

# PERSONAL INJURY QUESTIONNAIRE

Name \_\_\_\_\_ DOB \_\_\_\_\_  
Address \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Email \_\_\_\_\_ Occupation \_\_\_\_\_

## **Insurance Information**

Please note YOU must contact the responsible insurance company **prior** to treatment to report a claim

**YOUR Auto Insurance** \_\_\_\_\_ Policy# \_\_\_\_\_  
Address/contact info: \_\_\_\_\_ Claim # \_\_\_\_\_  
Do you have Medpay on your policy? **Y / N**

**Responsible party's auto insurance** \_\_\_\_\_ Policy# \_\_\_\_\_  
Address/contact info: \_\_\_\_\_ Claim # \_\_\_\_\_

## **Attorney Information (if retained)**

Attorney \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

## **ACCIDENT INFORMATION**

(please provide a copy of the accident report)

### **NATURE OF ACCIDENT**

(please circle the appropriate responses where applicable)

1. Date of accident \_\_\_\_\_ Time of day \_\_\_\_\_
2. Were you the: Driver Passenger / Front seat Back seat
3. Number of people in your vehicle \_\_\_\_\_ Were you wearing a seat belt? \_\_\_\_\_
4. What direction were you headed? North South East West
5. What direction was OTHER vehicle headed? North South East West
6. Were you struck from: Behind Front Left side Right side
7. Approximate speed of your car? \_\_\_\_\_ mph Other car \_\_\_\_\_ mph
8. Were you knocked unconscious? YES/NO If yes, for how long? \_\_\_\_\_
9. Were police notified? YES/ NO If yes, was a citation issued? \_\_\_\_\_
10. Were there any witnesses? YES/ NO Name(s) \_\_\_\_\_
11. Did you report injuries at the scene? Y / N If so, what type of injuries were sustained?  
\_\_\_\_\_  
\_\_\_\_\_
12. Did you go to the Emergency Room after the accident? Y / N If yes, were you transported via ambulance? Y / N
13. In your own words, please describe the accident:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
14. Did you have any physical complaints **BEFORE** the accident? YES/NO IF YES, please describe in detail:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

15. Please describe how you felt:

- DURING the accident \_\_\_\_\_
- IMMEDIATELY AFTER the accident \_\_\_\_\_
- LATER THAT DAY \_\_\_\_\_
- THE NEXT DAY \_\_\_\_\_

16. What are your **PRESENT** complaints and symptoms?

\_\_\_\_\_

17. Do you have any congenital (from birth) factors which relate to this problem? YES/NO If YES, please describe:

\_\_\_\_\_

18. Do you have any previous illnesses which relate to this case? YES / NO If YES, please describe:

\_\_\_\_\_

19. Have you ever been involved in an accident before? YES/ NO If YES, please describe, including date(s) and type(s) of accidents as well as injuries received:

\_\_\_\_\_

20. Have you been treated by another doctor since the accident? YES / NO If YES, please list doctor(s) name:

\_\_\_\_\_

21. Do you plan to seek other medical treatment in addition to chiropractic for your injuries? Y / N If yes, please provide doctor's name(s) \_\_\_\_\_

22. Since the injury occurred, are your symptoms: Improving Getting Worse Same

23. CHECK SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT:

- |  |   |  |  |
|--|---|--|--|
| <input type="checkbox"/> Headache          | <input type="checkbox"/> Irritability           | <input type="checkbox"/> Numbness in toes    | <input type="checkbox"/> Face flushed    |
| <input type="checkbox"/> Neck Pain         | <input type="checkbox"/> Chest Pain             | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Buzzing in ears |
| <input type="checkbox"/> Stick neck        | <input type="checkbox"/> Dizziness              | <input type="checkbox"/> Fatigue             | <input type="checkbox"/> Loss of balance |
| <input type="checkbox"/> Sleeping problems | <input type="checkbox"/> Head seems heavy       | <input type="checkbox"/> Depression          | <input type="checkbox"/> Fainting        |
| <input type="checkbox"/> Back pain         | <input type="checkbox"/> Pins & needles in arm  | <input type="checkbox"/> Light sensitivity   | <input type="checkbox"/> Loss of smell   |
| <input type="checkbox"/> Nervousness       | <input type="checkbox"/> Pins & needles in legs | <input type="checkbox"/> Loss of memory      | <input type="checkbox"/> Loss of taste   |
| <input type="checkbox"/> Tension           | <input type="checkbox"/> Numbness in fingers    | <input type="checkbox"/> Ringing in ears     | <input type="checkbox"/> Feet cold       |
| <input type="checkbox"/> Diarrhea          | <input type="checkbox"/> Stomach upset          | <input type="checkbox"/> Constipation        | <input type="checkbox"/> Hands cold      |

Symptoms other than the above \_\_\_\_\_

24. Have you lost time from work because of this accident? YES/ NO If yes, please complete this question:

a) Last day worked \_\_\_\_\_

b) Type of employment \_\_\_\_\_

25. Do you notice any activity restrictions as a result of this injury? YES / NO If YES, please describe in detail:

\_\_\_\_\_

\_\_\_\_\_

26. Other pertinent information:

\_\_\_\_\_

\_\_\_\_\_

Date

Patient Signature

# PATIENT HISTORY

Name \_\_\_\_\_ Date of 1<sup>st</sup> Appointment \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Email \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone (H) \_\_\_\_\_ (W) \_\_\_\_\_ (Cell) \_\_\_\_\_  
Spouse's Name \_\_\_\_\_ Children \_\_\_\_\_  
Your Occupation \_\_\_\_\_ Employer \_\_\_\_\_  
Insurance Company \_\_\_\_\_ Policy Number \_\_\_\_\_  
Have you ever received chiropractic care? Y / N Who & When? \_\_\_\_\_  
Who may we thank for your referral? \_\_\_\_\_

---

## WHAT BRINGS YOU TO OUR OFFICE?

### FIRST COMPLAINT:

Date when symptom first appeared \_\_\_\_\_  
Did it begin \_\_\_\_\_ Gradual \_\_\_\_\_ Sudden \_\_\_\_\_ Progressive over time  
How did it occur (if applicable) \_\_\_\_\_  
What makes the symptoms worse? \_\_\_\_\_  
What relieves the symptoms? \_\_\_\_\_  
Type of pain \_\_\_\_\_ Sharp \_\_\_\_\_ Dull \_\_\_\_\_ Ache \_\_\_\_\_ Burn \_\_\_\_\_ Throb \_\_\_\_\_ Constant \_\_\_\_\_ Intermittent  
Does the pain radiate into your \_\_\_\_\_ Arm \_\_\_\_\_ Leg \_\_\_\_\_ Does not radiate  
Do you experience numbness or tingling? \_\_\_\_\_ Y \_\_\_\_\_ N  
How often do you experience these symptoms? ( \_\_\_\_\_ 100% \_\_\_\_\_ 75% \_\_\_\_\_ 50% \_\_\_\_\_ 25% \_\_\_\_\_ 10%)  
Severity of pain/complaint (circle 1-10) No pain 1 2 3 4 5 6 7 8 9 10 Unbearable pain  
List previous treatments for this condition. Physician/other: \_\_\_\_\_

---

### OTHER COMPLAINT(S):

Date when symptom first appeared \_\_\_\_\_  
Did it begin \_\_\_\_\_ Gradual \_\_\_\_\_ Sudden \_\_\_\_\_ Progressive over time  
How did it occur (if applicable) \_\_\_\_\_  
What make the symptoms worse? \_\_\_\_\_  
What relieves the symptoms? \_\_\_\_\_  
Type of pain \_\_\_\_\_ Sharp \_\_\_\_\_ Dull \_\_\_\_\_ Ache \_\_\_\_\_ Burn \_\_\_\_\_ Throb \_\_\_\_\_ Constant \_\_\_\_\_ Intermittent  
Does the pain radiate into your \_\_\_\_\_ Arm \_\_\_\_\_ Leg \_\_\_\_\_ Does not radiate  
Do you experience numbness or tingling? \_\_\_\_\_ Y \_\_\_\_\_ N  
How often do you experience these symptoms? ( \_\_\_\_\_ 100% \_\_\_\_\_ 75% \_\_\_\_\_ 50% \_\_\_\_\_ 25% \_\_\_\_\_ 10%)  
Severity of pain/complaint (circle 1-10) No pain 1 2 3 4 5 6 7 8 9 10 Unbearable pain  
List previous treatments for this condition. Physician/other: \_\_\_\_\_

---

### Additional Symptoms:

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Headaches         | <input type="checkbox"/> Pins & Needles in Legs | <input type="checkbox"/> Fainting        |
| <input type="checkbox"/> Neck Pain         | <input type="checkbox"/> Pins & Needles in Arms | <input type="checkbox"/> Loss of Smell   |
| <input type="checkbox"/> Neck Stiff        | <input type="checkbox"/> Numbness in Fingers    | <input type="checkbox"/> Loss of Taste   |
| <input type="checkbox"/> Back pain         | <input type="checkbox"/> Numbness in Toes       | <input type="checkbox"/> Hands Cold      |
| <input type="checkbox"/> Nervousness       | <input type="checkbox"/> Shortness of Breath    | <input type="checkbox"/> Feet Cold       |
| <input type="checkbox"/> Tension           | <input type="checkbox"/> Chest Pains            | <input type="checkbox"/> Diarrhea        |
| <input type="checkbox"/> Irritability      | <input type="checkbox"/> Dizziness              | <input type="checkbox"/> Stomach Upset   |
| <input type="checkbox"/> Fatigue           | <input type="checkbox"/> Lights Bother Eyes     | <input type="checkbox"/> Constipation    |
| <input type="checkbox"/> Depression        | <input type="checkbox"/> Loss of Memory         | <input type="checkbox"/> Cold Sweats     |
| <input type="checkbox"/> Face Flushed      | <input type="checkbox"/> Ears Ring/Buzzing      | <input type="checkbox"/> Loss of Balance |
| <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Fever                  | <input type="checkbox"/> Allergies       |

### Please list all past surgeries:

Type \_\_\_\_\_ When \_\_\_\_\_ Doctor \_\_\_\_\_  
Type \_\_\_\_\_ When \_\_\_\_\_ Doctor \_\_\_\_\_  
Type \_\_\_\_\_ When \_\_\_\_\_ Doctor \_\_\_\_\_  
Type \_\_\_\_\_ When \_\_\_\_\_ Doctor \_\_\_\_\_

Please list all previous accidents/falls/injuries/hospitalizations:

What \_\_\_\_\_ When \_\_\_\_\_ Injuries \_\_\_\_\_  
What \_\_\_\_\_ When \_\_\_\_\_ Injuries \_\_\_\_\_  
What \_\_\_\_\_ When \_\_\_\_\_ Injuries \_\_\_\_\_  
What \_\_\_\_\_ When \_\_\_\_\_ Injuries \_\_\_\_\_

Please list any medications you are currently taking (include for how long and any side effects).

**Current Health Behaviors:**

Do you smoke/use tobacco? Y / N

Alcohol/drug use? Y / N Please explain \_\_\_\_\_

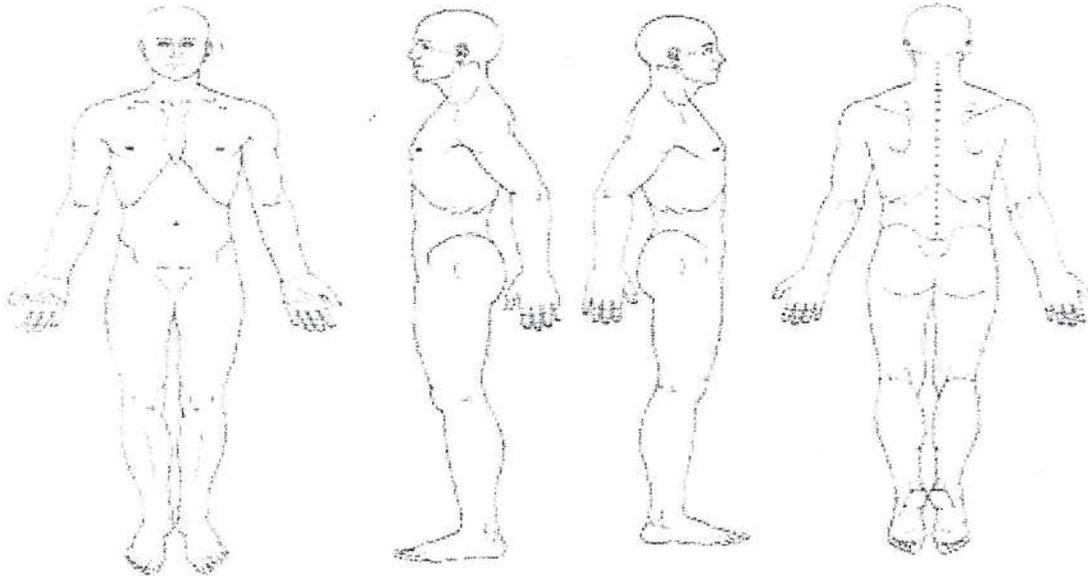
Do you exercise? Y / N What/How often? \_\_\_\_\_

Do you have a healthy/nutritious diet? Y / N Please explain \_\_\_\_\_

What supplements do you take (if any)? \_\_\_\_\_

**PATIENT HISTORY**

**PAIN LOCATION**



Please mark off the areas of your complaint on the diagram above.  
Please use the following symbols on the pain diagram to accurately describe your condition.

- PPP Where you experience Pain
- NNN Where you experience Numbness
- TTT Where you experience Tingling
- BBB Where you experience Burning
- CCC Where you experience Cramping

## NECK PAIN AND DISABILITY INDEX

Patient Name: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

### Please read instructions carefully.

This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage everyday life. Please read all statements in each section and then mark the box that most closely describes your problem.

#### SECTION 1 - PAIN INTENSITY

- I have no pain at the moment.
- The pain is very mild at the moment.
- The pain is moderate at the moment.
- The pain is fairly severe at the moment.
- The pain is very severe at the moment.
- The pain is worse than imaginable at the moment.

#### SECTION 2 - PERSONAL CARE (washing, dressing, etc.)

- I can look after myself normally without causing extra pain.
- I can look after myself normally but it causes extra pain.
- It is painful to look after myself and I am slow and careful.
- I need some help but manage most of my personal care.
- I need help every day in most aspects of self-care.
- I do not get dressed. I wash with difficulty and stay in bed.

#### SECTION 3 - LIFTING

- I can lift heavy objects without any extra pain.
- I can lift heavy objects, but it gives extra pain.
- Pain prevents me from lifting heavy objects off the floor but I can manage if they are conveniently positioned on a table.
- Pain prevents me from lifting heavy objects but I can manage light to medium objects.
- I can lift very light objects.
- I cannot lift or carry anything at all.

#### SECTION 4 - READING

- I can read as much as I want to with no pain in my neck.
- I can read as much as I want to with light pain in my neck.
- I can read as much as I want to with moderate pain in my neck.
- I can't read as much as I want to because of moderate pain in my neck.
- I can hardly read at all because of severe pain in my neck.
- I cannot read at all.

#### SECTION 5 - HEADACHES

- I have no headache at all.
- I have slight headaches which come infrequently.
- I have moderate headaches which come infrequently.
- I have moderate headaches which come frequently.
- I have severe headaches which come frequently.
- I have headaches almost all the time.

#### SECTION 6 - CONCENTRATION

- I can concentrate fully when I want to with no difficulty.
- I can concentrate fully when I want to with slight difficulty.
- I have a fair degree of difficulty in concentrating when I want to.
- I have a lot of difficulty in concentrating when I want to.
- I have a great deal of difficulty in concentrating when I want to.
- I cannot concentrate at all.

#### SECTION 7 - WORK

- I can do as much work as I want.
- I can do only my usual work, but no more.
- I can do most of my usual work, but no more.
- I cannot do my usual work.
- I can hardly work at all.
- I can't do any work at all.

#### SECTION 8 - DRIVING

- I can drive without any neck pain.
- I can drive as long as I want with slight neck pain.
- I can drive as long as I want with moderate neck pain.
- I can hardly drive at all because of severe neck pain.
- I can't drive at all.

#### SECTION 9 - SLEEPING

- I have no trouble sleeping.
- My sleep is slightly disturbed (less than 1 hr. sleepless).
- My sleep is mildly disturbed (1-2 hrs. sleepless).
- My sleep is moderately disturbed (3-5 hrs. sleepless).
- My sleep is completely disturbed (5-7 hrs. sleepless).

#### SECTION 10 - RECREATION

- I am able to engage in all my recreational activities with no neck pain.
- I am able to engage in all my recreational activities with some neck pain.
- I am able to engage in most, but not all of my usual recreational activities because of neck pain.
- I am able to engage in a few of my usual recreational activities because of neck pain.
- I can hardly do any recreational activities because of neck pain.
- I can't do any recreational activities at all.

#### NECK PAIN SCALE

Rate the severity of your Neck Pain by indicating on the following scale.

Absence I-----I Extreme

## LOW BACK PAIN AND DISABILITY INDEX (REVISED OSWESTRY)

Patient Name: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

### Please read instructions carefully.

This questionnaire has been designed to give the doctor information as to how your low back pain has affected your ability to manage everyday life. Please read all statements in each section and mark the box which most closely describes your problem.

#### SECTION 1 - PAIN INTENSITY

- The pain comes and goes and is very mild.
- The pain is mild and does not vary much.
- The pain comes and goes and is moderate.
- The pain is moderate and does not vary much.
- The pain comes and goes and is very severe.
- The pain is severe and does not vary much.

#### SECTION 2 - PERSONAL CARE

- I do not have to change my way of washing or dressing to avoid pain.
- I do not normally change my way of washing or dressing even though it causes some pain.
- Washing and dressing increases the pain but I manage not to change my way of doing it.
- Washing and dressing increases the pain and I find it necessary to change my way of doing it.
- Because of the pain, I am unable to do some washing and dressing without help.
- Because of the pain, I am unable to do any washing or dressing without help.

#### SECTION 3 - LIFTING

- I can lift heavy objects without any extra pain.
- I can lift heavy objects, but it gives extra pain.
- Pain prevents me from lifting heavy objects off the floor.
- Pain prevents me from lifting heavy objects off the floor but I can manage if they are conveniently positioned on a table.
- Pain prevents me from lifting heavy objects but I can manage light to medium objects.
- I can only lift very light objects at the most.

#### SECTION 4 - WALKING

- I have no pain on walking.
- I have some pain but it does not increase with distance.
- I cannot walk more than one mile without increasing pain.
- I cannot walk more than 1/2 mile without increasing pain.
- I cannot walk more than 1/4 mile without increasing pain.
- I cannot walk at all without increasing pain.

#### SECTION 5 - SITTING

- I can sit in any chair as long as I like.
- I can only sit in my favorite chair as long as I like.
- Pain prevents me from sitting more than one hour.
- Pain prevents me from sitting more than half an hour.
- Pain prevents me from sitting more than 10 minutes.
- I avoid sitting because it increases pain.

#### SECTION 6 - STANDING

- I can stand as long as I want without pain.
- I have some pain on standing but it does not increase with time.
- I cannot stand for longer than one hour without increasing pain.
- I cannot stand for longer than 1/2 hour without increasing pain.
- I cannot stand longer than 10 minutes without increasing pain.
- I avoid standing because it increases the pain.

#### SECTION 7 - SLEEPING

- I get no pain in bed.
- I get pain in bed but it does not prevent me from sleeping well.
- Pain reduces my normal sleep by 1/4 each night.
- Pain reduces my normal sleep by 1/2 each night.
- Pain reduces my normal sleep by 3/4 each night.
- Pain prevents me from sleeping at all.

#### SECTION 8 - SOCIAL LIFE

- My social life is normal and gives me no pain.
- My social life is normal but increases the degree of pain.
- My social life is unaffected by pain apart from limiting more energetic interests.
- Pain has restricted my social life and I do not go out very often.
- Pain has restricted my social life to my home.
- I have hardly any social life because of the pain.

#### SECTION 9 - DRIVING / RIDING IN CAR, ETC.

- I get no pain while traveling.
- I get some pain while traveling but none of my usual forms of travel make it any worse.
- I get extra pain while traveling but it does not compel me to seek alternate forms of travel.
- I get extra pain while traveling which compels me to seek alternate forms of travel.
- Pain restricts all forms of travel.
- Pain prevents all forms of travel except that done lying down.

#### SECTION 10 - CHANGING DEGREE OF PAIN

- My pain is rapidly getting better.
- My pain fluctuates but overall is definitely getting better.
- My pain seems to be getting better but improvement is slow at present.
- My pain is neither getting better or worse.
- My pain is gradually worsening.
- My pain is rapidly worsening.

### LOW BACK PAIN SCALE

Rate the severity of your **Low Back Pain** by indicating on the following scale.

**Absence** I-----I **Extreme**

**QUADRUPLE VISUAL ANALOGUE SCALE**

Patient Name \_\_\_\_\_

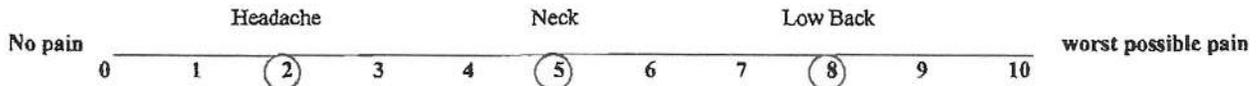
Date \_\_\_\_\_

**Please read carefully:**

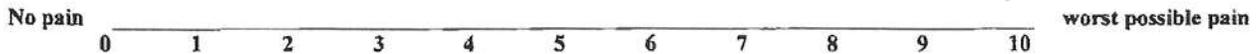
**Instructions:** Please circle the number that best describes the question being asked.

**Note:** If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

**Example:**



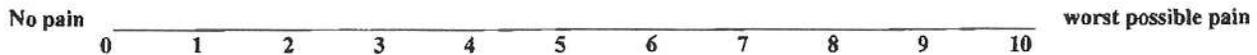
**1 – What is your pain RIGHT NOW?**



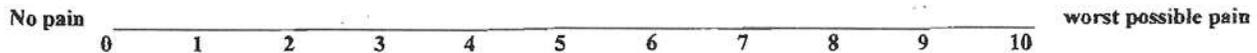
**2 – What is your TYPICAL or AVERAGE pain?**



**3 – What is your pain level AT ITS BEST (How close to “0” does your pain get at its best)?**



**4 – What is your pain level AT ITS WORST (How close to “10” does your pain get at its worst)?**



**OTHER COMMENTS:**

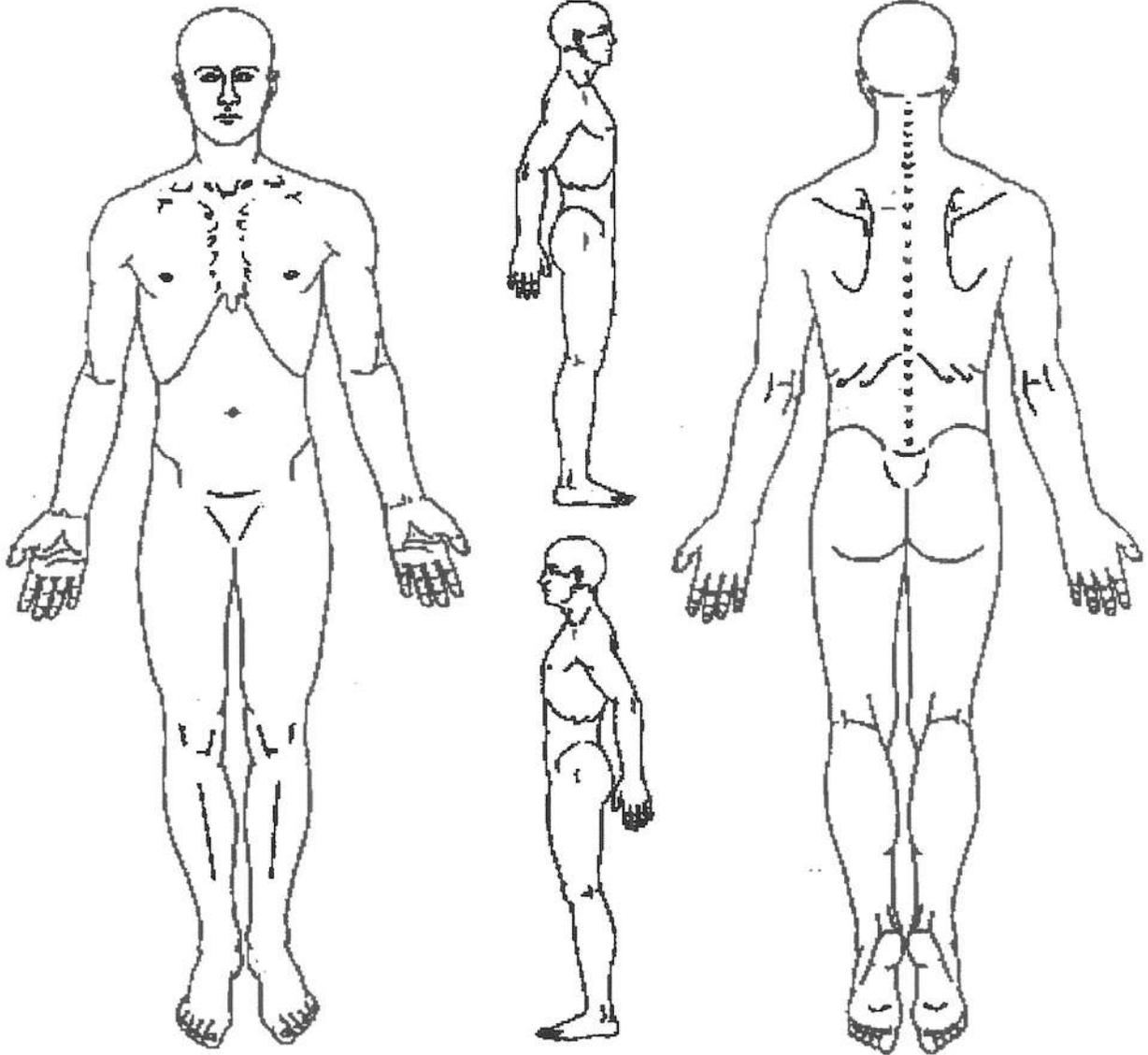
\_\_\_\_\_  
\_\_\_\_\_

## THE REVISED OSWESTRY PAIN QUESTIONNAIRE

NAME \_\_\_\_\_ DATE \_\_\_\_\_

How long have you had back pain \_\_\_\_\_ years \_\_\_\_\_ months \_\_\_\_\_ weeks

On the diagram below, please indicate where you are experiencing pain, right now. Please complete both sides of this form.



A = ACHE

B = BURNING

N = NUMBNESS

P = PINS & NEEDLES S = STABBING

O = OTHER

## Patient Provider Contract and Promissory Note

Entered this day between **HealthQuest Chiropractic and Spine Pain Solutions** (herein after "provider") and \_\_\_\_\_ (Herein after "patient"). Provider hereby agrees to establish an active account for Patient and to provide essential chiropractic services for the purpose of benefitting and improving Patient's current health condition. Patient herein agrees to pay Provider in full for services performed. Patient and Provider acknowledge that Patient retains any and all rights to suit to procure payment for any benefit Patient may be entitled. It is further acknowledged by both parties that this document does not create an express or implied assignment of benefits from any liability carrier, patient representative or from Patient or Provider.

In consideration of and for Provider rendering essential chiropractic and/or medical services to Patient and for the temporary suspension of any collection activity by Provider, by the maintenance of an active account while not receiving payment at the point of service, Patient hereby authorizes and directs the following actions on Patient's behalf:

- PATIENT AUTHORIZATIONS TO LIABILITY INSURANCE CARRIER:** In consideration of the services to be rendered to Patient by Provider, that Patient and Provider are in privity of contract and in lieu of Provider sending direct billing to liability insurance carrier, Patient authorizes and directs liability insurance company to disclose the settlement status of Patient's claim to Provider upon request, including settlement amounts thereof. After such time that Patient has settled the claim with the liability carrier, in consideration that the Provider has not demanded payment at the point of service, Patient directs the liability carrier to include the name of Provider on any check to Patient after such settlement. In the event payment is made to Patient's attorney after settlement of the claim, Patient further authorizes and directs liability company to issue a separate check to Provider for the full amount owed for Provider's services rendered to fully satisfy Patient's obligation to Provider.
- PATIENT AUTHORIZATION TO ATTORNEY, IF REPRESENTED:** If Patient retains an attorney, Patient and Provider stipulates that representation by Patient's named attorney shall be a material element to this Agreement, and furthermore in the event Patient terminates the service of named attorney prior to settlement, judgement or verdict in the Patient's claim, Provider shall have the option to terminate this agreement and immediately collect from patient the full amount owed to Provider. Patient directs attorney to disclose to Provider upon request the settlement status and amount of Patient's claim to include amount of all outstanding medical bills, dollar amount of any offers and counter offers as well as date and reason of termination or dismissal, Patient's last address, telephone number(s) and place of employment known. Patient further directs attorney to honor this agreement and to deduct medical expenses from total settlement prior to contingency fee being deducted and to pay Provider for services rendered after any settlement, judgement or verdict rendered in Patient's claim. Patient acknowledges and agrees to remain personally liable to Provider for any unpaid balance to Provider. This agreement survives this attorney client relationship and all others that may follow in reference to this claim.
- BINDING ARBITRATION:** In the event liability insurance carrier or Patient's attorney do not honor this agreement, both parties agree to submit to binding arbitration prior to issuance with any funds after settlement is reached. Both parties shall be entitled to legal representation at such hearing, with Patient's attorney the likely representation for Patient.
- PROMISSORY NOTE:** For the consideration stated above, Patient promises to pay Provider the balance in full for services rendered to Patient for treatment of injuries sustained by Patient and treated by Provider. Payment shall be due and payable within 180 days of last date of service or within 3 (three) days of settlement with liability carrier for aforementioned claim, whichever occurs first, provided agreement has not been terminated by a party prior to these events, in which case the account balance in full will be due 3 (three) days after termination. Further, Patient agrees to the following:

**IN THE EVENT PATIENT'S ACCOUNT IS NOT PAID IN FULL WITHIN 180 DAYS OF THE LAST DATE OF SERVICE OR WITHIN 3 (THREE) DAYS OF SETTLEMENT WITH LIABILITY CARRIER, PATIENT'S ACCOUNT SHALL BECOME DELINQUENT AND WILL BE SUBJECT TO COLLECTION EFFORTS WHICH MAY INVOLVE LEGAL ACTION. FUTUREMORE, PATIENT AGREES TO PAY ALL COURT COSTS AND ATTORNEY FEES SHOULD COLLECTION ACTION BE UNDERTAKEN BY PROVIDER.**

Either party may terminate this agreement at any time, provided Patient's account remains in active status. It is expressly agreed that in the event Patient terminates this agreement, Patient shall pay the full balance of Patient's account within 3 (three) days of termination or the account shall be in default. Patient and Provider acknowledge that this document contains the full final and entire agreement between both parties. There are no other terms to this agreement. In the event any portion of this agreement is rendered null and void, it is expressly agreed by the parties that all remaining provisions shall remain in full force.

I (Patient) have read and fully understand the term of this agreement \_\_\_\_\_

Signature of Patient (or Guardian if a minor)

\_\_\_\_\_  
Date of Agreement

\_\_\_\_\_  
Provider Signature



NOTICE OF DOCTOR'S LIEN

Patient's name: \_\_\_\_\_ Date of Incident: \_\_\_\_\_

Attorney's name: \_\_\_\_\_ Phone # \_\_\_\_\_

I do hereby authorize the staff of HEALTHQUEST CHIROPRACTIC & SPINE PAIN SOLUTIONS to furnish my attorney named above with all my records pertaining to the accident in which I was involved.

I hereby authorize and direct my attorney to pay directly to HEALTHQUEST CHIROPRACTIC & SPINE PAIN SOLUTIONS such sums as may be due and owed for medical services rendered to me both by reason of this accident and by reason of any other bills that are to due HEALTHQUEST CHIROPRACTIC & SPINE PAIN SOLUTIONS and to withhold such sums from any settlement, judgement or verdict as may be necessary to adequately protect said doctor(s). I hereby further give a lien on my case to HEALTHQUEST CHIROPRACTIC & SPINE PAIN SOLUTIONS against any and all proceeds of any settlement, judgement or verdict which may be paid to my attorney or myself as the result of the injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am completely responsible to HEALTHQUEST CHIROPRACTIC & SPINE PAIN SOLUTIONS for all medical bills submitted by them for services rendered to me and that this agreement is made solely for HEALTHQUEST CHIROPRACTIC & SPINE PAIN SOLUTIONS additional protection. I further understand that such payment is not contingent on any settlement, judgement or verdict by which I may eventually recover.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Doctor's signature

\_\_\_\_\_  
Patient's Printed Name

The undersigned attorney does hereby agree:

- To observe all the terms of the above authorization and assignment
- To withhold and pay any such sums from any settlement, judgement or verdict as may be necessary to adequately protect HEALTHQUEST CHIROPRACTIC & SPINE PAIN SOLUTIONS
- To notify any attorney who may assume representation of the patient named above

\_\_\_\_\_  
Date

\_\_\_\_\_  
Attorney's Signature

Treatment · Healing · Prevention

# HEALTHQUEST CHIROPRACTIC & SPINE PAIN SOLUTIONS

## PATIENT AUTHORIZATION

We are requesting this authorization of you due to various interpretations under federal law with respect to what is known as "incidental disclosures" of protected health information (PHI). It is our view that the kinds of matters related in an open environment are incidental matters, in the event that you or someone else would not agree, HealthQuest is providing this disclosure.

**PATIENT NAME:** \_\_\_\_\_

The person identified above authorizes **HealthQuest Chiropractic Center** to use and/or disclose protected health information (PHI) in accordance with the following:

- Permission to use my address, phone number and clinical records to contact me with appointment reminders, missed appointment notification, email newsletters, related cards (welcome, thank you, sympathy etc) or other health related information and to leave a message on an answering device.
- Permission to adjust me in a semi-open room near where other members are also being treated. I am aware that other members in the office may overhear some of my personal healthcare information. Should I need to speak with the doctor at any time in private, the doctor will provide a room for these communications.
- Acknowledge that **HealthQuest Chiropractic Center** utilizes a "sign in sheet" where my name can be seen by other members in the office.
- Use of your patient file by multiple **HealthQuest** staff members for the purpose of your treatment, filing of insurance, etc. and that your file may be placed on counters, wall slots and adjustment rooms where it may be seen in "incidental" contact with other people.
- Keeping of your credit card information on file (if you have requested this) and authorization to charge your card according to the terms agreed upon and applicable under the financial systems and policies in operation at HealthQuest Chiropractic Center.
- Awareness of all employees of HealthQuest including staff, interns, bookkeepers, accountants, coaches, consultants, cleaning crews or other temporary hired help being present at various times and having legal or illegal access to office property, including records (all required and appropriate protective measures are being utilized by HealthQuest).

Use of this is intended to make your experience with our office more efficient and productive. If you choose not to authorize this information, your decision will have no adverse effects on your care at HealthQuest Chiropractic Center or on your relationship with our staff.

**Your signature indicates your authorization of all the activity outlined herein this packet.**

**Patient:** \_\_\_\_\_ **DATE** \_\_\_\_\_  
(signed)

**HealthQuest Representative** \_\_\_\_\_ / \_\_\_\_\_  
(print) (signed)

This authorization may be revoked at any time. Revocation may be accomplished at any time by advising us (Dr. Christopher A. Rechter, privacy and security officer) in writing of your desire to withdraw your authorization. Please allow a reasonable processing time for the change in our system to be completed and be aware that revocation is not possible in situations where actions have already been taken relying on this authorization.

A copy of this authorization has been provided to you. A signed copy will be kept on file and serve as acknowledgement of your authorization.

# HEALTHQUEST CHIROPRACTIC & SPINE PAIN SOLUTIONS

## PRIVACY NOTICE

**THIS NOTICE DESCRIBES HOW CHIROPRACTIC AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

In the course of your care as a patient at **HealthQuest Chiropractic Center**, all/any of its staff may use or disclose personal and health related information about you in the following ways:

- Your personal health information, including your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.
- Your personal health information, including your clinical records, may be disclosed to all of the doctors, interns, staff at HealthQuest.
- Your health care records as well as your billing records may be disclosed to another party, such as an insurance carrier, an HMO, a PPO, or your employer, if they are or may be responsible for the payment of your services.
- Your name, address, email, phone/fax number, and your health care records may be used to contact you regarding appointment reminders, missed appointments, information about alternatives to your present care, any correspondences from the office, or other health-related information that may be of interest to you.

You are by law, hereby granted certain rights as follows:

- the right to amend your protected health information by notifying us, and we are to comply with this within 60 days
- the right to access, inspect, and copy your protected health information (inquire about exceptions)
- the right to request restrictions on certain uses and disclosures for treatment, payment, or health care operations to which we are not required to agree.
- the right to confidential communication by alternative means or location (bearing in mind our open floor plan & atmosphere for which you consent authorization)

Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in these following circumstances:

- If we are providing health care services to you based on the orders of another health care provider.
- If we provide health care services to you in an emergency.
- If we are required by law to provide care to you and we are unable to obtain consent after attempting to do so.
- If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.
- If we are ordered by the courts.

Any use or disclosure of your protected health information, other than as outlined above, will only be made upon your written-authorization.

This notice shall serve as valid from the time you first begin care and continue for anytime thereafter. You may revoke authorization at any time by submitting request in writing to **Dr. Christopher A. Rechter at 1000 Johnson Ferry Road, Suite D100, Marietta, GA 30068**. Revocation is not possible in situations where actions have been taken relying on this authorization.

For more information or to file a complaint, contact our security and privacy officer, Dr. Christopher A. Rechter, to whom you have the right to discuss your privacy and security questions or concerns, at 770-509-3400.

You also have the right to lodge a complaint with the Department of Health and Human Services through the Office of the Patient Advocate.

A copy of this notice is/has been promptly provided to you and this signed notice will be kept as part of your file and will serve for us as an "acknowledgment of (your) receipt of a privacy notice".

# INFORMED CONSENT TO CHIROPRACTIC TREATMENT

**The Nature of Chiropractic Treatment:** The doctor will use his hands or a mechanical device to move your joints. You may or may not feel a “click” or “pop”, such as the noise when a knuckle is “cracked”, and you may or may not feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, or trigger point myotherapy may also be used.

**Possible Risks:** As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or minor complications.

**Probability of risks occurring:** The risks of complications due to chiropractic treatment have been described as “rare”, about as often as complications are seen from the taking of a single aspirin tablet. The probability of adverse reaction due to ancillary procedures is also considered “rare”.

**Other Treatment Options which could be considered** may include the following:

- *Over-the-counter analgesics.* The risks of these medications include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases.
- *Medical care,* typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.
- *Hospitalization* in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.
- *Surgery* in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

**Risks of Remaining Untreated:** Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

**Unusual Risks:** I have had the following unusual risks of my case explained to me.

I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and hereby give my full consent to treatment.

**I have read and fully understand the above statements and accept chiropractic care on this basis.**

Printed Name

Signature

Date

## TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be able to attain it. This will prevent any confusion or disappointment.

**Adjustment:** An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

**Health:** A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

**Vertebral Subluxation:** A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal evaluation, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **OUR ONLY PRACTICE OBJECTIVE** is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, \_\_\_\_\_ have read and fully understand the above statements.  
(Print name)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Date)