Maximize Chiropractic –Personal Injury Intake Form

Whom may we thank for referring you to this office → _____

Today's Date: _____ HR#: _____

PATIENT DEMOGRAPHICS

Name: _____ Birth Date: _____-_____-_____ Age: _____ ☐ Male ☐ Female

Address: _____ City: _____ State: _____ Zip: _____

E-mail Address: _____ Home Phone: _____ Mobile Phone:_____

Marital Status: ❑ Single ❑ Married ❑ Other:_____ ❑ No Work Phone: _____

Social Security #: _____ Driver's License #: ___ _____

Employer: _____ Occupation: _____

Spouse's Name _____ Spouse's Employer _____

Name & Number of Emergency Contact: _____ _____Relationship: _____

Do you have an attorney representing you for your accident? ☐ Yes ☐ No If yes, attorney name: _____

HISTORY of COMPLAINT

Please check the symptoms you have developed since the accident

☐ Headache	☐ Numbness in feet **R L Both**	☐ Loss of Memory	☐ Pain Behind Eyes
☐ Neck Pain/Stiffness	☐ Arm Weakness **R L Both**	☐ Dizziness	☐ Jaw Popping
☐ Mid Back Pain	☐ Leg Weakness **R L Both**	☐ Sleeping Problems	☐ Numbness in Fingers
☐ Facial Pain	☐ Low Back Pain	☐ Eyes Light Sensitive	☐ Fainting
☐ Irritability	☐ Arm Pain **R L Both**	☐ Fatigue	☐ Shortness of Breath
☐ Loss of Balance	☐ Leg Pain **R L Both**	☐ Depression	☐ Ringing/Buzzing in Ears
☐ Cold Feet	☐ Muscle Sapsm/Cramping	☐ Cold Hands	☐ Chest Pain
☐ Diarrhea	☐ Shoulder Pain **R L Both**	☐ Constipation	☐ _____

ABOUT the ACCIDENT

1. What was the date of the accident? _____ Time of Day: _____ AM PM
2. Where were you in the vehicle: ☐ Driver Seat ☐ Front Passenger ☐Rear Passenger L R ☐ Other_____
3. Cars involved in accident: Year, Type, and estimated speed

   Your Car Year_____ Make _____ Model _____ Speed _____

   Other Car Year_____ Make _____ Model _____ Speed _____

   Third Car Year_____ Make _____ Model _____ Speed _____
4. Type of accident: ☐ Head-on Collision ☐ Broad-Side Collision ☐ Roll-over ☐ Pedestrian/Bicycle ☐ _____
5. Please describe the accident in your own words: _____

   _____

   _____

   _____
6. Head/Body position at time of impact: ☐ Head turned left ☐ Head turned right ☐ Head faced forward ☐ Body rotated left ☐ Body rotated right ☐ Body faced forward
7. Were you wearing your seatbelt? ☐ Yes ☐ No

8. Did you brace yourself for the impact: ☐ Yes ☐ No

9. Upon impact, do you recall striking any objects inside of the car? ☐ Yes ☐ No

   If yes, what objects did you strike? _____

10. Since the accident, how are conditions becoming ☐ Better ☐ Worse ☐ About the same

11. Do your symptoms ☐ Come and Go, or are they ☐ Constant

12. Describe the symptoms you felt:

   Immediately after the accident :_____

   Later that day:_____

   The next day:_____

13. Were you transported to the hospital by ambulance? ☐ Yes ☐ No

14. Did you go to the hospital on your own? ☐ Yes ☐ No

15. What helps relieve your symptoms?_____

16. What aggravates your symptoms? _____

17. What were the road conditions at the time of the accident? ☐ Dry ☐ Wet ☐ Icy ☐ Snow ☐ _____

18. What was the visibility at the time of the accident? ☐ Good ☐ Fair ☐ Poor

19. Where was your car struck? _____

20. Did you lose consciousness after the accident? ☐ Yes ☐ No

PAST HISTORY

Do you have any prior history of any of the symptoms you checked above? ☐ Yes ☐ No If yes, explain:_____

_____

Have you ever been involved in any prior automobile accidents or ever had any serious falls/injuries? ☐ Yes ☐ No If yes, explain:

_____

What medications are your currently taking? _____

_____

HEALTH HISTORY

If you have ever been diagnosed with any of the following conditions, please indicate with a P for in the Past, or C for Currently.

___ Broken Bone	___ Dislocations	___ Tumors	___Rheumatoid Arthritis	___ Fracture
___ Disability	___ Cancer	___ Heart Attack	___Osteo Arthritis	___ Diabetes
___ Cerebral Vascular	___ Other serious conditions:_____			

SOCIAL HISTORY

1. Smoking:	❑ Daily	❑ Weekends	❑ Occasionally	❑ Never
2. Alcoholic Beverage:	❑ Daily	❑ Weekends	❑ Occasionally	❑ Never
3. Recreational Drug use:	❑ Daily	❑ Weekends	❑ Occasionally	❑ Never

I hereby authorize payment to be made directly to Nicholl Chiropractic Inc., for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to Nicholl Chiropractic Inc. for any and all services I receive at this office.

Cancellation Policy – 24 hour notice for all scheduled appointments - $65 fee

_____ _____ - _____ - _____

Patient or Authorized Person's Signature **Date Completed**

Your car insurance company will only release this information to you, the policy holder. Please call *YOUR CARE INSURANCE* provider to obtain this information.

Do you have medical pay? YES NO

Is your medical pay primary or secondary? PRIMARY SECONDARY

If so, how much? $1,000 $2000 $5,000 $10,000

Do you have uninsured motorists policy on your insurance? YES NO

If so, what is the limit?_____

PATIENT NAME: _____

NAME OF **YOUR** INSURANCE COMPANY:_____

YOUR CLAIM #:_____

NAME OF PERSON HANDLING YOUR CLAIM:_____

HIS/HER DIRECT PHONE NUMBER:_____

DATE OF INJURY:_____

Using your medical pay will not raise your care insurance rates.

Please provide the following

□ Driver's License

□ Health insurance card

□ Auto insurance card

□ Auto Insurance Declaration Page

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

_____ ____/____/____ *Witness Initials*

Signature Date

INFORMED CONSENT

REGARDING: X-rays/Imaging Studies

FEMALES ONLY → *please read carefully and check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our receptionist for further explanation.*

☐ The first day of my last menstrual cycle was on ____-____-____ Date

☐ I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am not pregnant.

By my signature below I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

_____ ____/____/____  *Witness Initials*

Patient or Authorized person's Signature Date

Consent to Treat a Minor

The undersigned herby requests and authorizes Dr. Tim Nicholl to perform diagnostic testing and render chiropractic adjustments' to _____, who is a minor.

This authorization extends to radiographic examination.

If applicable, under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse or former spouse or other parent is not required.

Signature of parent: _____ Date: ____/____/_____

Print Name: _____

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Office Fee Schedule and Financial Policy

Service	***Fees***
Consultation	$0
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

Personal Injury- (Auto Accident) 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.

PROMISSORY NOTE

- I promise to pay Nicholl Chiropractic Inc. immediately upon settlement of my claim with the third party insurance company or 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 Nicholl Chiropractic Inc. may exercise its right to charge interest at the rate of 10% monthly on the unpaid balance until it is paid in full, starting at 90 days from the last visit.
- 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 Nicholl Chiropractic Inc. to contact the third party insurance company for the purpose of monitoring the settlement process.

Cancellation Policy

24 hour cancellation for scheduled appointments must be respected or appointment will be billed at $65.

_____ _____

Patient's 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