Patient Registration/Personal Injury

PATIENT INFORMATION

Patient Name: _____ Account #: _____
First Middle Last

Address: _____
Street Address City State Zip

Home Phone: _____ Work/Cell: _____

SSN: _____ Date of Birth: _____ ☐Male ☐Female

Name of Spouse: _____

Contact Number:_____

Employer Name: _____Work Number: _____

Address:_____
Street Address City State Zip

Please indicate any prescribed medications or over the counter medications you are currently taking?

_____

Health Insurance:_____ Name of Insured: _____

ID#: _____ Phone#: _____

PERSONAL INJURIES

Name: _____ Account # _____

Date of Injury: _____ Time of Injury _____

Type of Accident: ☐Auto Accident ☐ Work lnjury ☐Slip and Fall ☐ Other _____

Describe how the accident occurred: _____

_____

_____

If auto accident, were you? ☐Driver ☐Passenger ☐Pedestrian

Were 'you hit from? ☐ Behind ☐ Right Side ☐ Left Side ☐ Front ☐Other

How many people were in your vehicle? _____ Were you aware of the oncoming collision? ☐ YES ☐NO

Year and Model of your vehicle? _____ Other car? _____

Did you go to the hospital? ☐ YES ☐ NO If yes, which hospital? _____

If yes, by? ☐Ambulance ☐Drove yourself ☐Other What hurts? _____

Have you missed any days from work? ☐ YES ☐ NO If yes, how many days? _____

Do you have Auto Insurance? ☐ YES ☐NO

Auto Insurance Co:_____ Policy #: _____

Claim #: _____ Phone #: _____

_____ _____

Patient Signature Date

Nicholl Chiropractic, Inc.
2210 Lake Washington Blvd. #130
West Sacramento, CA 95691
916-594-7639

INFORMED CONSENT

Every type health care delivery system has same associated risks and the potential for occasional problems of same kind. Humans and their injuries are unique and something that might be effective tor one person might not be helpful to another. We are committed to providing you with the best and safest care possible however; we have a responsibility to you to inform you about some of the problems that are rarely or occasionally associated with chiropractic treatment. Before you start your treatment, you must review this notice and consent to receive chiropractic care. This is called informed consent. Please feel free to discuss directly with Dr. Nicholl any questions or concerns that you may have.

Disc Herniations: Disc herniations are frequently and successfully treated by chiropractors. Occasionally, chiropractic treatment may aggravate the problem and rarely surgical Intervention may become necessary if the chiropractic care is not successful. Vary rarely, chiropractic adjustments may also cause a disc problem if the disc is already damaged or in a weakened condition. These problems occur so rarely that there is no available statistical Information to quantify their probability.

Soft Tissue Injury: Soft tissues primarily refer to muscles, tendons, and ligaments. Rarely, a chiropractic adjustment, traction, massage, etc. may overstretch or tear same muscle, tendon, or ligament fibers. The result is a temporary increase in pain and a brief, temporary increased need tor, treatment, but in most every case there are no long-term effects to the patient. These problems occur so infrequently and are so rare that there are no available statistics to quantify there probability.

Rib Fracture: Rarely, chiropractic adjustment(s) may crack a rib bone. This risk is increased in elderly, osteoporotic bones. We adjust all patients very carefully, especially our elderly patients with osteoporosis. These problems of rib fracture occur so rarely that there are no available statistics to quantify their probability.

Burns: Some of the physiotherapy equipment generates heat (diathermy, ultrasound) and we also use ice and hot packs. Rarely, these modalities ice or heat can irritate or cause superficial skin burns. This can result in a temporary increase in localized pain reddening swelling or in some rare cases blistering of the skin. These problems occur so rarely that there are no available statistics to quantify their probability.

Soreness: Chiropractic adjustments, traction, massage therapy; exercise, etc. may result in temporary increase in soreness. This is usually a very temporary symptom. It is not dangerous, but please tell your doctor about lt.

Stroke: Stroke is VERY uncommon, but it is the most serious problem associated with vertebral manipulation of the cervical spine (neck). In the May, 1994 Chiropractic Report, they discuss this problem, **"By any medical standard, chiropractic cervical adjustment is an extremely safe treatment. Vertebral artery injury causing stroke is the only serious potential complication. There is a risk rate (incidence) of about .0002%, or one in two million," In another study, (Journal of CCA, Vol. 37, Na. 2, June 1993) they estimate that the risk of this type of stroke is .0003%, one in three million.**

Other Problems: There may be other problems or complications that might arise from chiropractic treatment, other than those noted above. These other problems am complications occur so rarely that it is not possible to anticipate, predict, or explain them all in advance of treatment. Chiropractic is a system of health care delivery, and, therefore, as with any health care delivery system, we cannot promise any guarantee to cure any Symptom, disease, or condition. Please keep your doctor advised of any situation that occurs, since early identification is important to minimize side effects and to provide you with the best came that you deserve. Finally, if you have questions regarding any of the above Information or concepts please ask your doctor. When you have a full and satisfactory understanding please sign and date below.

_____ _____

PATIENT SIGNATURE DATE

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Office Fee Schedule and Financial Policy

Service	***Fees***
Consultation	Free
Initial Exam	$202.00
Re-Exams	$97.00
X-rays	$87.00 - 200.00
Adjustments	$55.00 – 75.00
Ancillary Procedures	$30.00 – 60.00

Financial Policy

We are committed to providing you with the best chiropractic care possible in a caring environment and have established our financial policies to achieve that goal. You will be expected to pay for your chiropractic care at the time service is rendered unless you have an Active Life Plan in advance. Active Life Plans include yearly Corrective Adjustment Plans (CAP), monthly CAP's or extended payment plans. These Active Life Plans are designed to be the most cost effective way to keep you and your family as healthy as possible. Details of these plans will be discussed with you during your Chiropractic Report.

Cash- Charges for care in this office are due at the time of your service. If you need to set up a payment plan in order to make payments towards your balance, please talk to the Office Manager to set this up (In Advance).

Health Insurance- An insurance policy is an agreement between and insurance company and you. Most insurance companies cover Chiropractic, but this office makes no representation that yours does. Due to the variances between policies, which could range from a large deductible and, 100% of the bill, we therefore urge you to carefully review your coverage.

As a courtesy, we will prepare and bill your insurance company, providing you complete the employee portion of your insurance form.

We ask that you establish yourself with our office and pay 100% of your first office visit in fall. Monthly we will expect payment for the remaining unpaid percentage that your insurance company is not responsible for. We will accept your assignment of benefits; however you must remember you are directly responsible for your bill.

Medicare- Medicare will not pay for x-rays; however they require them and an exam before they will pay for your treatments. You will be responsible for the cost of your x-rays and exam. If you have not met your deductible, this must also be satisfied.

Personal Injury- (Auto Accident, slip/fall) If you have medical coverage (Med-Pay) on your auto insurance policy, we will bill them for prompt and direct payment for your care. (Med-Pay will cover your doctor's bill regardless of who was at fault). If you do not have Med-Pay we will defer to a third party lien however we do require that you obtain an attorney. If you do not have one, we can recommend several attorney's for you.

Patient's Signature

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PROMISSORY NOTE

I, _____ promise to pay Dr. Tim Nicholl, D.C., immediately upon settlement of my claim with the third party insurance company of any other pay source. I understand that I am financially responsible for the total amount of services provided resulting from injuries of said accident. I understand that Dr. Tim Nicholl, D.C. may exercise his right to charge interest at the rate of 1 1/2% monthly on the unpaid balance until it is paid in full.

I do not have any other insurance available for immediate payment for Dr. Tim Nicholl, D.C. services. Legal counsel does not represent me at the present time. In the event, I do obtain legal representation for this injury I will notify, Dr. Tim Nicholl's billing department.

I understand that in the event it becomes necessary to retain legal counsel, seek legal remedies or engage in any collection actives, I will be personally responsible for the additional costs incurred in recovery of said monies on behalf of Dr. Tim Nicholl, D.C.

Furthermore, I authorize Dr. Tim Nicholl, D.C. to contact the third party insurance company for the purpose of monitoring the settlement process.

_____

Patient Signature Date

Third Party Insurance: _____ Phone _____

Address: _____

Street Address City State Zip Code

Claim # _____ Insured Name: _____

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ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO DOCTOR PRIVATE AND GROUP ACCIDENT AND HEALTH INSURANCE

Patient Name: _____

Date of Birth:_____ SSN #: _____

I hereby instruct and direct _____ insurance Company

to pay by check made out and mailed directly to:

Nicholl Chiropractic, Inc.
2210 Lake Washington Blvd. #130
West Sacramento, Ca 95691

If my current policy prohibits direct payment to Dr. Tim Nicholl, then I hereby also instruct and direct you make out the check to me and mail it as follows:

Nicholl Chiropractic, Inc.
2210 Lake Washington Blvd. #130
West Sacramento, Ca 95691

The professional of medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY PJGHTS AND BENEFITS UDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charge over and above this insurance payment.

A photocopy of this assignment shall be considered as effective and valid as the original.

I also authorized the release of any information pertinent to my case to any insurance company, adjuster or attorney involved in this case.

Date at _____ this _____ day of_____ 20__

_____ _____
Signature of Policy holder Signature of Claimant, if other than policy holder

By signing above, the deductible and co-payments of my chiropractic treatments would be a financial hardship on me

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RESCISSION OF ATTORNEY ASSIGNMENT OF BENEFITS

Patient Name:_____ Account: _____

Insured Name:_____ Date of Injury: _____

Claim # / Policy #: _____ Social Security: _____

I, being the insured on this policy, specifically direct you, my insurance company to rescind and cancel any assignment given to you by any third part including my attorney, EXCEPT to my physician:

Nicholl Chiropractic, Inc.
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As the owner and beneficiary of this policy, further I direct that reimbursement for ALL services be paid DIRECTLY to my physician, the provider of services, under the terms of my contract with this company, NO other third party, including my attorney, should receive payment of my medical bills, except the treating physician for the remainder of this claim.

Thank you for your cooperation regarding this matter.

_____ _____
Patient / Insured Signature Date

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NOTICE OF DOCTOR'S LIEN

I do hereby authorize Dr. Tim Nicholl to furnish you, my attorney, with a full report of his examination, diagnosis, treatment, prognosis, etc. of myself in regard to the accident in which I was recently involved.

I hereby authorize and direct you, my attorney, to pay directly to said doctor such sums as may be due and owing him for medical service rendered to me both by reason of this accident and by reason of any other bills that are due at this office and to withhold such sums from any settlement, judgment or verdict as may be necessary in adequately protect the said doctor. I also, hereby further give a lien on my case to the said doctor against any and all proceeds of my settlement, judgment or verdict which may be paid to you, my attorney, or myself, as the result of the injuries for which I have been treated or injuries in connection therewith.

I agree never to rescind this document and that a recession will not be honored by my attorney. I hereby instruct that in the event another attorney is substituted in this matter, the new attorney will honor this lien as inherent in the settlement and enforceable upon the case as if he executed it.
I fully understand that I am directly and fully responsible to the said doctor for all medical bills submitted by him for Services rendered to me and that this agreement is made solely for the said doctor's additional protection and in consideration of his awaiting payment. I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover the said fee.

Please acknowledge this letter by signing below and returning to the doctor's office. I have been advised that if my attorney does not wish to cooperate in protecting the doctor’s interest, the doctor will not await payment but may declare the entire balance due and payable.

_____ _____
Patient Signature Date

_____ _____
Print Account Number

The undersigned being attorney of record for the above patient 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 the said doctor named above. Attorney further agrees that in the event his lien is litigated that the prevailing party will be awarded attorney fees and costs.

_____ _____
Attorney Signature Date

_____
Print

Attorneys' Stamp

Please date, sign, stamp and return one copy to the doctors' Office listed above. Also keep one copy for your records.

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CREDIT GUARANTEE
PERSONAL INJURY - CHIROPRACTIC CARE BALANCES

PERSONAL INJURY POLICY

Our Personal Injury Program is designed to render you immediate care and keep your out-of-pocket expenses to a minimum. As a courtesy to you, we submit bills to your personal injury attorney, on your behalf and wait up to 6 months for payment. Please remember, however, that you are ultimately responsible for payment of all services rendered to you regardless of insurance coverage or settlement status. Termination of care prior to your doctor's release will result in all balances being due immediately. As a prerequisite, we ask that you provide a credit card and bank information to guarantee payment of your bill.

FILING PROCEDURE

We will periodically submit claims on your behalf to your attorney. Balances not paid within 6 months after conclusion of your care may be charged to your designated credit card/bank account below unless other arrangements are mutually agreed upon. You will be sent a payment voucher. Should settlement be reached within the 6 month grace period or should care be terminated for any reason prior to your physician dismissal, all balances become due immediately. Any unpaid balance will be charged to your credit card/bank account and are subject to monthly interest charges.

CREDIT CARD: VISA or MASTERCARD (circle one)

CARDHOLDER NAME: _____

CARD #: _____ EXP. DATE: _____ / _____ / _____

-AND-

☐ Checking ☐ Savings

Name on Acct _____

Bank Name _____

Account Number _____

Bank Routing # _____

Bank City/State _____

I agree to the above terms and authorize you to bill my credit card. I understand that should payment not be received within 6 months after termination of my care or should I terminate care before being dismissed by my physician, I will be charged the amount outstanding on my account.

Signature: _____Date: _____/ _____ / _____

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Personal Medical Information Consent Form
HIPPA

The Health Insurance Portability Accountability Act of 1996 (HIPPA) requires that we receive your permission before we use the personal information in your medical records for any reason.

This consent form gives us permission to use your Protected Health Information (PHI) to carry out treatment, receive and/or as part of health care operations, of our practice.

HIPPA also requires us to have a written notice of our privacy policy describing how medical information about you may be used and disclosed. If you so desired, this written notice is available at the front desk for you to read.

You have the right to revoke, in writing to his consent form at any time, although any services performed prior to the revocation of this consent are covered by this consent

_____ _____
Patient Signature Date

RESTRICTIONS:
Right to Revise Privacy Practices: As permitted by law, we reserve the right to amend or modify our privacy policies and practice. These changes in our office's policies and practices may be required by changes in federal and state laws and regulations. Upon receipt, we will provide you with the most recent notice on an office visit. The revised policies and practices will be applied to all protected health information we maintain

Dr. Tim Nicholl, D.C. & Staff