ELITE SPINE AND SPORT CENTER

CHIROPRACTIC HEALTH QUESTIONNAIRE

Name:_____ SS#: _____ Today's Date: _____/_____/_____

Address:_____ City: _____

State: _____ Zip:_____

What you prefer to be called: _____ Age: _____ Birthdate: _____/_____/_____

Handedness: _____ Height: _____ Weight: _____ Number of Children: _____

☐ Male ☐ Female Marital Status: ☐ S ☐ M ☐ D ☐ W Spouse: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ E-Mail Address: _____

Occupation: _____ Employer: _____

Referred By: _____

Are you currently taking any medication? ☐ Muscle Relaxants ☐ Blood Thinners ☐ Insulin ☐ Stimulants ☐ Tranquilizers ☐ Pain Killers ☐ Other(s)_____

Have you ever had any of the following diseases or medical conditions?

☐ Arthritis	☐ Asthma	☐ Sinus Trouble	☐ Joint Replacement	☐ Allergies
☐ Tuberculosis	☐ Diabetes	☐ Epilepsy	☐ Thyroid Trouble	☐ High/Low BP
☐ Emphysema	☐ Ulcer / Colitis	☐ Cancer	☐ Polio	☐ Rheumatic Fever
☐ Emotional Disorders	☐ Bone Fracture	☐ Multiple Sclerosis	☐ Prostate Trouble	☐ Kidney Disease
☐ HIV +	☐ Heart Attack	☐ Stroke	☐ Hepatitis	☐ Anemia
☐ Neck Pain	☐ Low Back Pain	☐ Headaches	☐ STD's	☐ Joint Pain

Please list any other notable conditions that you had / have_____

Family history of any of the previous or other? ☐ Yes (please note_____) ☐ No

What are your habits?

Smoking	☐ Never	☐ Occ	☐ Moderately	☐ Excessively
Alcohol	☐ Never	☐ Occ	☐ Moderately	☐ Excessively
Recreational Drugs	☐ Never	☐ Occ	☐ Moderately	☐ Excessively
Exercise	☐ Never	☐ Occ	☐ Moderately	☐ Excessively

List any previous surgeries/hospitalizations and dates_____

Are you wearing any: ☐ Heel lifts ☐ Inner soles ☐ Arch Supports What is the age of your mattress?_____

For Women: Are you taking birth control? ☐ Yes ☐ No Are you pregnant? ☐ Yes (How many mo._____) ☐ No

Date of your last period?_____ Are you under the regular care of an OB/GYN? ☐ Yes ☐ No

Was your accident directly related to your work? ☐ Yes ☐ No **If NO, continue to next section please.**

Date & Time of Accident:_____

Briefly describe the events that occurred just before and during your accident: _____

_____

Give the address where the accident occurred (if other than the employer's address): _____

_____

Was anyone else present during your accident ☐ Yes ☐ No

Did you report your accident to your employer? ☐ Yes ☐ No

What recommendations did your employer make just after your accident? _____

_____

Has this type of accident happened to you before? ☐ Yes ☐ No

To the best of your knowledge, has this accident occurred in your workplace before? ☐ Yes ☐ No

In general:

Is your job physically stressful? ☐ Yes ☐ No

Is your job mentally stressful? ☐ Yes ☐ No

Is your workplace noisy? ☐ Yes ☐ No

Have you changed jobs in the last year? ☐ Yes ☐ No

Date & Time of **Auto** Accident:_____ Location: _____

Were you the: ☐ Driver ☐Front Passenger ☐ Rear Passenger

If a traffic violation was issued, to whom was it issued? _____

How did the accident occur? _____

_____

_____

Number of people in accident vehicle? _____

Did the police come to the scene? ☐ Yes ☐ No Was a police report filed? ☐ Yes ☐ No

Were there any witnesses? ☐ Yes ☐ No Were you wearing your seat belt? ☐ Yes ☐ No

Was this vehicle equipped with airbags? ☐ Yes ☐ No If yes, did they inflate? ☐ Yes ☐ No

What was the approx. speed of your vehicle? _____

Did the impact come from the: ☐ Front ☐ Rear ☐ R side ☐ L side ☐ Other

During impact, were you facing: ☐ Right ☐ Left ☐ Forward

Were you ☐ aware of or ☐ surprised by the impact?

Did any part of your body strike anything inside of the vehicle? ☐ Yes ☐ No If yes, please describe:_____

Did accident render you unconscious? ☐ Yes ☐ No If yes, for how long? _____

How did you feel immediately after the accident?_____

_____

Did you seek post-accident hospitalization?_____ If yes, at what hospital? _____

When did you go? _____ How did you get there? _____

Describe any treatment you received_____

Were x-rays taken? ☐ Yes ☐ No Was medication prescribed? ☐ Yes ☐ No

Have you been seen by any other doctors since this accident? ☐ Yes ☐ No If yes, by whom?_____

_____

What are your current complaints? _____

_____

Is your condition getting: ☐ Better ☐ Same☐ Worse

Indicate symptoms that are a result of this accident:

☐ Dizziness	☐ Difficulty Sleeping	☐ Jaw Problems	☐ Back Pain	☐ Arm/Shoulder Pain
☐ Nausea	☐ Memory Loss	☐ Irritability	☐ Headache(s)	☐ Fatigue
☐ Numb Hands/Fingers	☐ Low Back Pain	☐ Blurred Vision	☐ Back Stiffness	☐ Chest Pain
☐ Tension	☐ Buzzing in Ear	☐ Neck Pain	☐ Neck Stiffness	☐ Leg Pain
☐ Shortness of Breath	☐ Upset Stomach	☐ Numb Feet/Toes	☐ Other _____	

Have you retained an attorney? ☐ Yes ☐ No

Attorney's Name and Address: _____

His/Her Phone Number: _____

To evaluate the effect that continuing work will have on your recovery, please complete the following:

How many hours/day do you work?_____ Have you been able to work since this injury? ☐ Yes ☐ No

If you lost any days of work, please list those dates: _____

Are your work activities restricted as a result of this injury? ☐ Yes ☐ No

What are your job duties?_____

Do you work with others who can help you with any heavy lifting? ☐ Yes ☐ No ☐ N/A

While in recovery, is there any light duty work you can request? ☐ Yes ☐ No ☐ N/A

How was your health **prior** to the accident? (Please list all complaints)_____

_____

Have you had any **previous** accidents, auto or otherwise? _____

If yes, describe the accident and any resulting injuries: _____

_____

Primary Accident Coverage

Insurance Co. Name:_____ Address:_____

ID or Claim#:_____ GRP#:_____ Insured's Name:_____

Relation:_____ DOB:_____ Insured's Employer: _____

Secondary Accident Coverage

Insurance Co. Name:_____ Address:_____

ID#:_____ GRP#:_____ Insured's Name:_____

Relation:_____ DOB:_____ Insured's Employer: _____

We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.

- I authorize the staff to perform any necessary services needed during diagnosis and treatment.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Patient's Signature_____ Date _____/_____/_____

Guardian or Spouse's Signature_____ Date _____/_____/_____

PATIENT CONSENT AND AUTHORIZATION

1. _____**HIPPA Patient Disclosure:** I understand that, by signing this consent form, I am granting my consent to Dr. Russell to use and disclose my protected health information to carry out treatment; payment activities and heath care operations. Our Notice of Privacy Practices provides more detailed information about the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. You have a legal right to review our full Notice . We encourage you to read it carefully and completely before signing this consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue revised Notice Privacy Practices, which will be available by contacting our office. Those changes may apply to any of your protected health information that we maintain. I acknowledge that I have had an opportunity to review the Notice of Privacy Practices.

2. _____**Assignment of Benefits:** I hereby authorize my insurance company to make payment of medical benefits to Health First Chiropractic Center for medical services rendered to me. I also authorize the release of any medical or other information necessary to process this claim.

3. _____**Resolution of Disputes:** In the rare circumstances that a dispute arises regarding any matter connected with this office, I agree that independent arbitration will be entered into and completed before any legal action can be taken. I further understand that if I am not satisfied with the results of the arbitration, I am free to pursue any other legal remedy at that time.

4. _____**Medicare:** I authorize the release of any medical or other information necessary to process this claim. I also request payment of governmental benefits either to myself or to Elite Spine and Sport Center.

5. _____ **(Female Patients Only)Verification of Non-Pregnancy:** By my initials on this form, I do hereby state that to the best of my knowledge, I am not pregnant, nor is pregnancy suspected or confirmed at this particular time.

6. _____**Permission to Evaluate and Treat a Minor Child/Dependant Adult:** I authorize the office to evaluate and treat _____. (Relationship: _____)

Patient Name: _____

File #: _____

Date: _____

Patient Signature (after initialing above): _____

ELITE SPINE AND SPORT CENTER

OFFICE FINANCIAL POLICY

Our policy requires payment at time of service unless specific arrangements have been made in advance. Our agreement is with you and not your insurance company. Although this Chiropractic Office will prepare any necessary reports and forms to assist you in making collection from the insurance company, and any amount authorized to be paid directly to this Chiropractic Office will be credited to your account upon receipt, you are financially responsible for the services you receive. Payment to our office is not contingent upon payment by your insurance company. You are considered a cash-paying patient until you provide completed insurance information and we verify and accept your insurance coverage.

HMO and PPO members will be expected to pay co-pays or deductibles at the time of service.

If you wish to file you own insurance claims we will provide you with the necessary itemized statements to file for reimbursement.

If you request that we file your insurance claims for you and if we agree to accept assignment from your insurance company, and if your carrier has not paid a claim within thirty (30) days of submission, you agree to take an active part in the recovery of your claim. If your insurance carrier has not paid within sixty (60) days of submission, you accept responsibility for payment in full of any outstanding balance and authorize us to use your credit card to collect full payment.

Should your responsibility for any account balance go unpaid past ninety (90) days despite repeated attempts to collect payment, your account may be turned over to an outside collection agency. In that case, you will assume the further responsibility of, but not limited to, collection fees, legal fees and interest on any balances due past ninety (90) days, if no acceptable arrangements have been made with the business manager.

If you discontinue care for any reason other than discharge by the doctor, all balances will become immediately due and payable in full by you, regardless of any claim submitted.

If you have pre-paid for any services and do not receive them or if you cancel any pre-paid services, you will receive a pro-rated refund following a complete resolution of any outstanding payments from your insurance company.

If a check is returned, there will be a $25.00 service fee charged.

I have read and understand my financial responsibilities under this financial policy.

Guarantor's Name:

Relationship:

Signature:

Date:

For your convenience, you may retain your credit/debit card on file with us.

ELITE SPINE AND SPORT CENTER

ASSIGNMENT OF BENEFITS

I, _____, the insured and/or beneficiary of the policy or policies of the insurance providing medical benefits to me, do hereby authorize you to pay directly to the above named health care provider, benefits due me out of the indemnity under the terms of the applicable policy/policies issued by your company:

_____

_____

_____

_____

Payment is authorized upon receipt of the itemized statement for services rendered. This policy was in full force and effect at the time services were rendered. I also authorize the above health care provider to obtain counsel and enter legal or other action on my behalf and/or in my name to collect such sums due it should sums not be paid within the legally prescribed, or within a reasonable period of time. I do hereby promise full and complete cooperation with any legal counsel obtained by the medical provider including attending of any type of deposition, arbitration or court proceeding. I understand that if I fail to cooperate with legal counsel, I may be held personally responsible to the medical provider for any expenses not covered by the responsible insurance carrier. I realize that I am financially responsible for charges not covered by this assignment. Payment, in whole or in part, shall be considered the same as if paid by your company directly to me. A photocopy of this assignment shall be valid as the original.

The undersigned patient does hereby agree and acknowledge that he/she may receive benefit checks directly from the insurance carrier for services rendered by the provider. The undersigned patient hereby agrees to immediately forward said checks to the provider upon receipt of the same. It is understood and agreed that should the undersigned patient not forward any benefits to the provider, the provider does maintain the right to request said checks from the patient and initiate any and all collection efforts. If such action is taken by the provider, the undersigned agrees to be responsible for any and all benefit checks received, plus any and all collection costs incurred including attorney fees and court costs.

Insured:_____

Claimant:_____

Address:_____

Claim:_____

Legal Signature:_____

Parent Signature:_____

ELITE SPINE AND SPORT CENTER

MEDICAL REPORTS AND DOCTOR'S LIEN

Patient Name:_____ File No: _____

I do hereby authorize Dr. Bryan C. Russell to furnish you, my attorney, with a full report of his examination, diagnosis, treatment, prognosis, etc., in regard to the accident in which I was involved on _____.

I authorize the withholding of such sums from any settlement, judgment, or verdict as may be necessary to adequately protect Dr. Bryan C. Russell, DC and hereby authorize and direct you, my attorney, to pay directly to said doctor such sums as may be due and owing him for services rendered me both by reason of this accident and by reason of any other bills that are due his office. And I hereby further give a lien to Dr. Bryan C. Russell, DC, against any and all proceeds of any settlement, judgment, or verdict as a result of said accident which may be paid to you, my attorney or myself. In addition, this lien is irrevocable until Dr. Bryan C. Russell, DC is paid in full.

I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by him for service rendered me and that this agreement is made solely for said doctor's additional protection and consideration of his awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee. I agree that I will also maintain responsibility for any bills which my insurance carrier denies payment. I understand and agree that although you, my attorney, or Dr. Bryan C. Russell, DC may attempt to have any unpaid bills upheld and paid through arbitration hearings or a PIP suit against my insurance carrier, that I will maintain full responsibility for those charges even in the event of an unfavorable decision.

A photocopy of this lien shall be considered as valid as the original.

Date_____ Patient's Signature_____

I, the undersigned, being attorney of record for the above patient do acknowledge receipt of this lien and agree to honor all the terms of the above and agree to withhold such sums from any settlement, judgment or verdict after payment of legal costs and legal fees to adequately protect Dr. Bryan C. Russell, DC.

Date_____ Attorney's Signature_____

Kindly sign and date one copy and return in enclosed envelope. An additional copy has been provided for your records.