
In your own words, describe accident:

Please describe how you FELT:

- a. DURING the accident: _____
b. IMMEDIATELY AFTER the accident: _____
c. LATER THAT DAY: _____
d. THE NEXT DAY: _____

POST-INJURY INFORMATION:

Have you seen any other doctor(s) since the accident? YES NO
Name and Address _____
When did you go? IMMEDIATELY NEXT DAY 2 DAYS PLUS
How did you get there? AMBULANCE PRIVATE TRANSPORTATION
Please describe any treatment you received _____
Were X-Rays done? YES NO An MRI? YES NO CT scan? YES NO
Was medication prescribed? YES NO If yes, what? _____

Indicate symptoms you have noticed:

- | | | | | |
|---|---|---|---|--|
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Jaw Problems | <input type="checkbox"/> Arm/Shoulder Pain | <input type="checkbox"/> Leg Pain | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Memory Loss | <input type="checkbox"/> Nausea | <input type="checkbox"/> Numb Hands/Fingers | <input type="checkbox"/> Numb Feet/Toes | <input type="checkbox"/> Difficulty Sleeping |
| <input type="checkbox"/> Headache(s) | <input type="checkbox"/> Head Seems Too Heavy | <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Irritability |
| <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Lights Bother Eyes | <input type="checkbox"/> Mid-Back Pain | <input type="checkbox"/> Short Breath | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Ears Ringing | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Stomach Upset | |

OTHER _____

Did you have any physical complaints BEFORE THE ACCIDENT? YES NO

If yes, please describe in detail _____

Has your condition IMPROVED WORSENERD or STAYED SAME since the accident?

Other PRESENT complaints and symptoms? _____

Is your condition affecting your WORK SLEEP or DAILY ROUTINE? Please explain.

EMPLOYMENT:

Employer's Name _____ Employer's Address _____

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. Are you being compensated for time lost from work? YES NO If yes, please state type of compensation you are receiving: _____

HEALTH HISTORY

Have you ever had any of the following diseases or conditions?

- | | | | | |
|--|--|--|---|--|
| <input type="checkbox"/> Heart Attack or Stroke | <input type="checkbox"/> Cancer | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Difficulty Breathing | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Congenital Heart Defect | <input type="checkbox"/> Fainting/Seizure/Epilepsy | <input type="checkbox"/> Shingles | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> HIV+/Aids | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Ulcers/Colitis |
| <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Artificial Bones/Joints | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Heart Surgery or Pacemaker | <input type="checkbox"/> Rheumatic Fever |

Please list any other medical conditions that you have or have ever had. _____

Please list any allergies. _____

Do you smoke? YES NO How much? _____ How long? _____

For women: Are you taking birth control? YES NO

Are you pregnant? YES NO How long? _____ Nursing? YES NO

Please list previous surgeries and dates. _____

Please list any past motor vehicle accidents or traumas and dates. _____

Is there anything else about your health history or family health history that you feel is important to share? _____

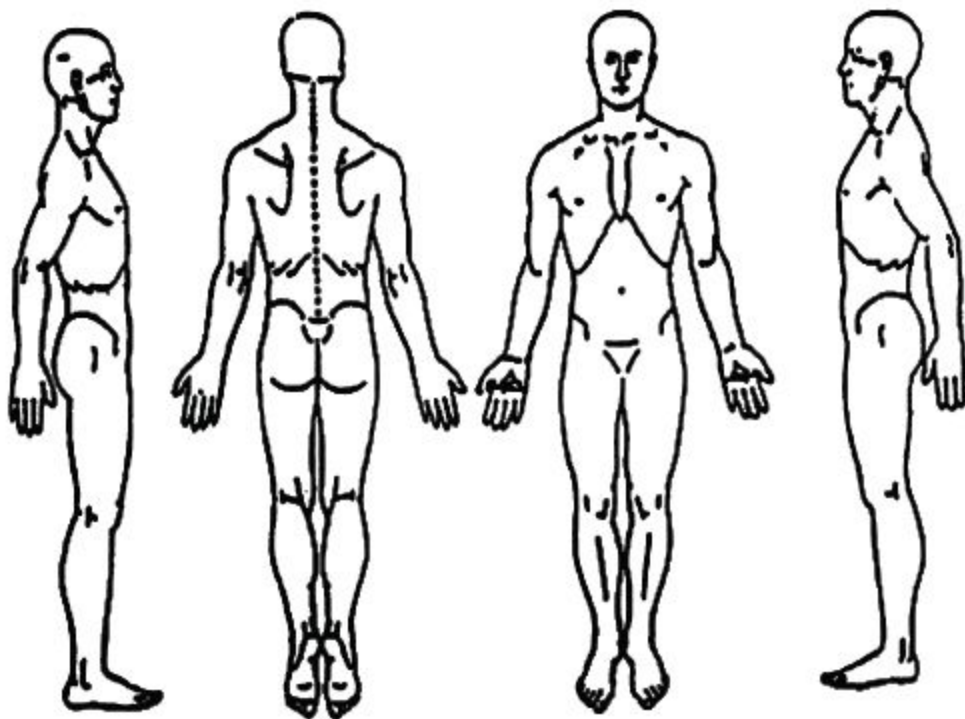
Other pertinent information: _____

PATIENT'S SIGNATURE

DATE

Name _____ Date _____

On the diagram below, please indicate where you are CURRENTLY experiencing pain or other symptoms.



A = ACHE
P = PINS & NEEDLES

B = BURNING
S = STABBING

N = NUMBNESS
O = OTHER



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 advise patients that there are risks associated with such 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 injuries to the arteries of the neck leading or contributing to serious complications including stroke. This occurrence is exceptionally rare and remote. However, you are being informed of the possibility regardless of the extreme remote chance.
- 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.

The probabilities of these complications are rare and generally result from some underlying weakness of the bone or tissue, which I check 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 consent to the chiropractic treatments offered or recommended to me by my chiropractor, including spinal manipulation. I intend this consent to apply to all my present and future chiropractic care.

Patient Signature

Patient Name

Witness Signature

Date