CHIROPRACTIC INTAKE & HISTORY

Name _____ Date _____

PATIENT INFORMATION

Patient Name _____
LAST NAME

_____
FIRST NAME MIDDLE INITIAL

Address _____

City _____ State & Zip _____

Home Phone _____

Cell Phone _____

Email _____

Sex ☐ M ☐ F Age ___ Birthday _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered

Who may we thank for referring you? _____

Employer / School _____

Occupation _____

Spouse's/Partner's Name _____

Spouse's/Partner's Employer/Occupation _____

IN CASE OF EMERGENCY, CONTACT

Name _____

Relationship _____

Contact Number _____

HOW CAN WE HELP YOU?

What brings you in today? _____

_____

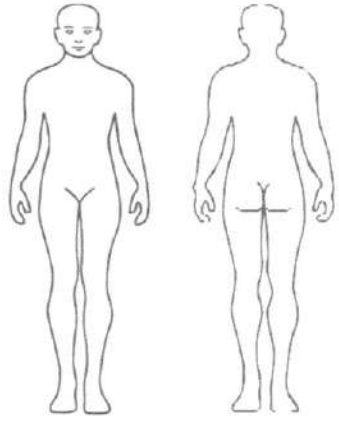
If you are already experiencing a symptom, what is it? _____

How bad is it? How intense are your symptoms? (circle)

0 1 2 3 4 5 6 7 8 9 10

NO SYMPTOMS — INTENSE SYMPTOMS

Please circle areas to the right where you have pain or other symptoms:



What does it feel like? (check where appropriate)

☐ Numbness ☐ Sharp

☐ Tingling ☐ Shooting

☐ Stiffness ☐ Burning

☐ Dull ☐ Throbbing

☐ Aching ☐ Stabbing

☐ Cramping ☐ Swelling

☐ Nagging ☐ Other _____

IMPACT OF YOUR SYMPTOMS

How is this symptom / condition interfering with your life? (check where appropriate)

	No Effect	Mild Effect	Moderate Effect	Severe Effect		No Effect	Mild Effect	Moderate Effect	Severe Effect
Work	☐	☐	☐	☐	Energy	☐	☐	☐	☐
Exercise	☐	☐	☐	☐	Attitude	☐	☐	☐	☐
Recreation	☐	☐	☐	☐	Patience	☐	☐	☐	☐
Relationships	☐	☐	☐	☐	Productivity	☐	☐	☐	☐
Sleep	☐	☐	☐	☐	Creativity	☐	☐	☐	☐
Self-Care	☐	☐	☐	☐	Other _____	☐	☐	☐	☐

How committed are you to correcting this issue?

0 1 2 3 4 5 6 7 8 9 10

NOT COMMITED — VERY COMMITED

PATIENT WELLNESS ASSESSMENT

ILLNESS-WELLNESS CONTINUUM

DISEASE	POOR HEALTH	NEUTRAL	GOOD HEALTH	OPTIMAL HEALTH
Multiple medications Poor quality of life Potential becomes limited Body has limited function	Symptoms Drug therapy Surgery Losing normal function	No symptoms Nutrition inconsistent Exercise sporadic Health not a high priority	Regular exercise Good nutrition Wellness education Minimal nerve interference	100% function Continuous development Active participation Wellness lifestyle

On the arrow diagram above:

A. What number do you think represents your health today? _____

B. In what direction is your health currently headed? _____

What are your health goals?

IMMEDIATE _____

SHORT TERM _____

LONGTERM _____

CHILDREN & PREGNANCY

How many children do you have? _____

Childrens' ages? _____

Childrens' health concerns? _____

Are you currently pregnant? ☐ No ☐ Yes, I am due _____

Number of past pregnancies? _____

Health concerns regarding this pregnancy? _____

HEALTH & ILLNESS HISTORY

Please check the box beside any condition that you have or have had.

- ☐ AIDS/HIV
- ☐ Alcoholism
- ☐ Anxiety
- ☐ Arteriosclerosis
- ☐ Arthritis
- ☐ Asthma/Allergies
- ☐ Back Pain
- ☐ Cardiovascular Issues
- ☐ Cancer
- ☐ Circulation Issues
- ☐ Childhood Illness
- ☐ Depression
- ☐ Diabetes
- ☐ Digestive Issues (Constipation/Diarrhea/GERD/IBS)
- ☐ Elbow/Wrist/Hand Issues
- ☐ Endocrine Issues (Thyroid)
- ☐ Foot/Ankle Issues
- ☐ Gout
- ☐ Headaches / Migraines
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hip Issues
- ☐ Immune Issues
- ☐ Lymphatic Issues
- ☐ Multiple Sclerosis
- ☐ Neck Pain
- ☐ Reproductive Issues
- ☐ Ringing in Ears
- ☐ Scoliosis
- ☐ Shoulder Issues
- ☐ Stroke
- ☐ TMJ Issues
- ☐ Urinary Issues
- ☐ Osteoporosis
- ☐ Other _____

ALLERGIES, MEDICATIONS & SUPPLEMENTS

ALLERGIES (list)	MEDICATIONS (list)	SUPPLEMENTS (list)

South Shore Family Chiropractic
33 Sea Street, Weymouth, MA 02191
Office: (781) 335-7671

Dr. William M. Byrnes: Director
Dr. Amy Hall-Newman
www.ssfamily.com email: info@ssfamily.com

Informed Consent to Chiropractic Treatment

The Nature of Chiropractic Treatment: The doctor will use his/her hands to perform an adjustment in order to realign your vertebrate. You may feel a "click" or "pop", such as the noise when a knuckle is "cracked", and you may also feel movement of the joint.
Possible Risks: As with any health care procedure, complications are possible following a chiropractic adjustment. A minority of patients may notice muscle stiffness or soreness after the first few days of adjustments similar to after a new workout. Rare complications, while extremely unlikely, can include fracture, ligamentous sprain, or injury to intervertebral discs. These complications are only seen with an inherent weakness in the body already present and our exam process is designed to pick up these red flags.
Probability of Risks Occurring: The risks of complications due to chiropractic treatment have been described as very rare, about as often as complications are seen from taking a single aspirin tablet.
Other Treatment Options: No other profession is trained to find and correct your subluxations.
Risks of Remaining Untreated: Delay of treatment allows degenerative changes to continue, and these changes can further reduce skeletal mobility and increase nerve irritation. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.
No Warranty: I understand that my doctor at South Shore Family Chiropractic cannot make any promises or guarantees regarding improvement in my condition. I understand that my doctor will share with me his/her opinion regarding potential results from chiropractic care and will discuss treatment options with me. I have read the explanation above of chiropractic care. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of chiropractic care. I have freely decided to undergo the recommended care plan, and hereby give my full consent to receive chiropractic care.

Printed Name _____ Signature _____ Date _____

Consent to Treat Minor – For use when applicable I hereby authorize South Shore Family Chiropractic Doctors of Chiropractic, to administer chiropractic care, as deemed necessary, to my child.

Printed Name _____ Signature _____ Date _____

Privacy Policy Acknowledgement/Assignment and Release

Patient Acknowledgement:

I acknowledge that I have read/received a copy of South Shore Family Chiropractic's Notice of Privacy Practices in accordance with federal regulations dictated by the Health Insurance Portability and Accountability Act (HIPA).

Printed Name/For Minors: Parent Guardian _____ Signature _____ Date _____

Assignment and Release: *I hereby authorize and direct my insurance benefits to be paid directly to South Shore Family Chiropractic and understand I am financially responsible for all non-covered services provided by South Shore Family Chiropractic.*

Printed Name/For Minors: Parent Guardian _____ Signature _____ Date _____

GUARANTOR NAME & ADDRESS - Person to Bill if Other Than Patient

Terms of Acceptance

When a patient seeks Chiropractic care and when a Chiropractor accepts a patient for such care, it is essential that they both be seeking the same goals.

It is not the goal of this office to treat, nor cure physical, mental, or emotional ailments; nor to diagnose or give advice about such ailments.

Our only goal and intention is to keep the body as free from vertebral subluxations as we can. We do this because of our absolute conviction that every human being functions better on all levels when no subluxations are present.

If at any time your care lapses for 6 months or longer and you choose to re-activate, you will be welcomed into our office once again as a new patient following our new patient protocol.

I _____ undertake Chiropractic Care in the office on the understanding of and in agreement with the above explanation.

_____	_____	_____
Print Name/For Minors: Parent/Guardian	Signed	Date

Congratulations on choosing Chiropractic. Follow through with your family and enjoy the health benefits that come with a Chiropractic lifestyle.

HIPPA: Health Insurance Portability & Accountability Act: Notices of Privacy Practices

This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review carefully. 164.528

Introduction: At SSFC, we are committed to creating and using protected health information about you responsibly. This Notice of Health Information Practices describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This notice is effective immediately and applies to all protected health information as defined by federal regulations.

Understanding your Health Record/Information: Each time you visit SSFC, a record of your visit is made. Typically, this record contains symptoms, examination, and test results, treatment and a plan for future care or treatment. This information, often referred to as your health or medical record serves as a basis for planning your care and treatment, means of communication among many health professionals who contribute to your care, legal document describing the care you received, means by when you or a third-party payer can verify that services billed were provided. A tool in educating health professionals and a source of information for public health officials charged with improving the health of the state and the nation. A source of data for our planning and marketing, a tool with which we can assess and continually work to improve the care we render and the outcomes we achieve. Understanding what is in your record and how your health information is used helps you to: ensure its accuracy, better understand who, what, and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

Your Health Information Rights: Although your health record is the physical property of SSFC, the information belongs to you. You have the right to:

- Obtain a paper copy of this notice of information practices upon request
- Inspect a copy of your health record as provided in 45 CFR 164.524
- Amend your health record as provided in 45 CFR 164.524
- Obtain an accounting of disclosures of your health information as provided in 45 CFR 164.524
- Request communications of your health information by alternative means at alternative locations
- Request a restriction on certain uses of your information as provided by 45 CFR 164.524
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken

Our Responsibilities: SSFC is required to:

- Maintain the privacy of your health information
- Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- Abide by the terms of this notice
- Notify you if we are unable to agree to a requested restriction
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will post these changes in our office. We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue using or disclosing your health information after we have received a written revocation of the authorization according to the procedures included in the authorization.

For More Information or to Report a Problem: If you have any questions and would like additional information, you may contact the practice's Privacy Officer, Lori Byrnes at 781-335-7671. If you believe your privacy rights have been violated, you can file a complaint with the practice's Privacy Officer, Lori Byrnes or with the office for Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either the Privacy Officer or the Office of Civil Rights. The online address for the OCR is: https://www.mass.gov/how-to/file-a-civil-rights-complaint

Examples of Disclosures for Treatment, Payment and Health Operations: We will use your health information for treatment. We will use your information for payment. We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information. We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to Worker's Compensation or other similar programs established by law. As required by law, we may disclose your health information to Public Health or legal authorities charged with preventing or controlling disease, injury, or disability. We may disclose health information to Law enforcement purposed as required by law or in a response to a valid subpoena. Federal law makes provisions for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers, or the public.

Personnel Records: It shall be the policy of SSFC to allow the following staff into the Secondary Personnel Records of Employees: Doctor of Chiropractic, Covering Chiropractor, Office Manager, Privacy Manager.

APPLICATION FOR BENEFITS- PERSONAL INJURY PROTECTION

DATE:	POLICY HOLDER:	DATE OF ACCIDENT:	CLAIM NUMBER:

YOUR NAME: | HOME PHONE #: | BUSINESS PHONE #:

YOUR ADDRESS (NO, STREET, CITY OR TOWN, STATE AND ZIP CODE): | DOB: / / | SOCIAL SECURITY #:

DATE & TIME OF ACCIDENT: / / AM PM | PLACE OF ACCIDENT (NO, STREET, CITY OR TOWN, STATE AND ZIP CODE):

BRIEF DESCRIPTION OF ACCIDENT:

AT THE TIME OF THE ACCIDENT:

Were you the driver of our policyholders car?	☐ YES	☐ NO
Were you a passenger in our policyholders car?	☐ YES	☐ NO
Were you a pedestrian?	☐ YES	☐ NO
Were you a member of our policyholders house?	☐ YES	☐ NO

AS A RESULT OF THIS ACCIDENT WERE YOU INJURED? ☐ YES ☐ NO

IF YOUR ANSWER IS YES, COMPLETE THE REST OF THIS FORM, IF NO, SIGN HERE AND RETURN THIS FORM TO US.

SIGNATURE: X _____ **DATE:** _____

DESCRIBE YOUR INJURY:

WERE YOU TREATED BY A DOCTOR? ☐ YES ☐ NO | DOCTOR'S NAME AND ADDRESS:

IF YOU WERE TREATED IN A HOSPITAL, WERE YOU? ☐ IN-PATIENT ☐ OUT-PATIENT | HOSPITALS NAME AND ADDRESS:

AMOUNT OF MEDICAL BILLS TO DATE: $ | WILL YOU HAVE MORE MEDICAL EXPENSE? ☐ YES ☐ NO | AT THE TIME, WERE YOU IN THE COURSE OF YOUR EMPLOYMENT? ☐ YES ☐ NO

DID YOU LOSE WAGES OR SALARY AS A RESULT OF THE INJURY? ☐ YES ☐ NO | IF YES, AMOUNT LOST TO DATE: $ | WHAT IS YOUR AVERAGE WEEKLY WAGE OR SALARY? $

IF YOU LOST TIME: DATE OF DISABILITY FROM WORK BEGAN: / / | DATE YOU RETURNED TO WORK: / /

HAVE YOU RECEIVED, OR ARE YOU ELIGIBLE FOR, PAYMENTS UNDER ANY WAGE OR SALARY CONTINUATION PLAN? ☐ YES ☐ NO | IF YES, AMOUNT: $ ☐ PER WEEK ☐ PER MONTH

HAVE YOU RECEIVED, OR ARE YOU ELIGIBLE FOR ANY PAYMENT UNDER A POLICY OF HEALTH, SICKNESS OR DISABILITY OR CONTRACT AGREEMENT WITH A GROUP, ORGANIZATION PARTNERSHIP OR CORPORATION TO PROVIDE, PAY FOR OR REIMBURSE THE COST OF OR MEDICAL EXPENSES?

☐ YES ☐ NO

IF YES, GIVE NAME, ADDRESS AND SOURCE OF PAYMENT:

LIST NAMES & ADDRESSES OF EMPLOYER OR EMPLOYERS FOR ONE YEAR PRIOR TO ACCIDENT. GIVE OCCUPATION AND DATES OF EMPLOYMENT:

EMPLOYER & ADDRESS: OCCUPATION FROM: TO:

EMPLOYER & ADDRESS: OCCUPATION FROM: TO:

AS A RESULT OF YOUR INJURY, HAVE YOU HAD ANY OTHER EXPENSES? ☐ YES ☐ NO | IF YES, EXPLAIN ON THE REVERSE SIDE.

ADVISORY: WE ARE OBLIGATED TO ADVISE YOU THAT ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT, OR KNOWINGLY PROVIDES FALSE INFORMATION IN AN APPLICATION FOR INSURANCE, IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND/OR CONFINEMENT IN PRISON, DEPENDING ON THE APPLICABLE STATE LAW.

SIGNATURE: X **DATE:**

IMPORTANT:

1. **To be eligible for benefits you must complete and sign this application.**
2. **You must also sign any attached authorization(s).**
3. **Return promptly with any medical bills you have received to date.**

FILE NUMBER: _____

INSURED: _____

DATE OF LOSS: _____

IN ACCORDANCE WITH CHAPTER 273 OF THE ACTS OF 1988, WE ARE NOW REQUIRED TO OBTAIN INFORMATION REGARDING OTHER HEALTH BENEFITS (HMO, MEDICARE, HEALTH INSURANCE, ETC.) AVAILABLE TO YOU BEFORE WE CAN PROCESS YOUR CLAIM FOR PERSONAL INJURY PROTECTION BENEFITS.

IF YOU HAVE OTHER BENEFITS AVAILABLE TO YOU, PLEASE COMPLETE SECTION I AND RETURN THIS FORM. IN ADDITION, IF YOU HAVE BENEFITS AVAILABLE TO YOU THROUGH ANY OTHER POLICY (SPOUSE, PARENT, LEGAL GUARDIAN), PLEASE BE SURE TO COMPLETE SECTION II AS WELL.

IF YOU DO NOT HAVE ANY OTHER BENEFITS AVAILABLE THROUGH YOUR OWN BENEFITS OR THOSE OF A HOUSEHOLD MEMBER, PLEASE SIGN SECTION III AND RETURN THIS FORM.

SECTION I - BENEFITS INFORMATION

YOUR NAME:

HEALTH INSURANCE CO:

POLICY #: _____

POLICYHOLDER (if not your policy):

DEDUCTIBLE AMT:_____AND/OR CO-INSURANCE (percentage paid by you):_____

SIGNATURE_____

DATE:_____

SECTION II - ADDITIONAL BENEFITS INFORMATION

YOUR NAME:

HEALTH INSURANCE CO:

POLICY #: _____

POLICYHOLDER (if not your policy):

DEDUCTIBLE AMT:_____AND/OR CO-INSURANCE (percentage paid by you):_____

SIGNATURE_____

DATE:_____

SECTION III

I CERTIFY THAT I DO NOT HAVE ANY ACCIDENT AND HEALTH BENEFITS AVAILABLE TO ME THROUGH MY OWN POLICY OR THAT OF A HOUSEHOLD MEMBER.

SIGNATURE_____

DATE:_____

CLAIM NUMBER: _____

AUTHORIZATION FOR MEDICAL INFORMATION

THIS AUTHORIZATION OR PHOTOCOPY HEREOF, WILL AUTHORIZE YOU TO FURNISH ALL INFORMATION YOU MAY HAVE REGARDING MY CONDITION WHILE UNDER YOUR OBSERVATION OR TREATMENT, INCLUDING THE HISTORY OBTAINED, X-RAY AND PHYSICAL FINDINGS, DIAGNOSIS AND PROGNOSIS. YOU ARE AUTHORIZED TO PROVIDE THIS INFORMATION IN ACCORDANCE WITH THE MASSACHUSETTS PERSONAL INJURY PROTECTION LAW.

_____ _____

SIGNATURE DATE

CLAIM NUMBER: _____

AUTHORIZATION FOR WAGE AND SALARY INFORMATION

THIS AUTHORIZATION OR PHOTOCOPY THEREOF, WILL AUTHORIZE YOU TO FURNISH ALL INFORMATION YOU MAY BE REGARDING MY WAGES OR SALARY WHILE EMPLOYED BY YOU. YOU ARE AUTHORIZED TO PROVIDE THIS INFORMATION IN ACCORDANCE WITH THE MASSACHUSETTS PERSONAL INJURY PROTECTION LAW.

_____

SOCIAL SECURITY NUMBER

_____ _____

SIGNATURE DATE

CLAIM NUMBER: _____

AUTHORIZATION FOR RELEASE OF COVERAGE INFORMATION BY EMPLOYER OR OTHER MEDICAL EXPENSE PROVIDER

THIS AUTHORIZATION OR PHOTOCOPY HEREOF, WILL AUTHORIZE YOU TO FURNISH ALL INFORMATION YOU MAY HAVE REGARDING ANY POLICY, CONTRACT OR AGREEMENT I HAVE WITH OR THROUGH YOU TO PROVIDE, PAY FOR OR REIMBURSE THE COST OF MEDICAL EXPENSES. THIS INFORMATION IS REQUIRED TO DETERMINE THE BENEFITS AVAILABLE TO ME UNDER THE MASSACHUSETTS PERSONAL INJURY PROTECTION BENEFITS LAW.

_____

SOCIAL SECURITY NUMBER

_____ _____

SIGNATURE DATE

South Shore Family Chiropractic:

Dr. William M. Byrnes *Director*
33 Sea Street, Weymouth, MA 02191
****
Office: 781-335-7671 Fax: 781-335-7856

Personal Injury

Patient Name/Address/Phone/DOB: _____

_____

_____

_____

Claim #: _____

Date of Injury: _____

Insurance Company: _____

Insurance Address: _____

_____

_____

Insurance Phone/Fax: _____

Adjuster Name/Phone/Fax: _____

_____

Patient Health Insurance Company/ID#: _____

_____

Attorney Name/Address/Phone/Fax: _____

_____

_____

SOUTH SHORE FAMILY CHIROPRACTIC

IRREVOCABLE ASSIGNMENT OF BENEFITS

INSURANCE CARRIER - ATTORNEY: _____

ADDRESS: _____

In consideration of receiving chiropractic services from South Shore Family Chiropractic, having its usual place of business at 33 Sea Street, Weymouth, MA 02191, I hereby assign and transfer to South Shore Family Chiropractic such sums as may be due South Shore Family Chiropractic upon receipt by the above named insurance company or attorney of an itemized statement for chiropractic services rendered to me by said chiropractic office.

It is further understood and agreed that payment of said itemized statement by the above named insurance carrier or attorney as herein directed by me shall be considered the same as if paid by the above named Insurance carrier or attorney directly to me.

PATIENT SIGNATURE: _____ **DATE:** _____

GUARDIAN SIGNATURE: _____ **DATE:** _____

_____

PRINTED NAME

_____

ADDRESS

_____

CITY, STATE, ZIP

_____

DATE OF INJURY

_____

CLAIM NUMBER

Financial Responsibility for Personal Injuries

- **It is YOUR responsibility to provide accurate information concerning your injury within 3 days of starting care at this office. If this information is not provided, you will be presented with a bill, which must be paid in full at that time. It is your responsibility to complete your Personal Injury Protection (PIP) form with your automobile insurance carrier.**

- **In Massachusetts we are a no-fault insurance state. Based on that, you are entitled to 100% coverage for treatment and wage loss under what is known as PIP (personal injury protection) insurance. The maximum benefit for an automobile accident is usually $2000.00 per person.**

- **After your $2000.00 is exhausted your health insurance will be billed at that time.**

- **We will file all the necessary paperwork to process this claim. Although, it is your responsibility to know where you stand at all times concerning this bill at South Shore Family Chiropractic.**

- **Any payment for services that the company denies or refuses to cover will become your responsibility.**

- **It is very important that you follow your plan of care so that you do not jeopardize the validity of your injuries.**

I have read and understand this policy.

Patient signature: _____ **Date:** _____

Guardian signature: _____ **Date:** _____

DR. WILLIAM BYRNES

SOUTH SHORE FAMILY CHIROPRACTIC

33 SEA ST.

N. WEYMOUTH, MA 02191

HEALTH INSURANCE AFFIDAVIT

In order for this office to process your claim efficiently, it is necessary to obtain the following information regarding other health benefits available to you.

Any medical expenses in excess of $2,000.00 will not be paid under your auto policy if those expenses will be compensated, paid or idemnified by an outside insurance carrier.

Bills submitted to your auto insurance carrier over the $2,000 limit must be accompanied by an Explanation of Benefits from your health carrier or a copy of this Affidavit.

If you have health insurance benefits available to you, please complete Section One.

If you do not have health benefits available to you, please Sign and Date Section Two.

SECTION ONE: (complete this section if you have health insurance)

Health Insurance Company _____

Policy Number _____

Signature _____ Date _____

SECTION TWO: (complete this section if you DO NOT HAVE health insurance)

I hereby certify that I do not have any accident and/or health benefits available to me through my own policy or that of a household member.

Signature _____ Date _____

TO: ATTORNEY/INSURANCE CARRIER

_____

_____

_____

FROM: South Shore Family Chiropractic
33 Sea Street
Weymouth, MA 02191
(781) 335-7671 office (781) 335-7856 fax
www.ssfamily.com

RE: PATIENT RECORDS AND DOCTOR'S LIEN

Ref Patient Name: _____ DOB: _____

RELEASE OF RECORDS: I do hereby authorize South Shore Family Chiropractic to furnish you, my attorney/insurance carrier, with a full report of the doctor's case history, examination, diagnosis, treatment, and prognosis of myself in regard to my accident /illness which occurred/began on _____ (date of accident or injury).

LIEN ON SETTLEMENT: I hereby give a Lien to South Shore Family Chiropractic on any settlement, claim, judgment, or verdict as a result of said accident / illness, and authorize and direct you, my attorney/insurance carrier, to pay directly to South Shore Family Chiropractic such sums as may be due and owing my doctor for service rendered me, and to withhold such sums from such settlement, claim, judgment, or verdict as may be necessary to protect South Shore Family Chiropractic adequately.

IRREVOCABLE LIEN: I understand that this Lien shall be irrevocable either by myself or any other agent that represents me; that in the event another attorney is substituted in this matter, the new attorney shall honor this lien as inherent to the settlement and enforceable upon the case as if it was executed by him.

RESPONSIBILITY FOR PAYMENT: I fully understand that I am directly and fully responsible to South Shore Family Chiropractic for all chiropractic bills submitted by the doctor for service rendered me, and that this agreement is made solely for South Shore Family Chiropractic's additional protection and in consideration of their awaiting payment. And I further understand that such payment is not contingent on any settlement, claim, judgment, or verdict by which I may eventually recover said fee.

A photocopy or facsimile of this executed instrument shall be considered as valid as the original.

Patient Signature: _____ Dated: _____

The undersigned, being attorney of record or authorized representative of insurance carrier for the above patient does hereby acknowledge receipt of the above lien, and does agree to honor the same to protect adequately South Shore Family Chiropractic and to withhold such sums from any settlement, judgment or verdict, after subtraction of attorney fees and expenses, as may be necessary to adequately protect the said provider and South Shore Family Chiropractic.

Auth. Signature: _____ Dated: _____

NOTICE: Please date, sign, and return the original to our office as soon as possible.
(Reply envelope attached)

Vehicle Accident Report

Name:

_____

_____

Enter the date of the accident: _____ Enter the time of the accident: _____ AM PM

Patient Role: ❑Driver ❑Front passenger ❑Rear passenger ❑Motorcycle operator ❑ Motorcycle passenger ❑ ATV operator ❑ATV passenger ❑Other

_____

Vehicle Size: ❑Not reported ❑Subcompact ❑Compact ❑Mid-size ❑Full-size ❑Other:

_____

Travel Direction: ❑Not reported ❑North ❑South ❑East ❑West ❑Other:

_____

Other Vehicle Size: ❑Not reported ❑Subcompact ❑Compact ❑Mid-size ❑Full-size ❑Other:

_____

Other Travel Direction: ❑Not reported ❑North ❑South ❑East ❑West ❑Other:

_____

Collision Location: ❑Not reported ❑Head On ❑Front ❑Behind ❑Passenger's Side ❑Driver's Side

❑Other: _____

Time of Day: ❑Not reported ❑Daylight ❑Dawn ❑Dusk ❑Night ❑Other:

_____

Road Conditions: ❑Not reported ❑Dry ❑Damp ❑Wet ❑Snow ❑Ice ❑Other:

_____

Accident Anticipated?: ❑Not reported ❑Yes ❑No

Patient Ejected?: ❑Not reported ❑Ejected ❑Not ejected

Patient Struck: ❑Not reported ❑Steering wheel ❑Air bag ❑Dashboard ❑Rear-view mirror ❑Windshield

❑Car Interior ❑Other:

_____

Patient Conscious: ❑Not reported ❑Lost consciousness ❑Did not lose consciousness

Seat Belt: ❑Not reported ❑Used ❑Not used

Shoulder Belt: ❑Not reported ❑Used ❑Not used

Head Rest: ❑Not reported ❑Above head ❑Below head ❑None

Air Bags: ❑Not reported ❑Deployed ❑Did not deploy

Injury Area:

❑Head ❑Neck ❑Shoulders ❑Upper/Mid Back ❑Lower Back

❑Chest/Ribs ❑Arms ❑Elbows ❑Forearms

❑Wrists

❑Hands ❑Abdomen ❑Buttocks ❑Pelvis ❑Hips

❑Thighs ❑Legs ❑Knees ❑Ankles ❑Feet

❑Other:

I hereby authorize the doctor to examine and treat my condition as he/she deems appropriate through the use of chiropractic health care, and I give authority for these procedures to be performed. It is understood and agreed the imaging is for examination only and the negatives will remain the property of this office, being on file where they may be viewed.

Patient's/Guardian's Signature: _____ **Date:** _____