PATIENT INTAKE / MVA

Name: _____ (Age) _____ Gender: M F

Home Address: _____ Home Phone: _____

City, State, Zip: _____ Work Phone:_____

Email Address: _____ Cell Phone: _____

Birth Date: _____ / _____ / _____ Social Security #: _____ - _____ - _____ Marital Status: S M D W

Names of Children: _____ Ages: _____

Occupation: _____ Employer Name: _____

Spouse's Name: _____ Work Phone: ( ) _____ Cell Phone: ( ) _____

Spouse's Employer: _____ Occupation: _____

How were you referred to this office? _____

RESPONSIBLE PARTY INFORMATION AND AUTHORIZATION

Your Auto Insurance Company _____ Phone # _____

Claim Number: _____ Adjuster's Name: _____

Name of Insured Person: _____ Phone # _____ Relationship _____

Other Party's Involved Auto Insurance Company Name _____ Phone # _____

Claim Number __ _____ Adjuster's Name _____

Name of Insured Person _____ Phone # _____ Relationship _____

Attorney's Name (if applicable) _____ Phone # _____

Name of Your Health Insurance Co. _____

Policy# _____ Group # _____

I clearly understand that all insurance coverage, whether accident, work-related, or general coverage is an arrangement between my insurance carrier and myself. Graceland Chiropractic and Worthington Physical Therapy and Rehab may perform a general verification of benefits. This verification is not a guarantee of coverage, and I accept that I am ultimately responsible for knowing my insurance coverage.

I understand if this office chooses to bill any services to my insurance carrier that they are performing these services strictly as a convenience to me. The doctor's office will provide any necessary reports or required information to aid in insurance reimbursement of services, but I understand that my insurance carriers may deny my claims and that I am ultimately responsible for any unpaid balances. Any monies received from the insurance will be credited to my account. If the insurance company would submit payment to myself instead of Graceland Chiropractic or Worthington Physical Therapy and Rehab, I agree to forward those payments to the office.

Signature of Patient/or Guardian of said minor: _____ Date: _____

ACCIDENT INFORMATION

Is this visit related to an auto accident? □ Yes □ No If yes, when was the date of the injury _____

Please describe the accident in detail (continue on back of this page if needed): _____

_____

_____

_____

_____

_____

PLEASE ANSWER THE FOLLOWING QUESTIONS ABOUT THE ACCIDENT

Were you driving? □ Yes □ No Was it your car? □ Yes □ No If not, whose? _____

Were you the passenger? □ Yes □ No If yes, where were you seated in the car? □ Front □ Back □ Right Side □ Left Side

Were you alone at the time of the accident? □ Yes □ No If no, who else was in the car? _____

If others were in the car, were they injured? □ Yes □ No □ N/A Please explain: _____

What type of vehicle were you in? Make: _____ Year: _____

What damage was done to the car you were in? Inside: _____ Outside: _____

Other Damage: _____

What condition was your vehicle in prior to the accident? _____

What type of vehicle was the other involved in the accident? □ Car □ Truck □ SUV □ Motorcycle □ Other: _____

What damage was done to the other vehicle? Inside: _____ Outside: _____

Other Damage: _____

Do you have pictures of the involved vehicle? □ Yes □ No

At the time of the accident was it? □ Day □ Night □ Dusk □ Dawn What were the weather conditions? _____

How long had you been in the car? _____ What were the traffic conditions? _____

Where did the accident happen at? □ Stop Sign □ Traffic Light □ Intersection □ Highway □ Other _____

On what type of road did the accident occur? □ 2 Lane □ 4 Lane □ Gravel □ Other _____

Did your vehicle go off the road? □ Yes □ No If yes, explain: _____

Were you moving at the time of the accident? □ Yes □ No What was your speed? _____ What was the speed limit? _____

Was the involved party moving when the accident occurred? □ Yes □ No What was their speed? _____

Was your vehicle hit? □ Yes □ No Where? □ Front □ Back □ R Side □ L Side □ R Front □ L Front □ R Back □ L Back

Did your vehicle strike anything? □ Yes □ No If yes, what? □ Vehicle □ Sign □ Tree □ Guardrail □ Median □ Other_____

If you struck another vehicle, where did you hit them at? □ Front □ Back □ Right Side □ Left Side

Did you have your seatbelt on at the time of the accident? □ Yes □ No Shoulder harness on? □ Yes □ No

Was your seat reclined at the time of the accident? □ Yes □ No What was the position of the headrest? _____

Was your head turned at the time of the accident □ Yes □ No If Yes, what direction were you looking? _____

Did you hit part of your body during the collision? (Example: Head on Dash, Chest on Steering Wheel, Arm on Console, etc.)? □ Yes □ No

If yes, please list them all: _____

_____

_____

How did you feel after the collision? □ Stunned □ Disoriented □ Frightened □ Tightness □ Felt Mild Discomfort □ Felt Moderate Discomfort □ Felt Severe Discomfort □ Felt Intense Pain □ Felt a Popping and Ripping Sensation □ Other _____

Were you completely conscious after the impact? □ Yes □ No Do you remember the impact? □ Yes □ No

Was an accident report made? □ Yes □ No With whom? Police of City _____ County _____ State _____

Who was cited for the accident? _____ For What? _____

Where did you go after the accident? _____

Were you hospitalized due to the accident? □ Yes □ No If yes, how long? _____ Hospital Name _____

Have you had any time loss from work? □ Yes □ No If yes, from _____ to _____

Have you ever had to have any outside help? □ Yes □ No If yes, what type? _____

My signature below indicates the above information is accurate and has been completed to the best of my knowledge.

Signature of Patient/or Guardian of said minor: _____ Date: _____

HEALTH LIFESTYLE

Do you exercise? □ Yes □ No How often? 1X 2X 3X 4X 5X 6X 7X per week Other:_____

What activities? □ Running/Jogging □ Weight Training □ Cycling □ Yoga □ Pilates □ Swimming □ Other _____

Do you smoke? □ Yes □ No How much? _____

Do you drink alcohol? □ Yes □ No How much/week? _____

Do you drink coffee? □ Yes □ No How many cups / day? _____

Do you take any supplements (i.e. vitamins, minerals, herbs)? □ Yes □ No Please list: _____

_____

Please list any medications you are currently taking _____

_____

Please list any health conditions not mentioned: _____

Please list any significant family history:_____

_____

Please list any surgeries: _____

Have you been tested HIV positive □ Yes □ No

PAST EXPERIENCE WITH CHIROPRACTIC OR PHYSICAL THERAPY

Have you seen a Chiropractor / Physical Therapist before? □ Yes □ No Who? _____ When? _____

Reason for visits: _____

How did you respond to care? _____

Did your previous Chiropractor take before and after x-rays? □ Yes □ No

Did you know posture determines your health? □ Yes □ No

Are you aware of any of your poor posture habits? □ Yes □ No

Explain:_____

Are you aware of any poor posture habits in your spouse or children? □ Yes □ No

Explain: _____

The most common postural weakness is **Forward Head Syndrome** (head and neck starting to bend forward and progressively moving downward weakening your whole body). Even less severe forms of this posture can cause many adverse affects on your overall health. Have you ever been told or felt like you carry your head forward, noticed a rounding of your shoulders or a developing "hump" at the base of your neck? □ Yes □ No

EMERGENCY CONTACT

In case of an emergency, who should we contact?

Name _____ Work Phone _____

Relationship _____ Home Phone _____

Cell Phone _____ Other _____

Patient's / Guardian's Signature_____ Date _____

RADIOGRAPH CONSENT

Our consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze your condition. By signing below, you give your consent to allow Graceland Chiropractic and/or Worthington Physical Therapy and Rehab and its representatives, as deemed by the examining physician to take radiographs of your spine and/or extremities.

I also hereby declare that to my knowledge that I am not pregnant _____ (Initial)

Signature of Patient/or Guardian of said Minor _____ Date _____

AUTHORIZATION OF CARE

I authorize and agree to allow the Doctor and/or physical therapist to work with my spine through the use spinal adjustments and rehabilitative exercises for the sole purpose of postural and structural restoration of normal biomechanical and neurological function.

The Doctor and/or physical therapist will not be held responsible for any health conditions or diagnoses which are pre-existing, given by another health care practitioner, or are not related to the spinal structural conditions diagnosed at this clinic. This clinic will attempt to identify and diagnose any ailments you may have that may be corrected through chiropractic care, physical therapy, massage therapy, and/or active/passive rehabilitation. If any condition or disease appears to be present out of our scope of practice, we will refer you to an appropriate physician to diagnose and/or treat that condition. The procedures performed in this clinic are usually beneficial and rarely cause any problem. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible for injury. The doctor or physical therapist, of course, will not provide specific treatment if he/she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known these things (deformities, illnesses, etc.) which otherwise might not come to the attention of the provider.

I also clearly understand that if I do not follow the Doctors' and/or physical therapist's specific recommendations at this clinic that I will not receive the full benefit from these programs, and that if I terminate my care prematurely that all fees incurred will be due and payable at that time. I authorize the assignment of all insurance benefits be directed to the Doctor and/or physical therapist for all services rendered.

I understand that I am financially responsible for all fees incurred for the services provided, regardless of any applicable insurance or benefit payments, and I agree to ensure full payment. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

NAME OF GUARANTOR (person responsible for guaranteeing payment for all services) _____

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

_____	_____	_____	_____
Patient's Name Printed	Date	**Patient's signature**	Date

I hereby authorize Graceland Chiropractic and Worthington Physical Therapy and Rehab to administer care as deemed necessary to my child, a minor under the age of 18 years old.

_____	_____	_____
Minor's Name	**Guardian's Signature of Authorizing care for minor**	Date

NOTICE OF PRIVACY PRACTICES – ACKNOWLEDGEMENT & CONSENT

USE AND DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION

Your Protected Health Information will be used by Graceland Chiropractic and Worthington Physical Therapy and Rehab or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

NOTICE OF PRIVACY PRACTICES

I give permission to Graceland Chiropractic and Worthington Physical Therapy and Rehab to use my name, address, phone numbers and clinical records to contact me with birthday cards, holiday related cards, health related e-mails messages and information about treatment alternatives or other health related information as well as any advertisements, newsletters or patient of the week/month postings.

I give permission to Graceland Chiropractic and Worthington Physical Therapy and Rehab to treat me in an open room where other patients are also being treated. I am aware that other persons in the office may overhear some of my protective health information (PHI) during the course of my treatment. Should I need to speak with a Doctor or Physical Therapist in private, the Doctor or Therapist will provide a private room for these conversations.

You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. You may review the Notice prior to signing this consent. You may request a copy of the Notice at the Front Desk.

REQUESTING A RESTRICTION

-You may request a restriction on the use or disclosure of your Protected Health Information
- This office may or may not agree to restrict the use or disclosure of your Protected Health Information
- If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected health information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

REVOCATION OF CONSENT

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

By my signature below, I give Graceland Chiropractic and Worthington Physical Therapy and Rehab permission to use and disclose my protected health information in accordance with the directives listed above.

_____ _____

Patient or Legally Authorized Individual Signature DATE

_____ _____

Patient's Full Name (Printed) TIME

_____ _____

Witness Signature DATE