CONFIDENTIAL PATIENT INFORMATION

PATIENT INFORMATION Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Male □ Female □ Social Security #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthdate\_\_\_\_\_\_\_\_\_\_ Age\_\_\_\_\_ Single□ Married□ Widowed□ Separated□ Divorced□ Children?\_\_\_\_\_\_ Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City/State/Zip\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone numbers: Home\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mobile\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMAIL\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer address/city/state/zip\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SPOUSE □ PARENT □ LEGAL GUARDIAN □ (check one)

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Male □ Female □ Social Security #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthdate\_\_\_\_\_\_\_\_\_\_ Age\_\_\_\_\_ Single □ Married □ Widowed □ Separated □ Divorced □ Children?\_\_\_\_\_\_ Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City/State/Zip\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer address/city/state/zip\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How were you referred to our office?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

INSURANCE

Who is responsible for this account?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relation to Patient\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s Insurance\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Spouse’s Insurance\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Ins.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name of Ins.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Policy #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Group # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Group #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

INSURANCE INFORMATION

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that Sullivan Family Chiropractic 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 Sullivan Family Chiropractic will be credited to my account upon receipt. I also give Sullivan Family Chiropractic power of attorney to endorse checks made out to me, to be credited to my account. However, I clearly understand and agree that all services rendered to me are charged directly to me and 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 to me will be immediately due and payable.

Patient’s Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CONSENT OF PROFESSIONAL SERVICES AND RELEASE OF INFORMATION

I hereby authorize and release Dr. Sullivan and whomever he/she may designate as his assistants to administer treatment, physical examination, X-ray studies, laboratory procedures, chiropractic care or any other services that he deems necessary in my case. I further authorize Dr. Sullivan to disclose all or any part of my patient record to any person or corporation which is or may be liable under a contract to Sullivan Family Chiropractic or to the patient or to a family member or employer of the patient for all or part of the services rendered to me, including and not limited to, hospital or medical service companies, insurance companies, worker’s compensation carriers, welfare funds or employers.

Patient’s Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**IF A MINOR**-Signature of Parent/Guardian\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HEALTH QUESTIONAIRE - CURRENT CONDITION**

Describe your symptoms/location of problems?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Your goals for treatment/what do you want to be able to do that you currently cannot:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date symptoms first appeared?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Is this related to an automobile or work-related accident?\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What caused your pain to begin?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What treatment, tests, xrays, and/or medications have you already received for your condition?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other doctors seen for this condition:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Type of pain (mark all that apply): □ sharp □ dull □ throbbing □ numbness □ aching □ burning □ shooting □ tingling □ cramps □ stiffness □ swelling □ other

How often are your symptoms present: □ constant □ frequent □ occasional □ intermittent (comes and goes)

Since it began, is your problem: □ improving □ no change □ getting worse

What makes the problem better ?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What makes the problem worse ?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Can you perform your daily home activities? □ yes □ yes, limited by myself □ yes, only with help □ not at all

Can you perform your daily work activities? □ yes □ yes, limited by myself □ yes, only with help □ not at all

Describe your daily job requirements:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Your stress level: □ none □ mild □ moderate □ severe

**PAST HEALTH HISTORY**

Have you been treated by a doctor or health care professional in the last year?\_\_\_\_ If yes, for what conditions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever been under chiropractic care before?\_\_\_\_\_\_\_\_ Where:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Same condition? \_\_\_\_\_\_\_\_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you have *ever* had a listed symptom in the *past*, please check the symptom in the *past column.* If you are presently experiencing a particular symptom, check that symptom in the *present column.* KNOWLEDGE OF THESE CONDITIONS MAY INFLUENCE THE TYPE OF TREATMENT OR THERAPY YOU ARE TO RECEIVE.

**Past Present Condition Past Present Condition Past Present Condition**

□ □ Neck pain □ □ Heartburn/Indigestion □ □ General fatigue

□ □ Shoulder pain R□ L□ □ □ Dermatitis/Eczema/Rash □ □ Irregular menstrual cycle

□ □ Pain in upper arm or elbow R□ L□ □ □ Numbness □ □ Abdominal pain

□ □ Hand pain R□ L□ □ □ Nosebleeds □ □ Breast soreness □ lumps □

□ □ Wrist pain R□ L□ □ □ Depression □ □ Endometriosis

□ □ Upper back pain □ □ Aortic Aneurysm □ □ PMS

□ □ Low back pain □ □ Heart Attack (date)\_\_\_\_\_\_\_\_ □ □ Loss of bladder control

□ □ Pain in upper leg or hip R□ L□ □ □ Stroke (date)\_\_\_\_\_\_\_\_\_\_\_\_\_ □ □ Painful urination

□ □ Pain in lower leg or knee R□ L□ □ □ Cancer, explain below □ □ Frequent urination

□ □ Pain in ankle or foot R□ L□ □ □ Tumor, explain below □ □ Excessive bowel action

□ □ Jaw pain □ □ Asthma □ □ Constipation

□ □ Swelling, stiffness of joint(s) □ □ Prostate problems Avg.# of bowel movements per day\_\_\_\_

|  |
| --- |
| **If a family member has had any of the following,**  **please mark the** **appropriate box:**  □ Cancer □ Epilepsy □ Rheumatoid  □ Diabetes □ Heart problems □ Lung problems  □ Stroke □ Mental problems □ Back problems  □ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Relationship to patient  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

□ □ Pain that wakes you at night □ □ Blood disorder □ □ HIV/AIDS

□ □ Fainting □ □ Emphysema (chromic lung disorders) □ □ Difficulty breathing

□ □ Visual Disturbance □ □ Arthritis □ □ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ □ Convulsions □ □ Rheumatoid Arthritis

□ □ Dizziness □ □ Diabetes

□ □ Headache □ □ Epilepsy

□ □ Muscular Incoordination □ □ Ulcer

□ □ Tinnitus (ringing or noises in ear) □ □ Liver/gallbladder problem

□ □ Rapid Heart Beat □ □ Kidney stones

□ □ Chest pain □ □ Hepatitis

□ □ Loss of Appetite □ □ Bladder Infection

□ □ Anorexia □ □ Kidney Disorders

□ □ Abnormal weight loss □ □ Colitis/Irritable Colon

□ □ Abnormal weight gain □ □ Excessive thirst

□ □ Chronic cough □ □ Chronic sinusitis (sinus infections)

**Please check all that apply to you**:

□ currently pregnant □ # of births­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_ □ Tobacco □ Alcohol □ Drug or alcohol dependence

**CURRENTMEDICATIONS/HOSPITALIZATIONS/SURGERIES:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PRIMARY CARE PHYSICIAN:** NAME/LOCATION\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I AUTHORIZE DR. SULLIVAN TO SEND A MEDICAL UPDATE OF MY CURRENT CONDITION TO MY PRIMARY CARE PHYSICIAN Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**INFORMED CONSENT**

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future work at the clinic or office listed below or any other office or clinic.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient/guardian Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_

Witness Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_

**HEALTH CARE AUTHORIZATION FORM**

This form authorizes us to file your insurance, have your signature on file for insurance purposes, comply with Health Insurance Portability and Accountability Act (HIPAA) regulations, and provide you with better overall service. THE PATIENT IDENTIFIED BELOW AUTHORIZES SULLIVAN FAMILY CHIROPRACTIC TO USE AND OR DISCLOSE PROTECTED HEALTH INFORMATION IN ACCORDANCE WITH THE FOLLOWING:

* I give Sullivan Family Chiropractic permission to treat me in an area where other patients are also being treated. I give permission to use my name aloud in the office during my visit (Including but not limited to, general conversation with me, calling me from the waiting area, taking me to treatment room). I am aware that other persons may overhear some of my protected health information during the course of care. Please hold any private information or questions until you are in a private room with the staff or doctor. (It is our office policy to not discuss health information and private issues in front of other patients, all precautions will be made to adhere to this policy.)
* I authorize the use of my name in print for general purpose; such as posting my name on an internal Referral Board if and when I refer people to their office for evaluation and treatment, patient of the month listing, etc. I further authorize the use of my signature to be on a universal (consecutively viewed by each patient signing in) sign in sheet for each visit.
* I authorize Sullivan Family Chiropractic to use my address, phone numbers and clinical records to contact me with appointment reminders, to leave a message, to reschedule an appointment, missed appointment notification, birthday cards, newsletters, holiday cards, or other health related information. If I am contacted by phone, I give permission to leave a message with a member of my household, on my answering machine or voice mail.
* I authorize use of this form on all of my insurance submissions [SIGNATURE ON FILE] I authorize release of information to all my insurance companies. I authorize Sullivan Family Chiropractic to act as my agent in helping me obtain payment from my insurance companies. I authorize payment direct to Sullivan Family Chiropractic from my insurance companies.
* I understand that I am ultimately responsible for my bill and payment is due when services are rendered, unless other arrangements have been made.
* I permit a copy of this authorization to be used in place of the original.
* I understand that this office is complying with federal HIPAA guidelines by advising me that they are doing everything in their power to protect my private health information. At any time, I am able to ask this office of the safety and protected nature of my health information, or any other related issues or concerns.
* By signing this form I am giving Sullivan Family Chiropractic permission to use and disclose my protected health information in accordance with the directives listed above.

Name (Please print)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**GENERAL PAIN DISABILITY INDEX**

The rating scales below are designed to measure the degree to which several aspects of your life are presently disrupted by chronic pain. In other words we would like to know how much your pain is preventing you from doing what you would normally do. Respond to each category indicating the overall impact of pain in your life, not just when the pain is at its worst.

For each of the six categories or daily living listed, **PLEASE NUMBER EACH ITEM WITH A SCORE OF 0-10 WHICH BEST DESCRIBES YOUR TYPICAL LEVEL OF ACTIVITIES**. A score of 0 means no limitations at all and a score of 10 signifies that all of the activities in which you would normally be involved have been totally disrupted or prevented by your pain.

|  |
| --- |
| **0 1 2 3 4 5 6 7 8 9 10** |

NO LIMITATION TOTAL LIMITATION COMPLETELY ABLE TO FUNCTION UNABLE TO FUNCTION

**\_\_\_\_1.** **Family/Home Responsibilities-**Chores and duties performed around the house (ex. Yard work, carpool, etc.)

**\_\_\_\_2. Recreation-**Hobbies, sports, and other similar leisure time activities.

**\_\_\_\_3.** **Social Activity**-Participation with friends and family. Parties, theater, concerts, dining out and other social functions.

**\_\_\_\_4.** **Occupation**-Directly related to your job. Full, part, or non-paid positions; including homemaker.

**\_\_\_\_5.** **Self Care**-Personal maintenance and independent daily living (ex. Taking a shower, driving, getting dressed, etc.)

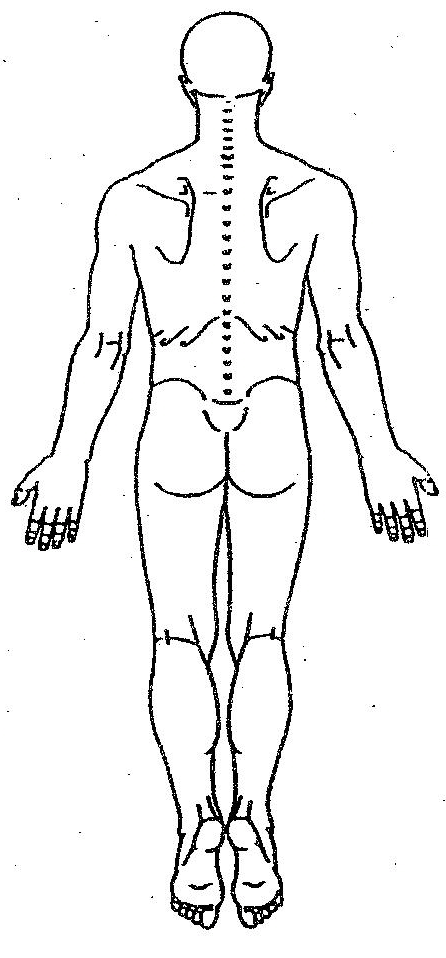
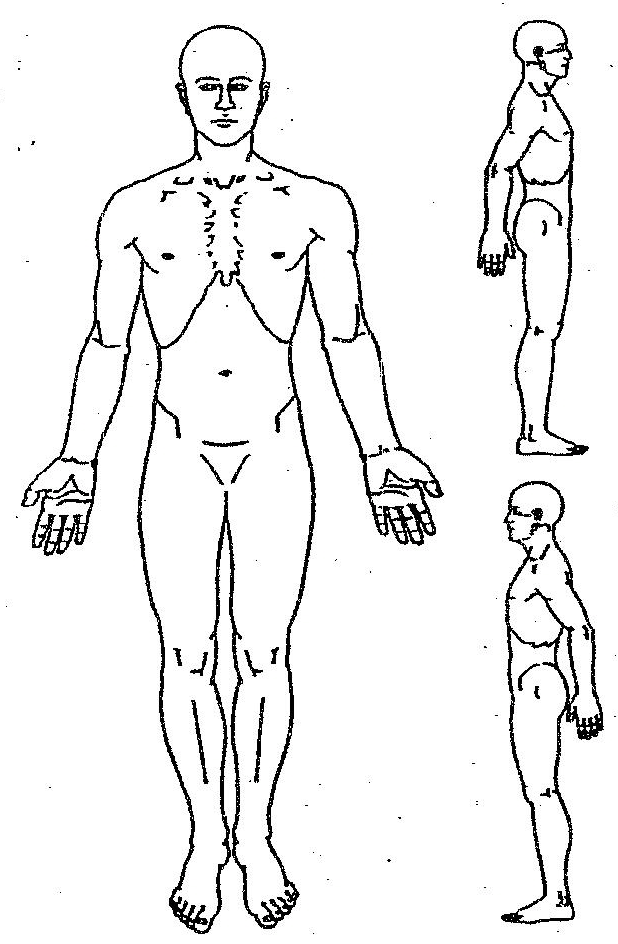
**\_\_\_\_6.** **Life-Support Activity**-Eating, sleeping, and breathing.

\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Total Signature Date

|  |
| --- |
| **VISUAL ANALOG PAIN SEVERITY SCALE (VAS SCALE)**  INSTRUCTIONS: Please mark on the line below how you currently feel.    **NO PAIN-------------------------------------------------------WORST PAIN EVER** |

|  |
| --- |
| **PLEASE MARK ON THE BODIES TO THE LEFT, THE LOCATION AND TYPE OF PAIN YOU ARE EXPERIENCING** |



NUMBNESS ====

BURNING XXXXX

SHARP/STABBING ///////

PINS AND NEEDLES ooooo

ACHING aaaaa





*TO ANY INSURANCE COMPANY WITH COVERAGE APPLICABLE TO MY CLAIM(S) AND TO MY ATTORNEY REPRESENTING ME:*

**ASSIGNMENT OF BENEFITS**

IN CONSIDERATION of Sullivan Family Chiropractic’s willingness to treat me on credit without demand for payment at the time of services are rendered, I hereby agree and stipulate as follows:

I irrevocably assign to Sullivan Family Chiropractic any proceeds or compensation that I am or may become entitled to receive as a result of injuries that occurred on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_to the extent of the chiropractic services rendered. I make this agreement without prejudice to any rights I may have to prosecute legal claims against any party who may be liable for my injuries, but I hereby authorize and instruct you to pay directly to Sullivan Family Chiropractic, from any disability benefits, medical payments benefits, liability benefits, health and accident benefits, workers compensation benefits, judgments, settlements or proceeds of any kind that would otherwise be payable to me, such sums as are due or may become due to Sullivan Family Chiropractic for its services rendered.

I appoint Sullivan Family Chiropractic as my attorney in fact to affix my name as an endorsement upon the reverse of any check or draft in which I am named payee and to deposit said check or draft and apply the proceeds to any unpaid balance I may have with Sullivan Family Chiropractic.

I authorize Sullivan Family Chiropractic to release to any insurer with applicable coverage or to my attorney or successor attorney any information regarding my injuries, prior medical history, or treatment as may be necessary to facilitate collection of proceeds under this agreement.

I acknowledge that I remain personally liable for the total amount due to Sullivan Family Chiropractic for services rendered, including and balance remaining after the application of insurance payments and settlement or judgment proceeds. If Sullivan Family Chiropractic is required to take legal action against me to recover any unpaid balance on my account, I agree to reimburse Sullivan Family Chiropractic for its costs of recovery, including reasonable attorney’s fees.

I further agree this assignment of benefits (AOB) cannot be revoked and the right to receive payment cannot be transferred to any other party or re-asserted by me in any way.

Patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_

PRINT NAME SIGNATURE

Witness\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**NOTICE OF LIEN**

Pursuant to N.C.G.S. 44-49 and 44-50, Sullivan Family Chiropractic hereby asserts and gives notice of a lien upon any sums recovered in damages for personal injury in any civil action and also upon all funds paid to the above-named patient in compensation for or settlement of injuries sustained, whether in litigation or otherwise.

Sullivan Family Chiropractic hereby requests that if its claim is not paid in full from the foregoing proceeds, a full disclosure and accounting of proceeds be provided in conformity with N.C.G.S. 44-50.1. Sullivan Family Chiropractic agrees to be bound by any confidentiality agreements regarding the contents of the accounting.

Sullivan Family Chiropractic By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

AUTOMOBILE INJURY REPORT

Patient Name/Acct #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Accident \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Location \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Time of Accident \_\_\_\_\_\_\_\_\_\_\_\_\_\_ What was your position in car? □ driver □ front right passenger □ back right passenger □ back middle passenger □ back left passenger □ other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Describe in your own words what happened:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Impact: □ my car struck another car □ another car struck my car

Vehicle struck: □ left □ right □ front □ rear □ side Wearing seatbelt? □ yes □ no □ lap □ shoulder

What law enforcement official came to accident? □ police □ state trooper □ sheriff □ other \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Where was your body before accident: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Where was your body after accident: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Where were you looking upon impact: □ straight ahead □ left □ right

Did you strike anything in vehicle at time of impact? □ yes □ no If yes, specify:

Body part: □ head □ chest □ chin □ knee □ shoulder □ arm □ hand □ other \_\_\_\_\_\_\_\_\_\_

Location: □ steering wheel □ dashboard □ windshield □ side door □ arm rests □ other \_\_\_\_\_\_\_\_ How did you feel immediately after the accident? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did you lose consciousness? □ yes □ no

Did you feel: □ dazed □ confused □ dizzy □ weak □ nervous □ other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did you have any open wounds, cuts, or bleeding? □ yes □ no where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did you go to the hospital? □ yes □ no

When did you go to the hospital? □ at time of accident □ later in the day □ next day □ other \_\_\_\_\_\_\_\_\_\_\_\_\_

How did you get to the hospital? □ ambulance □ private transportation

Did the paramedics place you in: □ neck collar □ brace □ splint Where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Hospital \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_X-rays taken? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Treating Doctor \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Were you admitted to hospital? □ yes □ no

What treatment was rendered?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What recommendations were made by doctor at hospital: Follow-up treatment with: □ Primary Physician □ Orthopedic Surgeon □ Chiropractic □ Physical Therapy □ none

What other doctors have you seen as a result of this accident? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you lost any time from work? □ yes □ no Dates: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

What can’t you do now that you could before? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Can you perform normal household chores? □ yes □ no □□

What damage did your vehicle sustain?

□ minimal □ moderate □ extensive □ totaled □ unsure □ other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What damage did the other vehicle sustain?

□ minimal □ moderate □ extensive □ totaled □ unsure □ other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other information: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

OFFICE POLICY

RE: PERSONAL INJURY

The following information applies to patients involved in an automobile accident or related accident, and is provided for you to better understand the options available for you in this time of injury and mental anguish. The more you understand, the better we will be able to serve you and have your financial arrangements in working order.

* If you have an attorney, please let us know as soon as possible. Ask your attorney to send us a letter of representation, all bills will be directed through your attorney.
* If you do not have an attorney, you will need to provide for us the police report and all information required for billing the liable insurance company. We must speak with the insurance adjustor to verify your treatment will be covered.
* If you have med-pay as part of your automobile policy, we recommend that you use your med-pay coverage. Med-pay coverage, if you have it, is designed to be used in the event of an accident, regardless of who is at fault, to cover any medical expenses incurred during this time.
* If none of the above applies to you by the second visit to our office, you will be expected to make payments at that time.

When your case has been settled and all medical bills paid, if an overpayment exists on your account (due to filing more than one insurance ie; liable, and/or med-pay) we will forward that overpayment to you.

I, □ DO □ DO NOT have an attorney

I WISH TO FILE:

□ LIABLE INSURANCE-(Attorney will typically file for this insurance)

□ MED-PAY INSURANCE-(From my auto insurance policy)

□ OTHER\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ I was involved in an automobile accident on \_\_\_\_\_\_\_\_\_\_ and have chosen at this time to NOT file any claims against the liable insurance company or my med-pay from my insurance company for treatment.

By signing below I understand the above presented information, and that I will not be presented with copies of bills until the proper procedures have been followed.

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_