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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Name:_____ DOB:_____

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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Name: _____ DOB: _____

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

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

Patient Name_____ **DOB**_____

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

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.

DOB_____/_____/_____

_____ 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.