

WELCOME

Patient Information

Insurance

Date _____

Patient _____

Address _____

City _____ State _____ Zip _____

Sex: M F Age _____ Birthdate ____/____/____

Single Married Widowed Separated Divorced

Patient Social Security Number _____

Occupation _____

Employer _____

Employer Phone _____

Children's Name(s)/Age _____

E-Mail: _____

Whom may we thank for referring you? _____

Have you ever received treatment by a Chiropractor before? Yes No

If yes, when and who? _____

Primary Care Physician _____

May we send the doctor a report? Yes No

Insurance Company _____

Subscriber's Name _____

Birthdate ____/____/____ SS# _____

ASSIGNMENT AND RELEASE:

I hereby direct any and all insurance carriers, attorneys, and individuals to directly pay Reynoldsburg Chiropractic Center for charges incurred by me. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature _____

Relationship _____ Date _____

Phone Numbers

HIPAA NOTICE

Home _____ Work _____ Ext _____

Cell Phone _____

IN CASE OF EMERGENCY, CONTACT:

Name _____ Relationship _____

Home Phone _____

Work Phone _____ Ext _____

The patient understands and agrees to allow this chiropractic office to use their patient health information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your patient health information is going to be used in this office and your rights concerning those records. 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. If there is anyone you do not want to receive your medical records please inform our office.

Patient's signature _____ Date _____

Guardian's signature _____ Date _____

Patient Condition

Reason for Visit _____

When did your symptoms appear? _____

Is this condition getting progressively worse? Yes No Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling

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

Type of pain: Sharp Dull Throbbing Numbness Aching

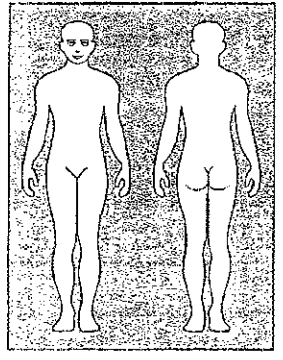
Shooting Burning Tingling Cramps Stiffness Swelling Other

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your Work Sleep Daily Routine Recreation

Activities or movements that are painful to perform Sitting Standing Walking Bending Lying Down



Reynoldsburg Chiropractic Center

7323 East Main Street • Reynoldsburg, Ohio 43068

Phone: (614) 861-6222 • Fax: (614) 861-1940

AUTO/ PERSONAL ACCIDENT QUESTIONNAIRE

Date of Accident: _____ Time _____ am pm

Location: _____

How did accident occur? _____

Describe the Circumstances _____

Vehicle you were in: Year: _____ Make: _____ Model: _____

Other vehicle: Year: _____ Make: _____ Model: _____

Did you report accident to employer? ___yes ___no

If auto accident were you: ___driver ___passenger ___pedestrian

Were you struck from: ___behind ___front ___L side ___R side ___parked

Were you wearing a seat belt? ___yes ___no if yes, ___lap seat belt ___shoulder-lap seat belt

Was your car stopped at time of impact? ___yes ___no if no, approximate speed _____m p h

Was the other vehicle moving at time of impact? ___yes ___no if yes, approximate speed _____mph

Did your vehicle strike another vehicle? ___yes ___no

Did another car strike you? ___yes ___no

Traffic citations were issued to: ___you ___driver of other car ___driver of your car

What is the estimated cost of damage to the vehicle you were in? \$_____

Did you go to the emergency room as a result of this accident? ___yes ___no

List the extent of injuries as you know them: _____

Check symptoms you have noticed since the accident:

- | | | |
|--|---|---|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Loss of memory |
| <input type="checkbox"/> Head seems too heavy | <input type="checkbox"/> Pins and needles in arms | <input type="checkbox"/> Loss of smell |
| <input type="checkbox"/> Neck pain/stiffness | <input type="checkbox"/> Pins and needles in legs | <input type="checkbox"/> Loss of taste |
| <input type="checkbox"/> Upper back pain/stiffness | <input type="checkbox"/> Numbness in fingers | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Mid back pain/stiffness | <input type="checkbox"/> Numbness in toes | <input type="checkbox"/> Feet cold |
| <input type="checkbox"/> Low back pain/stiffness | <input type="checkbox"/> Loss of balance | <input type="checkbox"/> Hands cold |
| <input type="checkbox"/> Shoulder pain/stiffness | <input type="checkbox"/> Ringing/buzzing in ears | <input type="checkbox"/> Stomach upset |
| <input type="checkbox"/> General stiffness | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Cold sweats |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Fever |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Light bothers eyes | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Tension | <input type="checkbox"/> Sleeping problems | |

Symptoms other than above: _____

Have you missed any days of work? ___yes ___no if yes, how many? _____

Insurance companies involved:

My insurance company _____

Company of person responsible for injuries _____

Do you have an attorney that has advised you in this claim? ___yes ___no

Attorney information: Name _____ Phone _____

Address _____

Have you considered using an attorney to handle the settlement of your claim? ___yes ___no

ASSIGNMENT

This Assignment, made effective on the _____ day of _____, 20____, by and between _____ ("Patient") and _____, and its officers, agents, members, shareholders, subsidiaries, assigns, employees, and directors (collectively referred to as "Clinic")

Witnesseth:

WHEREAS, _____ insurance company insures Patient through uninsured/underinsured motorist coverage and/or medical payment coverage; and Patient was involved in an accident on or about _____ in which he/she was injured and for which he/she have or may have a claim against another person(s) for causing his/her injuries ("Claim"); and

WHEREAS, to the best of Patient's knowledge, the person(s) who caused the Claim is(are) insured by _____; and

WHEREAS, Patient is entering into this Assignment voluntarily and without duress, and

WHEREAS, Patient acknowledges that he/she has the right and opportunity to seek independent legal counsel to review this Assignment; and

WHEREAS, Patient seeks to have the Clinic provide medical care, treatment, and services as a result of Patient's Claim; and

WHEREAS, Clinic agrees to provide medical care, treatment, and services to Patient and additionally agrees to delay billing Patient in a personal capacity for said medical care, treatment, and services until the resolution of Patient's Claim; and

WHEREAS, Patient and Clinic desire to enter into this Assignment in accordance with the terms contained herein

NOW, THEREFORE, in consideration of the mutual promises and covenants contained herein, and for other good and valuable consideration, the receipt of which is hereby acknowledged, it is agreed as follows:

1. Patient hereby assigns, without any right to later revoke, a part of any proceeds from his/her claim equal to the fees incurred by Patient to the Clinic for all treatment and other services rendered by the Clinic. Patient is not assigning any legal cause of action in the Claim above, but only prospective proceeds. Patient also assigns to the Clinic his/her right to enforce the obligation of any insurance company to pay settlement proceeds for any settlement agreement made by or for Patient in exchange for his/her signing such insurance company's release of claim. Prior to settlement or other disposition of the Claim, Patient understands and permits Clinic to pursue payment from any third party, including medical payments coverage in an automobile liability policy. Patient also assigns, without any right to later revoke, a part of available medical payments coverage equal to fees incurred by Patient to Clinic for all treatment and other services rendered by Clinic.
2. This Assignment and related documents which Patient has signed in connection with it states the entire agreement and Patient's complete understanding regarding the Clinic's fees. Patient has not relied on any statements by the Clinic or other information before making this Assignment. Patient understands that he/she remains responsible for any Clinic fees not paid out of Patient's Claim.

(signature of Patient)

3. Patient understands that it is Patient's responsibility during treatment to remain aware of his/her cumulative account balance for services rendered. Patient has received a schedule of treatment fees for the Clinic, or if Patient has not, Patient will request one in writing
4. Patient understands that this is an express contract to pay for the services rendered by the Clinic. Patient agrees to pay his/her account balance in full and/or direct its payment from the Claim proceeds regardless of whether any other person or entity attempts to or fails to fully reimburse me for it. If Patient disputes his/her account balance or treatment rendered, Patient agrees that his/her remedy will be to resolve it with a separate action from the Claim.
5. **NOTICE: PATIENT HEREBY NOTIFIES AND DIRECTS ANY AND ALL INSURANCE COMPANIES, THIRD PARTY ADMINISTRATORS, ATTORNEYS, OTHER PERSONS AND/OR OTHER ENTITIES WHO HOLD OR LATER HOLD ANY PROCEEDS FROM PATIENT'S CLAIM THAT CLINIC NOW HAS A VALID INTEREST (AS THAT TERM IS USED AND APPLIED IN RULE 1.15(d) OF THE OHIO RULES OF ATTORNEY PROFESSIONAL CONDUCT) IN SAID PROCEEDS AND PATIENT HEREBY DIRECTS YOU TO PROMPTLY DELIVER AND APPLY ANY PROCEEDS FROM PATIENT'S CLAIM TO PATIENT'S TOTAL ACCOUNT BALANCE WITH THE CLINIC OUT OF THE TOTAL PROCEEDS HELD IN PATIENT'S BEHALF, UNLESS THE CLINIC CONFIRMS PRIOR PAYMENT OF IT IN WRITING. "TOTAL PROCEEDS" HELD BY AN ATTORNEY FOR PATIENT'S CLAIM SHALL MEAN PROCEEDS AFTER DEDUCTION OF ATTORNEY FEES.**
6. This Assignment is governed by Ohio law. Jurisdiction shall be in Ohio, and venue shall lie in the county which the Clinic is located, unless otherwise required by applicable law
7. **PATIENT REALIZES THAT HE/SHE HAS NOW GIVEN AWAY A PART OF ANY PROCEEDS FROM HIS/HER CLAIM FOR WHICH THE CLINIC NOW HAS A VALID INTEREST. IF PATIENT RECEIVES ANY PROCEEDS FROM HIS/HER CLAIM, PATIENT AGREES TO IMMEDIATELY DETERMINE IF THE CLINIC HAS BEEN SEPARATELY PAID IN FULL. UNLESS THE CLINIC CONFIRMS FULL PAYMENT IN WRITING, PATIENT REALIZES THAT ANY USE BY PATIENT OF THESE PROCEEDS CONSTITUTES A TAKING OR CONVERTING MONEY THAT IS THE PROPERTY OF THE CLINIC.**
8. If any provision of this Assignment is determined to be invalid or unenforceable pursuant to applicable law, then the invalid or unenforceable provision will be deemed superceded by a valid, enforceable provision that most closely matches the intent of the original provision, and the remaining provisions shall continue in full force and effect

IN WITNESS WHEREOF, the parties hereto have caused this Assignment to be executed and effective as of the date first written above

PATIENT

CLINIC

Signed: _____

Print Name: _____

By: _____

Signature of Parent/Legal Guardian: _____

Title: _____

Date: _____

Date: _____