BLAKE CHIROPRACTIC
INJURY CARE | SPORTS REHAB | WELLNESS

Motor Vehicle Accident Intake

PATIENT INFORMATION

Name: _____ Today's Date: _____
(First, Middle, Last)

Address: _____ Apt. # _____

City: _____ State: _____ Zip Code: _____

Primary Phone: _____ Gender: ☐ Male ☐ Female

Email: _____ Date of Birth: _____
(For communication about your account and appointments)

How did you hear about our clinic? ☐ Internet ☐ Location ☐ Referral ☐ Other

EMPLOYMENT INFORMATION

Current Employment: ☐ Unemployed ☐ Employed ☐ Student ☐ Other

Employer's Company Name: _____

Job Title: _____

EMERGENCY CONTACT

Name: _____ Relationship: _____ Phone #: _____

THE ACCIDENT

Date of the Accident: _____

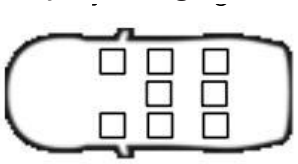
Please describe the accident in your own words: _____

_____

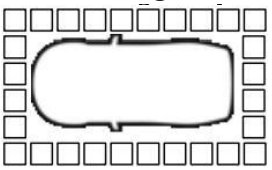
_____

Where did the accident occur? _____

Where were you sitting in the vehicle?



Where was the damage to the vehicle?



What were the driving conditions? _____

What type of vehicle were you driving? ☐ Compact ☐ SUV ☐ Truck ☐ Van _____

What type was the other vehicle involved? ☐ Compact ☐ SUV ☐ Truck ☐ Van ☐ N/A

How was your vehicle hit? ☐ Rear-Ended ☐ Head-On ☐ T-Boned ☐ At An Angle ☐ Roll Over

Did you anticipate the accident? _____ Were you braced for impact? _____

What direction were you looking at the time of impact? _____

Were you wearing a seatbelt? ☐ Yes ☐ No Were airbags deployed? ☐ Yes ☐ No

Did any part of your body strike the interior of the vehicle? _____

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HOSPITAL/EMERGENCY CARE

Did you receive any emergency or hospital care following the accident? ☐ Yes ☐ No

If yes, where? _____

What was done there? _____

AFTER THE ACCIDENT

Have you been evaluated by any other health care professional since the accident? ☐ Yes ☐ No

If yes, who? _____

What was done there? _____

CURRENT COMPLAINTS

What are your current areas of complaint? _____

_____

_____

_____

PAST MEDICAL HISTORY

Have you had any prior injuries to the areas you currently have pain? ☐ Yes ☐ No

_____

_____

Have you sustained injuries in any other motor vehicle accidents in the past? ☐ Yes ☐ No

_____

_____

INSURANCE INFORMATION

Insurance Company's Name _____ Claim # _____

Agent's Name _____ Agent's Phone # _____

To the best of my knowledge, the above information is complete and correct.
I understand it is my responsibility to inform my doctor if I, or my minor child, have any changes in health.

Patient's Name _____ Date: _____

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Consent to Chiropractic Treatment

The Nature of Chiropractic Treatment: The doctor will use his hands or a mechanical device in order to move your joints. You may feel a "click" or "pop", such as the noise when a knuckle is "cracked", and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound or dry hydrotherapy may also be used.

Possible Risks: As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular incident could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or minor complications.

Probability of Risks Occurring: The risks of complications due to chiropractic treatment have been described as "rare", about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular incident, has been estimated at one in twenty million, and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered "rare".

Other Treatment Options: May include over-the-counter analgesics, prescription medications, injections, and surgery.

Risks of Remaining Untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

No Warranty: I understand that my doctor at Blake Chiropractic, cannot make any promises or guarantees regarding a cure for or improvement in my condition. I understand that my doctor will share with me his opinion regarding potential results from chiropractic treatment for my condition and will discuss treatment option with me before I consent to treatment.

I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and herby give my full consent to treatment.

Printed Name Signature Date

Consent to Treat Minor – For use when applicable

I hereby authorize Blake Chiropractic doctor of chiropractic, to administer chiropractic care, as deemed necessary, to my child.

Name of Child Signature (Parent/Guardian) Date

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Financial Agreement

Please remember that insurance is considered a method of reimbursing the patient for fees put to the doctor and is NOT A SUBSITUTE FOR PAYMENT. Some companies pay fixed amounts for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid by your insurance.

IN ORDER TO CONTROL YOUR OUTSTANDING BALANCE, IT IS OUR POLICY TO COLLECT CO-PAYS, CO-INSURANCE AND DEDUCTIBLES AT THE TIME OF SERVICE.

If this account is assigned to an attorney/outside agency for collection and/or suit, Blake Chiropractic shall be entitled to reasonable attorney's fees and for cost of collection.

I authorize the release of any information necessary to determine liability for payment and to obtain reimbursement on any claim.

_____

PATIENT OR GUARDIAN SIGNATURE DATE

LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee healthcare benefits coverage with the above captioned, and hereby assign and convey directly to Blake Chiropractic all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize any plan administrator or fiduciary, insurer or my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under any applicable insurance policies and/or employee healthcare plan any claim, chose in action, or other right I may have to such insurance and/or employee healthcare benefits coverage under any applicable insurance policies and/or employee healthcare plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim chose in action or right against my insurers and/or employee healthcare plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee healthcare plan in my name but at such doctor and clinic's expenses.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered and valid as the original. I have read and fully understand this agreement.

_____

PATIENT OR GUARDIAN SIGNATURE DATE

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Acknowledgement of Receipt of Notice of Privacy Practices

Purpose of Consent

This Consent for the use and/or disclosure of personally identifiable health information is made pursuant to the requirements of 42 C.F.R. §164.506, which sets out the federal privacy regulations for the Health Insurance Privacy and Accountability Act of 1996 (the "Privacy Regulations").

Please read the following information carefully:

1. I understand and acknowledge that I am consenting to the use and/or disclosure of personally identifiable health information about me by Blake Chiropractic (the "Practice") for the purposes of treating me, obtaining payment for treatment of me, and as necessary in order to carry out any healthcare operations that are permitted in the regulations.

2. I am aware that the Practice maintains a Privacy Notice which sets forth the types of uses and disclosures that the Practice is permitted to make under the Privacy Regulations and sets forth in detail the way in which the Practice will make such use or disclosure. By signing this Consent, I understand and acknowledge that I have the right to review the Privacy Notice prior to signing this Consent.

3. I understand and acknowledge that I have the right to request that the Practice restrict how my information is used or disclosed to carry out treatment, payment or healthcare operations. I understand and acknowledge that the Practice is not required to agree to restrictions requested by me, but if the Practice agrees to such a requested restriction it will be bound by that restriction until I notify it otherwise in writing. I request the following restrictions be placed on the Practice's use and/or disclosure of my health information **(leave blank if no restrictions)**: _____

_____

4. I understand and acknowledge that I may revoke this Consent at any time by sending a written revocation to the Practice. However I also understand and acknowledge that if I revoke this Consent, my revocation will not be effective to the extent that the Practice has already acted action in reliance on this Consent.

I understand the foregoing provisions, and I wish to sign this Consent authorizing the use of my personally identifiable health information for the purposes of treatment, payment for treatment and healthcare operations.

By signing this form I acknowledge that I have reviewed this consent and agree to the practice's use and disclosure of my protected health information for treatment, payment, and healthcare operations.

_____ _____

Patient or Guardian Signature Date