Canyon Chiropractic Center

Dr. Craig Pearson

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Today's Date: _____

Date of Loss: _____

Personal Injury: New patient or Existing Patient

Patient Information:

Patient (Legal Name): _____

Patient Address: _____

City: _____ State: _____ Zip Code: _____ Date of Birth: _____

Home Phone: _____ Cell: _____ M or F Age: _____

E- mail Address: _____ Social Security Number: _____

Name of Parent, Spouse, or Guardian: _____ Relationship: _____

Address: _____ Phone Number: _____

Employment Information- Patient (18 or older) or Responsible Party:

Employer: _____ Occupation: _____

Employer Address: _____ Phone: _____

MedPay Lien UM/UIM Subrogation (Please circle one)

Claim # _____ Company Name: _____

Adjustor's Name: _____

Adjustor's Phone Number: _____

Does the driver have MedPay? Yes: _____ No: _____ Approximate amount left on MedPay? _____

Please provide as much information as it becomes available to assist in claim collection effort.

Consent to Treatment: Please initial each statement.

_____ I voluntarily consent to receive medical and health care services that may include diagnostic procedures, examinations, and treatment at Canyon Chiropractic Center.

Release of Records:

_____ I hereby authorize the release of medical records, or information necessary to process my claim, to my insurance company, adjuster, or attorney.

Financial Responsibility and Assignment of Benefits:

_____ In order to provide you and our other patients with the best optimal spinal care, we request that you follow our guidelines regarding broken/cancelled appointments. Please remember that we have reserved appointment times especially for you. Therefore, we request at least 24 hours notice in order to reschedule your appointment. This will enable us to offer your cancelled time to other patients that desire to complete their treatment. When you cancel your appointment last minute, everyone loses: you, the doctor and other patients that would like to have utilized your appointment time. There is a $30 cancellation fee that will be charged to your account if you either miss or cancel your appointment without the appropriate 24 hour notice. Thank you for your consideration of our policies and for the opportunity to be your chiropractic office of choice. **I understand I will be charged for any appointments I miss if I do not give 24 hours cancellation notice without good cause.**

_____ I hereby assign to Canyon Chiropractic Center all monies to which I am entitled for treatment procedures relative to the service rendered by this practice, but not to exceed my indebtedness to said practice. It is understood that any monies received from the above named insurance company(s), over and above my indebtedness, will be refunded to me or my insurance company(s), as it is determined to be appropriate, when my bills are paid in full. I understand I am financially responsible to Canyon Chiropractic Center for charges not covered by this assignment. In the event I default, I agree to pay, whether or not legal proceedings are instituted, a reasonable COLLECTION FEE which shall be 18% per annum of the principal balance for any debt incurred hereunder and to pay all reasonable LEGAL COSTS as a result of my default.

I certify that I have read this form and understand its contents.

_____ **Date** _____

(Patient -18 or older- or other legally Authorized Person)

Release of Medical Information to Specific Person(s):

I request and authorize Canyon Chiropractic Center to release medical information to the organization, agency, or individual named on this request.

I certify that this request has been made voluntarily and that the information given is accurate to the best of my knowledge. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken to comply with it. Those receiving the authorized information without my further written consent may not disclose my medical information. Without my express revocation, this consent will automatically expire upon satisfaction of the need for disclosure. **Below, please specify a date that you would like this consent to expire**.

Date: _____

Please release information to: _____

Relationship(s) to patient: _____

Signature of patient: _____

Personal Information:

Major complaint: _____

Other complaints: _____ How long have you had this condition?_____

Have you had this or similar conditions in the past? _____ Is it getting progressively worse? _____

What aggravates your condition? _____

Does it interfere with: Work Sleep Daily Routine Other: _____

How long has it been since you have felt good? _____ Date of last physical exam: _____

Have you received chiropractic care in the past? _____ If yes, who and when? _____

Were X-rays taken? _____ Date X-rays were taken: _____

Operations you have had: _____

Serious illness: _____

Are you currently seeing any other Health Care Providers?

Providers Name: _____ Specialty: _____

Providers Name: _____ Specialty: _____

Providers Name: _____ Specialty: _____

Providers Name: _____ Specialty: _____

Are you wearing: Heel lifts Sole Lifts Orthotics

What type of accident(s) have you been in (e.g. auto, bicycle, pedestrian, skiing)? _____

Describe: _____

Date(s) of accident(s): _____

Drugs you take now: Painkillers Muscle Relaxers Anti-inflammatory Anti-depressants Tranquilizers

Birth Control Insulin Thyroid Medication Statins Anti-Coagulants

Other: _____

_____

_____

_____

Accident Information:

Were the police notified? Yes: _____ No: _____ Who received the citation? _____

Has fault been established? Clear: _____ Unclear: _____ Contested: _____ Contributory: _____

Were you wearing a seatbelt? Yes: _____ No: _____

Did you strike anything in the vehicle at the time of impact? Yes: _____ No: _____

If yes, specify: _____

Where in the car were you after the accident? _____

Immediately following the accident, how did you feel? _____

_____

Were you unconscious? Yes: _____ No: _____ In a daze? Yes: _____ No: _____

Taken to a hospital? Yes: _____ No: _____ Where? _____

Directly from the accident scene? Yes: _____ No: _____ By ambulance? Yes: _____ No: _____

Were you admitted? Yes: _____ No: _____ If so, how long? _____

What was the diagnosis? _____

Were X-rays taken? Yes: _____ No: _____

Have you seen any other provider(s) as a result of this accident? Yes: _____ No: _____

If so, names: _____

May we send relevant medical information to them? Yes: _____ No: _____

Have you ever been in an auto accident before? Yes: _____ No: _____

Please describe (include date, type, and any injuries): _____

_____

Have you lost time from work as a result of this accident? Yes: _____ No: _____

If yes, what was the last date that you worked? _____

Please indicate your experience in relation to your accident for each of the following:

Use the following codes: 1- Experienced before the crash 2- Experienced following the crash
3- Presently experiencing

Musculo-Skeletal System		Gastro-Intestinal System		Cardio- Vascular	
Neck problems		Poor appetite		Chest pain	
Upper back problems		Excessive hunger		Irregular heartbeat	
Mid back problems		Excessive thirst		Blood pressure problems	
Low back problems		Nausea		Varicose veins	
Arm problems		Vomiting		Bruise easily	
Leg problems		Abdominal pain		Retain fluid	
Hip problems		Diarrhea		Breathing difficulty	
Sore muscles		Constipation		Persistent cough	
Weak muscles		Bloody stool		Coughing phlegm	
Walking problems		Hemorrhoids		Coughing blood	
Broken bones		Swollen abdomen		Fatigue	
EENT		Nervous System		Genito-Urinary	
Eye strain		Numbness		Bladder trouble	
Eye inflammation		Dizziness		Painful urination	
Vision problems		Fainting		Blood in urine	
Ear pain		Headaches			
Hearing loss		Convulsions		Female Only	
Nose bleeds		Nervousness		Vaginal bleeding	
Dental problems		Forgetfulness		Irregular menstrual cycle	
Sore mouth		Confusion		Breast pain	
Sore throat		Depression		Are you pregnant?	
Swollen glands		Muscle Twitching		Yes:___ No:___ Unsure:___	
Hoarseness					

Please describe any other unusual physical findings or symptoms not listed above that you have noticed since the accident: _____

_____

_____

_____

_____

_____

Please check the following practices that apply to you:

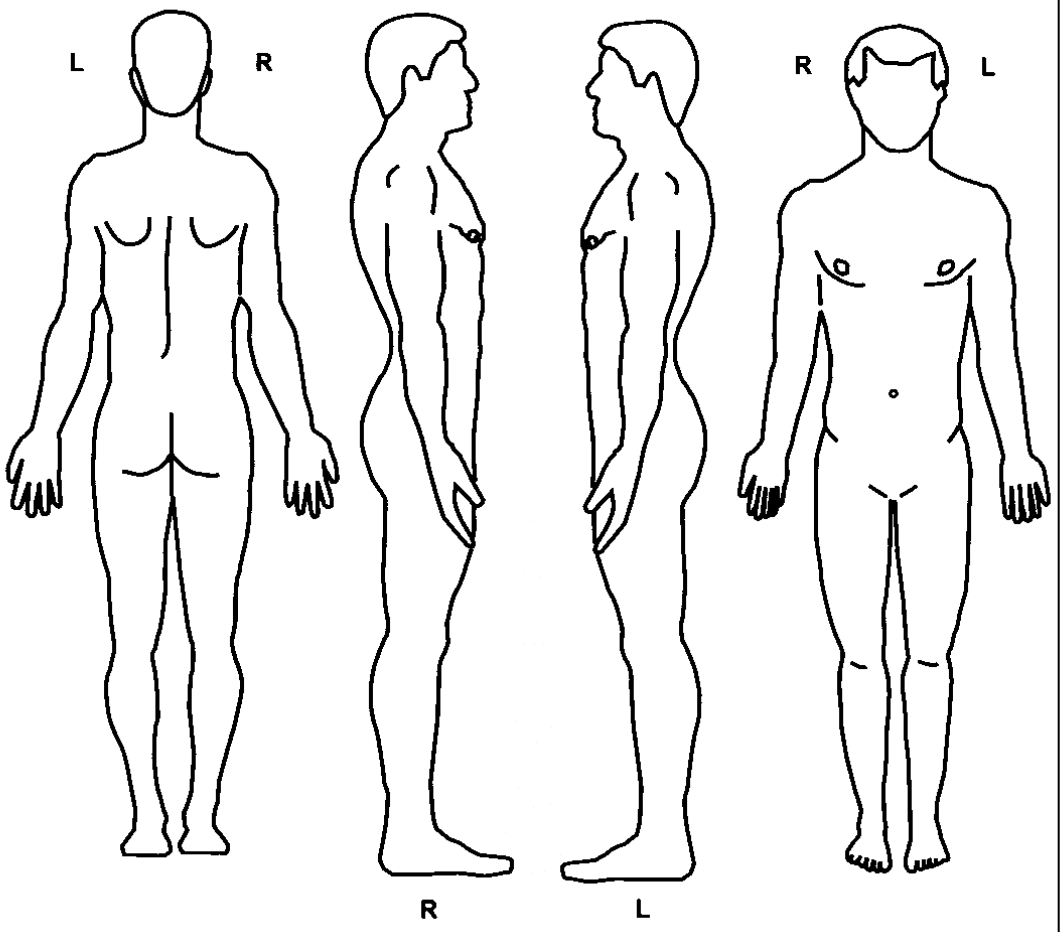
	Heavy	Moderate	Light	None		Heavy	Moderate	Light	None
Alcohol					Exercise				
Coffee					Sleep				
Tobacco					Appetite				
Drugs					Sugar				

Answer yes or no in "self" column (required), and please check those that apply to family:

Condition	Self (Yes or No)	Father	Mother	Brother	Sister	Children
Acid Reflux						
Anemia						
Arthritis						
Asthma/Hay fever						
Back Trouble						
Bursitis						
Cancer						
Constipation						
Diabetes						
Disc Problem						
Epilepsy						
Headaches						
Heart Disease						
High Blood Pressure						
Influenza						
Insomnia						
Kidney Trouble						
Liver Trouble						
Migraines						
Nervousness						
Pinched Nerves						
Pneumonia						
Polio						
Rheumatoid Arthritis						
Scoliosis						
Sinus Trouble						
Stomach Trouble						
Stroke						
Other:						

Sensation Diagram

Name: _____ **Date:** _____



Mark as Follows:
A- Ache B-Burning N-Numbess P-Pins & Needles S-Stabbing
O- Other Describe:_____
_____
_____

Please check the expectation of your care with us:

Quick Fix ("Band-Aid") _____
Full Recover of Injury or Problem _____
Lifestyle Change with Maintenance _____

Patient Health Information Consent Form

We want you to know how your Patient Health Information **(PHI)** is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to all this chiropractic office to use their Patient Health Information **(PHI)** for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

_____ _____

Patient (18 or older) or other Legally Authorized Person **Date**

Personal Injury Benefit Assignment, Lien Agreement, Release of Information

Patient:_____Attorney:_____

Insurance Company:_____Claim No:_____Date of Injury_____

Whereas patient desires to receive chiropractic services from Canyon Chiropractic Center and desires to assign certain rights and benefits to Canyon Chiropractic Center as consideration for Canyon Chiropractic Center awaiting payment of such benefits. Accordingly, it is hereby agreed:

A. Patient fully understands that patient is directly and fully responsible to Canyon Chiropractic Center for all charges submitted for services rendered for the aforementioned claim and that this agreement is made solely for the protection of Canyon Chiropractic Center in consideration for awaiting payment in full for all charges incurred.
B. Patient fully understands that the lien and assignment given to Canyon Chiropractic Center is herein irrevocable.
C. Patient assigns to Canyon Chiropractic Center any and all benefits payable by insurance as a result of charges incurred by patient for services rendered by Canyon Chiropractic Center. Patient also assigns to Canyon Chiropractic Center any and all contractual rights patient has against insurance company or any other party possibly liable to patient for payment of health care costs incurred as a result of services rendered by Canyon Chiropractic Center.
D. Patient hereby authorizes Canyon Chiropractic Center to receive a complete copy of patient's insurance policy, including any endorsements, condition, limitation, or exclusions
E. Patient further understands that health care costs incurred as a result of services rendered by Canyon Chiropractic Center are subject to interest at a rate of 12% APR to commence 30 days from onset of treatment, reasonable attorney's fees and costs if incurred and patient agrees to be responsible for any such outstanding balance beyond payments received from the liable third party or its agent.
F. Patient hereby authorizes Canyon Chiropractic Center to furnish medical records or Personal Health Information necessary to process the claim, to the Insurance Company, Adjustor, or attorney.
G. By executing this agreement, patient hereby instructs and directs any attorney representing patient to honor this lien and assignment and make payment directly to Canyon Chiropractic Center. Canyon Chiropractic Center is providing the care and treatment for which this lien, assignment, and directive provide security for payment. Moreover, patient agrees that Canyon Chiropractic Center is to be viewed as a third party beneficiary and it is the patient's intent to impose upon the patient's attorney an obligation to comply with the terms of this directive.
H. Patient hereby directs all insurers and other persons possibly responsible for patient's health care costs to make all payment for health care services rendered by Canyon Chiropractic Center directly to Canyon Chiropractic Center.
I. Patient agrees that in the event patient receives any check, draft, or other payment subject to this agreement, patient will act as fiduciary agent for Canyon Chiropractic Center and will immediately deliver said check, draft or payment to Canyon Chiropractic Center to be applied to patient's debt for services rendered.
J. Canyon Chiropractic Center agrees to submit a copy of this agreement with the initial claim forms which Canyon Chiropractic Center submits to third party payers as notice to the third party payer of the assignment and reasonable request during normal business hours, or upon written request by patient.
K. A copy of these documents shall be as binding as the document bearing the original signatures.

Patient's Signature_____ Date:_____

Provider's Signature_____ Date:_____

Attorney's Signature_____ Date:_____