Automobile Accident Questionnaire

Please answer all questions completely

Dear Patient: This information is considered confidential. We need this information because we care enough to want to know, and your answers will help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. In order for us to understand you condition properly, please be as neat and accurate as possible while completing this form. Thank you.

Name: _____ Sex: _____ Marital Status: _____ Date of Birth: _____/ _____/_____

Mailing Address: _____ City: _____ ST: _____ Zip:_____

S. S. #: _____ Home Phone: _____ Cell Phone:_____

E-Mail Address: _____

Please explain in detail how your accident happened

_____

_____

_____

_____

_____

	Driver of vehicle in which you where injured	At-Fault Driver
Insured's Name and Policy #		
Insurance Company		
Insurance Company Address		
Adjuster Phone		
Claim #		

Have you retained an attorney? ☐ YES ☐ NO If so, his/her name and phone: _____

Were police notified? ☐ YES ☐ NO Were you knocked unconscious? ☐ YES ☐ NO

You were: ☐ Driver ☐ Passenger ☐ Front Seat ☐ Back Seat ☐ Wearing Seat Belts ☐

Other Protective Devices

What was the time and date of present injury?

_____

Where did you feel pain immediately after the accident?

_____

Where were you taken after the accident? _____ What treatment was given?

_____

Was any other doctor consulted after the accident? ☐ YES ☐ NO If so, Who

_____

What was the diagnosis given? _____ What treatment was given?

_____

How often did you see the doctor? _____How long did you see the doctor?

_____

Have you ever had any complaints in the involved area before? ☐ YES ☐ NO

If so, the complaints?

_____

Before the accident were you capable of working on an equal basis with others your age? ☐

YES ☐ NO

Are your work activities restricted as a result of this accident? ☐ YES ☐ NO

Since this injury are your symptoms ☐ Improving ☐ Getting Worse ☐ Same

Signature: _____Date:

_____

HEALTH QUESTIONNAIRE

Patient Name: _____ Date:

_____

Musculo-Skeletal System	**Genito-Urinary System Cardio-Vascular-**	**Gastro-Intestinal System**
		Respiratory
__ Low Back Problems	__ Bladder Trouble	__ Poor Appetite
__ Pain Between Shoulders	__ Excessive Urine	__ Excessive Hunger

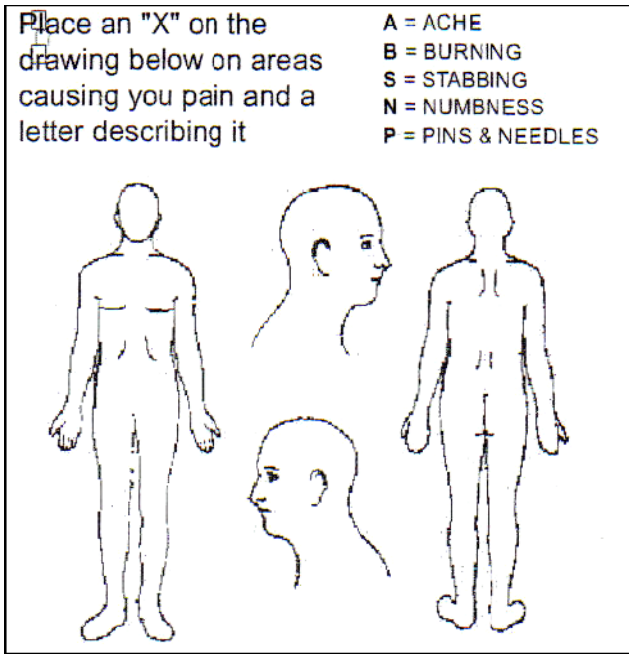
__ Chest Pain
__ Neck Problems
__ Difficulty Breathing
__ Arm Problems
__ Persistent Cough
__ Leg Problems
__ Coughing Phlegm
__ Swollen Joints
__ Coughing Blood
__ Painful Joints
__ Rapid Heartbeat
__ Sore Muscles
__ B. P. Problems
__ Weak Muscles
__ Heart Problems
__ Walking Problems
__ Lung Problems
__ Broken Bones
__ Varicose Veins

__ Scanty Urination
__ Painful Urination
__ Discolored Urine

Female

__ Vaginal Discharge
__ Vaginal Bleeding
__ Vaginal Pain
__ Lumps on Breast

__ Difficult Chewing
__ Difficult Swallowing
__ Excessive Thirst
__ Nausea
__ Vomiting Food
__ Vomiting Blood
__ Abdominal Pain
__ Diarrhea
__ Constipation



__ Black Stool
__ Bloody Stool

__ Hemorrhoids

__ Liver Trouble
__ Gall Bladder Problems

__ Weight Trouble

Eye, Ear Nose &

Throat

__ Eye Strain

__ Eye Inflammation

__ Vision Problems

__ Ear Pain

__ Ear Noises

__ Hearing Loss

__ Ear Discharge

__ Nose Pain

__ Nose Bleeding

__ Difficulty Breathing
Through Nose

__ Sore Gums

__ Hoarseness

__ Difficult Speech

Nervous System

__Numbness

__ Paralysis

__ Dizziness

__ Fainting

__ Headaches

__ Muscle Jerking

__ Convulsions

__ Depression

Childhood Diseases:
_____
_

Health Complications:
_____

Medication Presently Taking:
_____

Prior Surgery:
_____
_____

Previous Accidents:
_____
_

_____
_____
Mother living? Y / N In Good Health? Y / N

Father living? Y / N In Good Health Y / N

Informed Consent to Chiropractic Adjustments and Care

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 treat me while employed by, working or associated with or serving as backup for the doctor of chiropractic named below, including those working 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/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures.

I understand and am informed that as in the practice of medicine, in 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 wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interest.

I have read, or have had read to me, the above consent. I have also had the 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.

Print Patient Name: _____ Date: _____

Signature of Patient:

_____

—

Signature of Legal Gaurdian (if patient is minor):

_____

Print Name:

_____

River Parishes Chiropractic
River Parishes Chiropractic
1108 W. Airline Hwy
1959 Hwy. 3125
LaPlace, LA 70068
Lutcher, LA 70071

Treating Physician(s):

Robert Dale, D. C. Physician
_____Date_____
J. Kevin Martin, D. C.
Dwayne Burch, D.C.
Witness_____Date_____

Doctor's Lien

I, the undersigned, understand that all past, present and future bills incurred at River Parishes Chiropractic, are my responsibility for payment. I hereby ratify my agreement to pay all bills incurred during my health care at this clinic.

In consideration for River Parishes Chiropractic having agreed to treat me without payment at the time of service and enabling me to obtain treatment for my accident/ injury/ illness, without financial hardship, I give you a lien on any settlement, claim, judgment, verdict, or result of said accident/ injury/ illness and I judgment related to this accident/ injury/ illness.

I also understand that if the settlement does not cover my entire bill at this clinic, I am still responsible for the remainder and the payment by me of this bill is not contingent on any settlement, claim, or judgment, which I may eventually recover.

Furthermore, in consideration for River Parishes Chiropractic refraining from

attempting to collect immediate payment for services rendered for my accident/ injury/ illness, I do hereby waive and tall any applicable statute of limitation on the collection of my account until I notify River Parishes Chiropractic of the conclusion of my efforts to obtain a settlement of judgment through the assistance of my attorney and for a period of three (3) months thereafter.

_____ _____

Patient Name (Please Print) Patient Signature

Date

Instructions To Counsel

I do hereby instruct you, my Attorney, named below, to pay River Parishes Chiropractic in full for services to me for my accident/ injury/ illness from any proceeds of settlement, claim, or judgment regarding said accident/ injury/ illness. You are to pay River Parishes Chiropractic prior to distributing any proceeds to me and I instruct you not to attempt to reduce by means of negotiation my doctor's bill for the services that have been provided to me for the accident/ injury/ illness, which I have agreed to pay in full.

_____

Firm Name Patient Signature

_____

Attorney Name Date

Attorney's Acceptance Of Lien

Being the attorney of record or authorized representative, I acknowledge receipt of my client's instructions to Counsel and Lien and agree to honor the same.

_____

Attorney Signature Date

River Parishes Chiropractic
Patient Consent For Protected Health Information To Carry Out

Treatment, Payment and Health Care Operations

I, _____, hereby state that by signing this consent, I acknowledge and agree as follows:

1) The Practice's Privacy Notice has been provided to me prior to my signing this consent. The Privacy Notice includes a complete description of the uses and / or disclosures of my protected health information ("PHI") necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out its health care operations. The Practice has explained to me that the Privacy Notice would be available to me in the future at my request. The Practice has further explained my rights to obtain a copy of the Privacy Notice Prior to signing this consent.

2) The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.

3) I understand that, and consent to, the following appointment reminders that will be used by the Practice: a) a postcard mailed to me at the address provided by me; and b) telephoning my home and leaving a message on my answering machine to with the person answering the phone.

4) The Practice may use and / or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the Practice to treat me and obtain payment for that treatment, and as necessary for the Practice to conduct its specific health care operations.

5) I understand that I have the right to request that the Practice restrict how my PHI is used and / or disclosed to carry out treatment, payment, and / or health care operations. However, the Practice is not required to agree to any restrictions that I have requested. If the Practice agrees to a requested restriction, then the restriction is binding on the Practice.

6) I understand that this consent is valid for seven years. I further understand that any such revocation shall not apply to the extent that the Practice has already taken action in reliance on this consent

7) I understand that if I revoke this consent at any time, the Practice has the right to refuse to treat me.

8) I understand that if I do not sign this consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then the Practice may not treat me.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

_____ _____

_____

Patient Name (Please Print) Patient Signature

Date