Andy Minor Chiropractic PC/A Minor Adjustment

PERSONAL INJURY PATIENT INFORMATION

PATIENT INFORMATION

Last Name	First	Middle	Age	Birth Date	Sex (Circle One)
				/ /	M / F

How Many Children?	Home Phone #	Alternate Phone #	Spouse Parent	Other Cell	Marital Status (Circle One)	Name of Spouse
	( )	( )			S / M / D / W	

Street Address	City	State	Zip	Contact Preference (Circle One)
				Email Alternate # Home # Work # Text/Phone Carrier______

Occupation	Employer	Office Phone	Referred By
		( )	

Emergency or minor	Name	Phone #	Address (if different)

INSURANCE INFORMATION

Medical Pay Insurance:	Policy Holder's Name:	Claim Number:	Adjuster's Name & Phone Number:

Responsible Party's Name:	Address	City	State	Zip

Name 3rd Party Insurance:	Policy Holder's Name:	Claim Number:	Adjuster's Name & Phone Number

Attorney Name	Address	City	State	Zip	Phone

ACCIDENT INFORMATION

PLEASE PROVIDE A COPY OF THE ACCIDENT REPORT

Were there any witnesses? O Yes O No Name(s)

Date Of Accident: Time of Day Were you: O Driver O Passenger O Front Seat O Back Seat

Number of people in your vehicle? Number of vehicles involved? Did the airbag deploy? O Yes O No

Were you wearing seatbelts? O Yes O No What was the estimated damage to the vehicle you were in?

Did you slide out of your seatbelt during the accident? O Yes O No

What direction were you heading? O North O South O East O West On what street or intersection?

City, State?

Did you brace for impact? O Yes O No O I braced with my hands O I braced with my feet

What type of impact was the accident? What type of vehicle were you in? What type of vehicle impacted yours?

Did your vehicle hit anything after the accident? If yes, Please describe:

At the time of impact, how fast was your vehicle moving? How fast was the other vehicle moving?

Which way were you facing at the time of impact? O Straight ahead O Left O Right

During and after the crash what happened to your vehicle? (Check all that apply)

- O Kept going straight
- O Kept going straight, hitting a car in front
- O Spun around
- O Was hit by another vehicle
- O Spun around and hit a stationary object
- O Hit a stationary object

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Did you lose consciousness during the accident? O Yes O No

How was your head positioned during the accident? ______

How was your torso positioned during the accident? ______

How were your hands positioned during the accident? ______

Did you strike anything in the vehicle at the time of impact? O Yes O No If yes, specify what part of your body struck what.

O Steering Wheel ______ O Dashboard ______ O Windshield ______ O Roof ______

O Left Side Door ______ O Right Side Door ______ O Left Side Window ______ O Right Side Window ______

What type of headrest was in your vehicle? O movable fixed O non-moveable fixed O no headrest

What was damaged in your vehicle? (Check all that apply)

O Windshield O Steering Wheel O Dashboard O Seat Frame O Side Window

O Rear Window O Rear Bumper O Front Bumper O Trunk O Front Left Door

O Front Right Door O Back Left Door O Back Right Door O Mirror O Knee Bolster

O Completely Totaled O Other: ______

Check the items that dented inward:

O Floorboards O Side Door O Dashboard

Did all doors open after the accident? If no, which doors would not?

Immediately following the accident, how did you feel? O Dizzy/Dazed O Disoriented O Unconscious O Nervous O Nauseous

O Upset O Weak O Other ______

Did you go to the hospital? O Yes O No Were you admitted to the hospital? O Yes O No If yes, how long?

If you went to the hospital, when did you go? O At the time of the accident O Next day

How did you get to the hospital? O Ambulance O Police car O Private transportation

Name of hospital: ______ Attended by Dr. ______

What treatment was given?

O None O Placed in cervical collar O Given instructions re: sprains and strains

O X-rayed O Given Pain Medication O Given instructions re: concussion

O Bandaged O Physical therapy O Instructed to call an Orthopedic Surgeon

O Given Stitches O Given Muscle Relaxers O Instructed to call a private physician

O Referred to this office for treatment O Other ______

Have you seen any other doctor as a result of this accident? O Yes O No

Doctor's name: ______

CHIEF COMPLAINTS OR SYMPTOMS

Neck Pain: O Yes O No O Left shoulder O Left arm O Left forearm O Left hand O Right shoulder O Right arm O Right forearm O Right hand O Headache O Migraine Headache O Upper back pain

Numbness: O Left hand O Left upper arm O Right hand O Right upper arm O Left foot O Left leg O Right foot O Right leg

Ringing in ears: O Yes O No O Left O Right O Both ears **Blurry vision:** O Yes O No O Left O Right O Both eyes

Wrist pain: O Yes O No O Left O Right O Both wrists **Jaw pain:** O Yes O No O Left O Right O Both sides

Other:
O Dizziness O Nervousness O Fatigue O Anxiety O Depression O Excessive irritability O Fear of driving a car O Loss of concentration O Jaw clenching O Grinding of teeth at night O Nightmares O Difficulty sleeping

Low Back Pain: O Yes O No O Left Buttocks O Right Buttocks O Right hip O Left hip

Leg Pain: O Left thigh O Left knee O Left foot O Right thigh O Right knee O Right foot

Pain Scale: Circle one

Last 24 hours: no pain 0 1 2 3 4 5 6 7 8 9 10 worst pain

Past Week: no pain 0 1 2 3 4 5 6 7 8 9 10 worst pain

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How often do you experience your symptoms?
O Constantly (75%-100% of the time) O Frequently (50%-75%) O Occasionally (25%-50%) O Intermittently (0%-25%)

How would you describe the type of pain? Check all that apply.
O Sharp O Dull O Diffuse O Achy O Burning O Sharp with motion
O Shooting O Stiff O Numb O Tingly O Shooting with Motion O Stabbing with motion
O Electric with motion O Other: ____________________

How are your symptoms changing with time?
O Getting worse O Staying the same O Getting better

How often have your symptoms interfered with your usual daily activities?
O Not at all O A little bit O Moderately O Quite a bit O Extremely

Do you consider this problem to be severe?
O Yes O No O Yes, At times

What aggravates your problem? ____________________

What alleviates your problem? ____________________

In general, would you say your overall health right now is...
O Excellent O Very good O Good O Fair O Poor

List all Prescription medications you are currently taking: ____________________

List all over-the-counter medications you are currently taking: ____________________

List all surgical procedures you have had: ____________________

What activities do you do at work?

Sit:	O Most of the day	O Half of the day	O A little of the day	O Not at all
Stand:	O Most of the day	O Half of the day	O A little of the day	O Not at all
Computer Work:	O Most of the day	O Half of the day	O A little of the day	O Not at all
On the phone:	O Most of the day	O Half of the day	O A little of the day	O Not at all

What activities do you do outside of work? ____________________

Additional Complaints or symptoms:
____

LOST TIME FROM WORK

Have you lost any time from work due to your injuries? O Yes O No If yes, please give dates: ____________________

Type of employment: ____________________ Have you had any previous injuries or accidents? O Yes O No

Description of previous accident: ____________________ Description of previous injuries: ____________________

Do you have residual pain from previous injuries? O Yes O No

How much better did you feel prior to this accident? ____________________

AGREEMENT

PAYMENT IS EXPECTED AT THE TIME SERVICES ARE RENDERED

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Chiropractic office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Chiropractic office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are charge directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

X ____________________
PATIENT/GARDIAN SIGNATURE DATE SOCIAL SECURITY #

EMAIL (**Required or reason not given**): ____________________

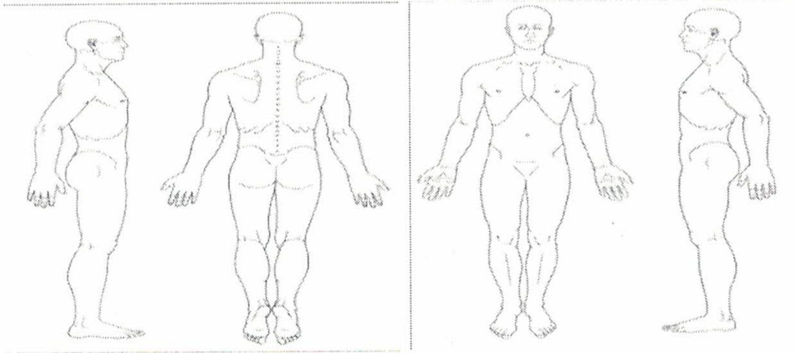
____
Information taken by Date

Andy Minor Chiropractic PC
A Minor Adjustment

CONFIDENTIAL PATIENT INFORMATION

Patient Name:____ Date:________________

1. **Is today's problem caused by:** O Auto Accident O Workman's Compensation O None
2. **Indicate on the drawings below where you have pain/symptoms**



3. **How often do you experience your symptoms?**
   - O Constantly (76-100% of the time)
   - O Occasionally (26-50% of the time)
   - O Frequently (51-75% of the time)
   - O Intermittently (1-25% of the time)
4. **How would you describe the type of pain? (Check all that apply)**
   - O Sharp O Dull O Diffuse O Sharp with motion
   - O Achy O Burning O Shooting O Shooting with motion
   - O Stiff O Numb O Tingly O Stabbing with motion
   - O Other:______________________________ O Electric with motion
5. **How are your symptoms changing with time?**
   - O Getting worse O Staying the same O Getting Better
6. **Using a scale from 0-10 (10 being the worst), how would you rate your problem in the...** (Circle One)

Last 24 hours ?	0	1	2	3	4	5	6	7	8	9	10
Past week ?	0	1	2	3	4	5	6	7	8	9	10

7. **How much has the problem interfered with your work?**
   - O Not at all O A little bit O Moderately O Quite a bit O Extremely
8. **How much has the problem interfered with your social activities?**
   - O Not at all O A little bit O Moderately O Quite a bit O Extremely
9. **Who else have you seen for your problem?**
   - O Chiropractor O Neurologist O Primary Care Physician O ER Physician
   - O Orthopedist O Massage Therapist O Physical Therapist O No One
   - O Other____
10. **How long have you had this problem and how did it begin?**______________________________

    ____
11. **Do you consider this problem to be severe?**
    - O Yes O No O Yes, At times
12. **What concerns you the most about your problems? What does it prevent you from doing?**__________

    ____
13. **List All Prescription medications you are currently taking:**________________________

    ____
14. **List all of the over-the-counter medications you are currently taking:**_______________

    ____
15. **List all surgical procedures you have had:**________________________________

    ____
16. **List your Primary and any other doctors you see and their specialties:**_____________

    ____

FRONT & BACK

17. For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

Past	Present		Past	Present		Past	Present	
O	O	Headaches	O	O	High Blood Pressure	O	O	Diabetes
O	O	Neck Pain	O	O	Heart Attack	O	O	Excessive Thirst
O	O	Upper Back Pain	O	O	Chest Pains	O	O	Frequent Urination
O	O	Mid Back Pain	O	O	Stroke	O	O	Smoking/Tobacco Use
O	O	Low Back Pain	O	O	Angina	O	O	Drug/Alcohol Dependance
O	O	Shoulder Pain	O	O	Kidney Stones	O	O	Allergies
O	O	Elbow/Upper Arm Pain	O	O	Kidney Disorders	O	O	Depression
O	O	Wrist Pain	O	O	Bladder Infection	O	O	Systemic Lupus
O	O	Hand Pain	O	O	Painful Urination	O	O	Epilepsy
O	O	Hip Pain	O	O	Loss of bladder control	O	O	Dermatitis/Eczema/Rash
O	O	Upper Leg Pain	O	O	Prostate Problems	O	O	HIV/AIDS
O	O	Knee Pain	O	O	Abnormal Weight Gain/Loss			
O	O	Ankle/Foot Pain	O	O	Loss of Appetite			****For Females Only**
O	O	Jaw Pain	O	O	Abdominal Pain	O	O	Birth Control Pills
O	O	Joint Pain/Stiffness	O	O	Ulcer	O	O	Hormonal Replacement
O	O	Arthritis	O	O	Hepatitis	O	O	Pregnancy
O	O	Rheumatoid Arthritis	O	O	Liver/Gall Bladder Disorder			
O	O	Cancer	O	O	General Fatigue			
O	O	Tumor	O	O	Muscular Incoordination			
O	O	Asthma	O	O	Visual Disturbances			
O	O	Chronis Sinusitis	O	O	Dizziness			
O	O	Anxiety/Nervousness	O	O	OTHER________________________			

Do you smoke? Y N If yes, how often? ______________________

18. What aggravates your problem?

Check all that apply for activities in which you have **Pain** or **Difficulty** with: O **Always or** O **Sometimes**

	A	S		A	S		A	S
Bending/Twisting/Turning	O	O	Heavy Lifting and Movement	O	O	Housework/Yard work: Specify________________	O	O
Climbing Stairs	O	O	Exercise/Sports	O	O	Sexual intercourse	O	O
Running	O	O	Dressing the lower/upper body	O	O	Shopping	O	O
Sitting	O	O	Grooming/Bathing	O	O	Stress	O	O
Sleeping	O	O	Going to the bathroom	O	O	Taking care of baby/child	O	O
Standing	O	O	Driving/Riding in car	O	O	Weather Change	O	O
Walking	O	O	Getting in and out of car	O	O	Typing/Computer work/Reading	O	O
Breathing/Coughing	O	O	Cooking	O	O	Recreational/Work/Other activities:	O	O
Carrying Groceries/Laundry	O	O	Needlework, knitting, hand sewing	O	O	Specify________________	O	O

19. What alleviates your problem? Check all that apply

O Adjustments O NSAIDS O Prescription Pain Meds O Resting O Stretching
O Massage O Ice O Heat O Nothing O Acupuncture
O Analgesic Creams O Other ____

20. What activities do you do at work?

Sit:	O Most of the day	O Half of the day	O A little of the day	O Not at all
Stand:	O Most of the day	O Half of the day	O A little of the day	O Not at all
Computer Work:	O Most of the day	O Half of the day	O A little of the day	O Not at all
On the Phone:	O Most of the day	O Half of the day	O A little of the day	O Not at all

21. What activities do you do outside of work?____

____

22. Anything else pertinent to your visit today?____

____

Andy Minor Chiropractic PC
A Minor Adjustment

801W Main
Blue Springs, MO 64015
Phone: (816)228-5522 Fax: (816)220-0205

FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered as part of your treatment. The following is a statement of our Financial Policy which we require that you read, agree to and sign prior to any treatment. Any breach of contract due to non-payment of any portion of your services will be billed to you in full with all promotions removed and court costs and collection fees as well as attorney's fees will be assessed as your responsibility at that time.

FULL PAYMENT IS DUE AT THE TIME OF SERVICE

We accept cash, checks, and Visa/MasterCard

We do offer an extended payment plan with prior credit approval

REGARDING INSURANCE

We will accept payment directly from the insurance company. Not all insurance pays at 100% of the charges, and the patient will be responsible for charges up front for what the insurance deems their patient responsibility. During specials we charge a fee up front for your patient responsibility and we bill the insurance our usual and customary rates at the specialist office rate according to guidelines. There will be several codes sent regarding your care.

UCR (Usual and Customary Rates)

Our practice is committed to providing the best treatment possible for our patients and we charge what is **usual and customary** for our area which is governed by state and federal guidelines. You are responsible for paying your patient responsibility determined at time of service.

AUTOMOBILE ACCIDENTS AND WORKMAN'S COMPENSATION

We accept 3rd party automobile accidents with signed liens and assignment of direct pay we will submit to all parties including attorney, med pay, PIP, 3rd party insurance as applicable.

XRAY RELEASE AND MEDICAL RECORDS RELEASE GUIDELINES

The full medical chart, including hard copy of x-rays, is the property of Andy Minor Chiropractic PC. All patients are entitled to a copy of their records or x-rays with a 3 day notice. Main Street digital x-ray copy charge is $25.00 with signed release. We will assume liability of mailing x-rays directly to a health care provider with a signed medical release and agreement to return the original within 30 days can be established. We prefer to send a radiologic findings report to the provider with 3 days notice. We will not release hard copy x-rays to any patient directly.

I have read, understand, and agree to the above Financial Policy.

Patient Name (Please Print)____

Patient or Responsible Party_______________________________Date___________

Signature

Co-Responsible Party___________________________________Date___________

Andy Minor Chiropractic PC
A Minor Adjustment

801 W. Main St.
Blue Springs, MO 64015
Phone: (816)228-5522 Fax: (816)220-0205

Patient Name ____

CONSENT TO X-RAY

I hereby authorize A Minor Adjustment and whomever the clinician may designate as his assistant(s) to take x-rays

Dated this ______ day of ______________, 20____

Signed ____________________________________

Witnessed __________________________________

*Consultation, Examination and X-ray charges have been explained to me.
Xrays are 40.00 a view billed to insurance company and remain the office property.
Copies of medical records or a report to patient is 25.00 charge to patient. Xray report can be sent to another medical professional with medical release sent from them.

____
Initial

*(PATIENTS WITH MEDICARE COVERAGE: Medicare DOES NOT pay for consultations, examinations or x-rays but does require X-rays on file, in most cases, before any payment can be made. Medicare only pays on spinal manipulation charges.)

CONSENT TO X-RAY
PREGNANCY RELEASE*

I hereby release A Minor Adjustment from any and all liability.

Date of last menstrual cycle ______________________________

Signed ________________________________

Witnessed ______________________________

*To be signed where applicable

Andy Minor Chiropractic PC
A Minor Adjustment

Andy Minor, D.C.
Cary Minor, D.C.

801 W Main Street, Blue Springs, MO 64015
Phone: 816-228-5522 Fax: 816-220-0205

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: ______________________ Date of Birth: ______________________

Previous Name: ______________________ Social Security #: ______________________

I request and authorize ____ to release healthcare information of the patient named above to:

Name: ____

Address: ____

City: ______________________ State: __________ Zip Code: __________

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: ______________________

____

☐ All healthcare information

☐ Other: ____

☐ Yes ☐ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Name: ______________________ Date Signed: ______________________

Signature of Patient/Guardian: ____

Approved by: ______________________ Attending Doctor: ______________________

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.

Request a Paper Copy of this Notice

You have the right to request and obtain a copy of the Notice of Privacy Practices directly from our office at any time. Just let us know of your request. We are required by law to maintain the privacy of your health information and to provide to you and your representative this Notice of our Privacy Practices. We are required to practice the policies and procedures described in this notice, but we do reserve the right to change the terms of our notice. Patients would be notified of any such changes.

You have the right to express concerns or complaints to us or the Secretary of Health and Human Services if you believe your privacy rights have been comprised. We encourage you to express in writing, and concerns you may have regarding the privacy of your health information.

Patient Acknowledgment
Please print your name and the names of any others with access to your medical records:

____

____

____

Thank you very much for taking time to review how we are carefully using your health information. If you have questions, please let us know. If not, we would appreciate your acknowledging by signature that you have received, thoroughly reviewed and understand this policy.

______________________________ Date ____/_____/_______
Patient Signature

Thank You For Your Trust and Confidence

HIPAA HAPPENINGS

This notice describes how your health information may be used and how you can gain access to this information. Please review it carefully.

Our Promise To You Our Valued Patient…

This is not meant to alarm you, quite the opposite. We want to assure you that we take the Federal law (HIPAA – Health Insurance Portability and Accountability Act) seriously. These laws were written to protect the confidentiality of your health information. We trust you will never delay treatment in our offices because of fear that your personal health information might be unnecessarily disclosed to others outside our office.

Why A Privacy Policy Now?

The most significant variable that has motivated the Federal government to legally enforce the privacy of health information is the rapid evolution of the use of electronic technology in the administration of the health care business. The government has appropriately sought to standardize and protect the electronic exchange of your health information. This has challenged us to review not only how your information is used within our computers, but also with the Internet, phones, fax machines and any device used to copy or transfer that data.

We want to advise you that we have developed policies and procedures for our practice to assure that your personal or health information will be shared only as required and only for that purpose of administering your case. Our office is subject to State and Federal laws regarding the confidentiality of your health information and we will assure adherence to those laws and we want you to understand our procedures and your rights as a valued patient.

Your health information will be communicated only for the purpose of obtaining payment for services and conducting health care business. Be assured that without your written permission, your health information will not be used for any other purpose.

How Your Health Information May Be Used To Provide Treatment

Within our office, your health information will be used to provide you the best care and services possible. This may include administrative and clinical procedures designed to optimize scheduling and coordination between you and all office personnel. In addition, we may share this information with referring physicians, clinical pathology laboratories or other health professionals providing you treatment.

To Obtain Payment

Your health information may be included with an invoice for the purpose of collecting payment for services provided to you in this office. We may do this with insurance forms filed for you by mail or electronically. We will make all efforts to work with companies with a similar commitment to the security of your health information.

A Minor Adjustment / Andy Minor Chiropractic PC

Andy L Minor DC, owner
801 W Main St.
Blue Springs, MO 64015
Phone: 816-228-5522 Fax: 816-220-0205
TAX ID#: 20-2203267

Standard Auto Accident Plan of Treatment: **3-4 Times a week for 4 weeks or 12 visits**
13th visit Reexam/Rexray
14th visit Report of Findings and send to Radiologist if improved Reduction in Treatment
2-3 Times a week for 4 weeks or 20 visits
Every four weeks at this point Reexam

With a personal injury case it is extremely important to keep close to your schedule or notify us with any changes to your schedule and the reason so we may document to ensure a positive outcome toward pre-accident status and well being.

The balance will be kept in your folder and the medical payment portion of your auto insurance and/or liable person's auto insurance will reimburse at time of treatment or in a settlement at the end of treatment. The insurance company might offer to settle up front during your course of treatment. I strongly recommend you wait to settle until after your treatment plan and all health considerations; as well as your bill are taken into consideration. If an attorney is warranted please advise us right away as all communication will go directly to the attorney at that point.

Our Office Manager, **Cyndi Denham**, has been handling auto claims needs for over 9 years and is available full time for any concerns you may have at **816-228-5522**. Communication is important with personal injury cases and peace of mind will help you with the healing process.

The following information is needed to process a claim from all insurance companies and/or attorneys involved with the claim:

Each payor:

Name of company
Name of Adjustor handling case
Claim Number
Phone Number for Adjustor

Your health and wellness are first priority and peace of mind will create a healing environment.