PATIENT INFORMATION

Today's Date: _____

Patient Information

Name: (First MI Last) _____ **Preferred Name:** _____

DOB: _____ **Gender**: M / F **SSN:** _____

Address: _____ **Apt:** _____ **City:** _____ **State:** _____

Zip:_____

Mobile Phone: _____ **Home Phone:** _____

Email: _____

Preferred Method of Contact: Phone / Email

Who may we thank for referring you to our office? _____

Emergency Contact Information

Name: _____

Phone: _____

Relationship: Child / Parent / Spouse / Other: _____

Financial Information

Is today's visit the result of an accident? No / Auto / Work Other: _____

Will we be working with insurance? No / Yes (*See Details Below)*

Insurance Company: Blue Cross Blue Shield / Cigna / Medicare / Other: _____

Please give insurance card to front desk if you have not already done so.

Patient or Guardian Signature: _____ **Date:** _____

It is Usual and Customary to Pay for Services as Rendered Unless Otherwise Arranged

AUTO ACCIDENT QUESTIONNAIRE

ACCIDENT INFORMATION *(Please use back of this page if needed.)*

Date of Accident: _____ **Approximate Time of Accident:** _____ **Number of People in Accident Vehicle** _____

Location/Street of Accident: _____

Were you the: ❑ Driver ❑ Front Passenger ❑ Rear Passenger – Behind Driver / Middle / Behind Passenger / 2nd Row / 3rd Row

Name of Driver *(If not you)* _____ **Name of Driver of Other Vehicle** _____

Year/Make/Model of Vehicle you were in: _____

Were you wearing a seatbelt? ❑ Yes ❑ No **Is vehicle equipped with airbags?** ❑ Yes ❑ No **Did airbags inflate?** ❑ Yes ❑ No

Where was your vehicle impacted? ❑ Front ❑ Rear ❑ Driver side ❑ Passenger side

During impact, where were you facing? ❑ Forward ❑ Backward ❑ Left ❑ Right

Did any part of your body strike anything in the vehicle? ❑ No ❑ Yes *(Describe)* _____

_____

Did you lose consciousness? ❑ No ❑ Yes **For how long?** _____

Were you ❑ Aware ❑ Surprised **by the impact?**

In your own words, please describe the accident in detail: _____

_____

MEDICAL INFORMATION

Before the Accident

Have you ever had complaints in the involved area? ❑ No ❑ Yes

If yes, were they present at the time of the accident? ❑ No ❑ Yes *(Describe)* _____

Were you able to work without restrictions before the accident? ❑ Yes ❑ No

At the Time of the Accident

Did you feel pain immediately after the accident? ❑ Yes ❑ No – **When?** ❑ Later that Day ❑ Next Day ❑ When? _____

Did you go to a hospital or see any other doctor? ❑ No ❑ Yes – **When did you go?** ❑ Immediately ❑ Next Day ❑ Other

How did you get there? ❑ Ambulance ❑ Private Transportation – **Name of hospital and/or doctor:** _____

Were any x-rays taken? ❑ Yes ❑ No **Was any medication prescribed?** ❑ Yes ❑ No

Since the Accident

Are your symptoms: ❑ Getting Better ❑ Staying the Same ❑ Getting Worse

Have you been missed any work since this accident? ❑ No ❑ Yes *(Describe)* _____

Are your work activities restricted because of this injury? ❑ No ❑ Yes *(Describe)* _____

LEGAL INFORMATION

Did the police come to the scene of that accident? ❑ No ❑ Yes – **Was a police report files?** ❑ Yes ❑ No

Have you retained an attorney? ❑ No ❑ Yes – **Name** _____

Your Auto Insurance Company _____ **Policy #** _____

Other Auto Insurance Company _____ **Claim #** _____

I have answered these questions to the best of my knowledge and certify them to be true and correct.

Patient or Guardian Signature_____ Date _____

Print Name *(First MI Last)*_____ Account # _____

Patient Primary Complaint Form

Major Complaint:_____

When did this episode start (date): _____ **What event caused it?** _____

If this is NOT the first time, how long has this been a recurring problem? _____

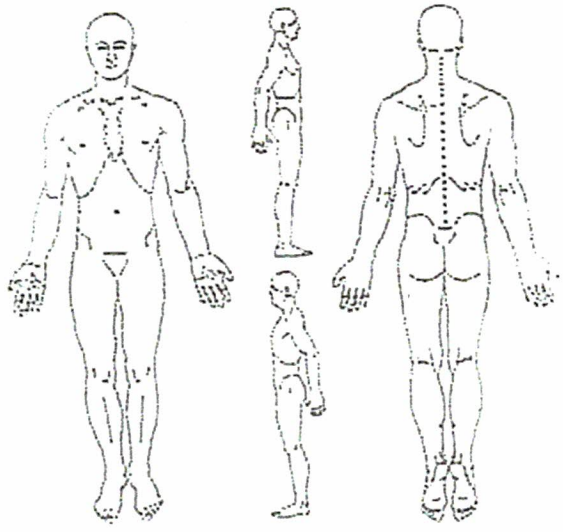
Intensity: None (0) Mild (1-2) Mild-Moderate (2-4) Moderate(4-6) Moderate-Severe (6-8) Severe (8-10)

The complaint is: Constant / Comes and Goes

Is the complaint: Sharp / Stabbing / Burning / Achy / Dull / Stiff & Sore / Pins & Needles Other: _____

Does it radiate/shoot to any area of your body? No / Yes **If YES, where:** _____

DRAW AREAS OF COMPLAINTS:



What makes it better? Ice / Heat / Rest / Movement / Stretching / OTC Meds / RX Meds / Chiropractic

What makes it worse? Sit / Stand / Walk / Lying / Sleep / Movement / Lifting / Overuse

Who else have you seen for this? No one / DC / MD / PT / Massage / ER / Other: _____

- **Where:** _____

Diagnostic Tests: None / X-rays / MRI / CT / Other: _____ **When & Where?:** _____

List of past surgeries: _____

Any other complaints: _____

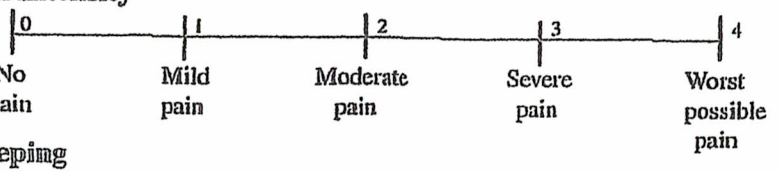
Patient Signature: _____ **Date:** _____

Functional Rating Index

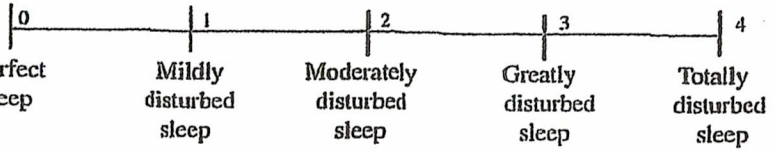
For use with Neck and/or Back Problems only.

In order to properly assess your condition, we must understand how much your neck and/or back problems have affected your ability to manage everyday activities. For each item below, please circle the number which most closely describes your condition right now.

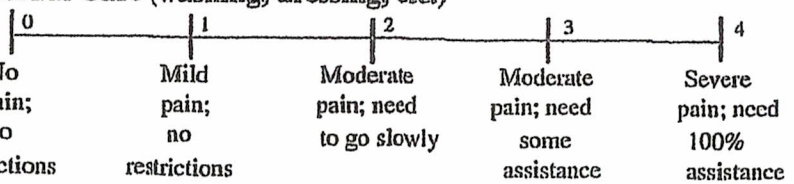
1. Pain Intensity



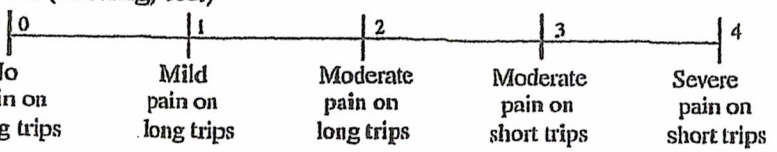
2. Sleeping



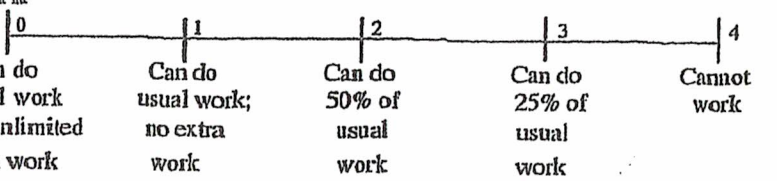
3. Personal Care (washing, dressing, etc.)



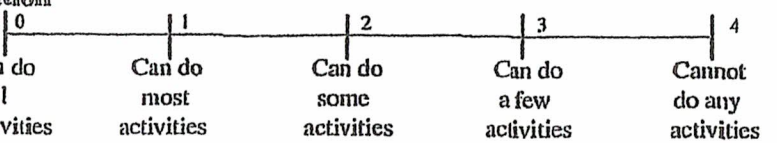
4. Travel (driving, etc.)



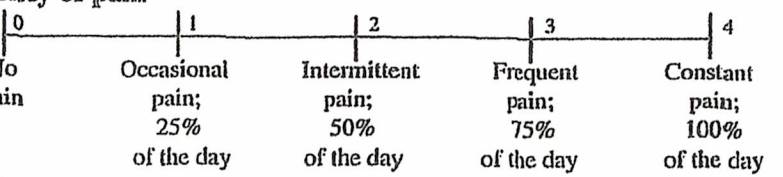
5. Work



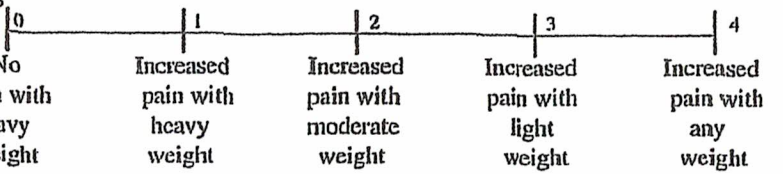
6. Recreation



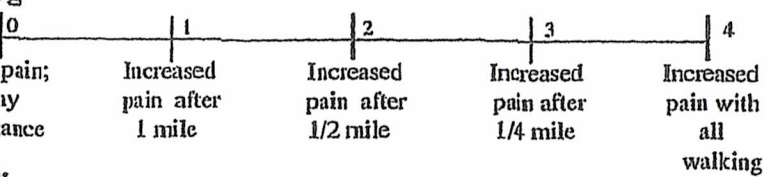
7. Frequency of pain



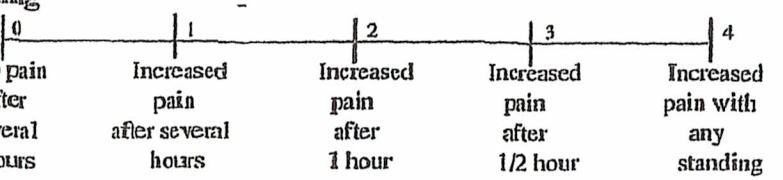
8. Lifting



9. Walking



10. Standing



Name _____
PRINTED

_____
Signature

_____
Date

Total Score _____

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www.chiroevidence.com

Knehmaner Chiropractic

Notice of Privacy Practices

Effective September 23, 2013

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

The Practice (the "Practice"), in accordance with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule, (the "Privacy Rule") and applicable state law, is committed to protecting the privacy of your protected health information ("PHI"). PHI includes information about your health condition and the care and treatment you receive from the Practice. The Practice understands that information about your health is personal. This Notice explains how your PHI may be used and disclosed to third parties. This Notice also details your rights regarding your PHI. The Practice is required by law to maintain the privacy of your PHI and to provide you with this Privacy Notice detailing the Practice's legal duties and practices with respect to your PHI. The Practice is also required by law to abide by the terms of this Notice.

HOW THE PRACTICE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

The Practice, in accordance with this Notice and without asking for your express consent or authorization, may use and disclose your PHI for the purposes of:

For Treatment – We may use your PHI to provide you with treatment. We may disclose your PHI to doctors, nurses, technicians, clinicians, medical students, hospitals and other health facilities involved in or consulting in your care. We may also disclose information about you to people outside the practice, such as other health care providers involved in providing treatment to you, and to people who may be involved in your care, such as family members, clergy, or others we use to provide services that are part of your care. If we refer you to another health care provider, we would, as part of the referral process share PHI information about you. For example, if you were referred to a specialist, we would contact the doctor's office and provide such information about you to them so that they could provide services to you.

For Payment – We may use and disclose your PHI so we can be paid for the services we provide to you. For example, we may need to give your insurance company information about the health care services we provided to you so your insurance company will pay us for those services or reimburse you for amounts you have paid. We also may need to provide your insurance company or a government program, such as Medicare or Medicaid, with information about your condition and the health care you need to receive prior approval or to determine whether your plan will cover the services.

For Health Care Operations – We may use and disclose your PHI for our own health care operations and the operations of other individuals or organizations involved in providing your care. This is necessary for us to operate and to make sure that our patients receive quality health care. For example, we may use information about you to review the services we provide and the performance of our employees in caring for you.

OTHER USE & DISCLOSURES THAT ARE REQUIRED OR PERMITTED BY LAW

The Practice may also use and disclose your PHI without your consent or authorization in the following instances:

Appointment Reminders - We may use and disclose your PHI to remind you by telephone, email, text message or mail about appointments you have with us, annual exams, or to follow up on missed or cancelled appointments.

Individuals Involved in Your Care or Payment for Your Care – We may disclose to a family member, other relative, a close friend, or any other person identified by you. Certain limited PHI that is directly related to that person's involvement with your care or payment for your care. We may use or disclose your PHI to notify those persons of your location or general condition. This includes in the event of your death unless you have specifically instructed us otherwise. If you are unable to specifically agree or object, we may use our best judgment when communicating with your family and others.

Disaster Relief - We also may use or disclose your PHI to an authorized public or private entity to assist in disaster relief efforts. This will be done to coordinate information with those organizations in notifying a family member, other relative, close friend or other individual of your location and general condition.

De-identified Information – The Practice may use and disclose health information that may be related to your care but does not identify you and cannot be used to identify you.

Business Associate – The Practice may use and disclose PHI to one or more of its business associates if the Practice obtains satisfactory written assurance, in accordance with applicable law, that the business associate will appropriately safeguard your PHI. A business associate is an entity that assists the Practice in undertaking some essential function, such as a billing company that assists the office in submitting claims for payment to insurance companies.

Personal Representative – The Practice may use and disclose PHI to a person who, under applicable law, has the authority to represent you in making decisions related to your health care.

Emergency Situations – The Practice may use and disclose PHI for the purpose of obtaining or rendering emergency treatment to you provided that the Practice attempts to obtain your Consent as soon as possible. The Practice may also use and disclose PHI to a public or private entity authorized by law or by its charter to assist in disaster relief efforts, for the purpose of coordinating your care with such entities in an emergency situation.

Public Health and Safety Activities – The Practice may disclose your PHI about you for public health activities and purposes. This includes reporting information to a public health authority that is authorized by law to collect or receive the information. These activities generally include:

- To prevent or control disease, injury or disability
- To report births or deaths
- To report child, elder, or dependent adult abuse or neglect
- To report reactions to medications or problems with products
- To notify people of recalls of products they may be using
- To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

Victims of Abuse, Neglect or Domestic Violence – We may disclose your PHI to a government authority authorized by law to receive reports of abuse, neglect, or domestic violence, if we believe an adult or child is a victim of abuse, neglect, or domestic violence. This will occur to the extent the disclosure is (a) required by law, (b) agreed to by you, (c) authorized by law and we believe the disclosure is necessary to prevent serious harm, or, (d) if you are incapacitated and certain other conditions are met, a law enforcement or other public official represents that immediate enforcement activity depends on the disclosure.

Health Oversight Activities – We may disclose your PHI to a health oversight agency for activities authorized by law, including audits, investigations, inspections, licensure or disciplinary actions. These and similar types of activities are necessary for appropriate oversight agencies to monitor the nation's health care system, government benefit programs, and for the enforcement of civil rights laws.

Judicial and Administrative Proceedings – We may disclose your PHI in response to a court or administrative order. We also may disclose information about you in response to a subpoena, discovery request, or other legal process but only if efforts have been made to tell you about the request or to obtain an order protecting the information to be disclosed.

Disclosures for Law Enforcement Purposes – We may disclose your PHI to law enforcement officials for these purposes:

- As required by law
- In response to a court, grand jury or administrative order, warrant or subpoena
- To identify or locate a suspect, fugitive, material witness or missing person
- About an actual or suspected victim of a crime if, under certain limited circumstances, we are unable to obtain that person's agreement
- To alert a potential victim or victims or intending harm ("duty to warn")
- To alert law enforcement officials to a death if we suspect the death may have resulted from criminal conduct
- About crimes that occur at our facilities
- To report a crime, a victim of a crime or a person who committed a crime in emergency circumstances

To Avert Serious Threat to Health or Safety – We will use and disclose your PHI when we have a "duty to report" under state or federal law because we believe that it is necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure would be to help prevent a threat.

Coroners, Medical Examiners and Funeral Directors – We may disclose your PHI to a coroner or medical examiner for purposes such as identifying a deceased person and determining cause of death. We also may disclose information to funeral directors so they can carry out their duties.

Organ, Eye or Tissue Donation – To facilitate organ, eye or tissue donation and transplantation, we may disclose your PHI to organizations that handle organ procurement, banking or transplantation.

Workers Compensation – We may disclose your PHI to the extent necessary to comply with worker's compensation and similar laws that provide benefits for work-related injuries or illness without regard to fault.

Special Government Functions – If you are a member of the armed forces, we may release your PHI as required by military command authorities. We may also release information about foreign military authority. We may disclose information about you to authorized federal officials for intelligence, counter-intelligence and other national security activities authorized by law.

Research – We may use and/or disclose your PHI for research projects that are subject to a special review process. If researchers are allowed access to information that information that identifies who you are, we will ask for your permission.

Fundraising – We may contact you with respect to fundraising campaigns. If you do not wish to be contacted for fundraising campaigns, please notify our Privacy Officer in writing.

AUTHORIZATION

The following uses and/or disclosures specifically require your express written permission:

Marketing Purposes – We will not use or disclose your PHI for marketing purposes for which we have accepted payment without your express written permission. However, we may contact you with information about products, services or treatment alternatives directly related to your treatment and care.

Sale of Health Information – We will not sell your PHI without your written authorization. If you do authorize such a sale, the authorization will disclose that we will receive compensation for the information that you have authorized us to sell. You have the right to revoke the authorization at any time, which will halt any future sale.

Uses and/or disclosures other than those described in this Notice will be made only with your written authorization. If you do authorize a use and/or disclosure, you have the right to revoke that authorization at any time by submitting a revocation in writing to our Privacy Officer. However, revocation cannot be retroactive and will only impact uses and/or disclosures after the date of revocation.

YOUR RIGHTS

Right to Revoke Authorization – You have the right to revoke any Authorization or consent you have given to the Practice, at any time. To request a revocation, you must submit a written request to the Practice's Privacy Officer.

Right to Request Restrictions – You have the right to request that we restrict the uses or disclosures of your information for treatment, payment or healthcare operations. You may also request that we limit the information we share about you with a relative or friend of yours. You also have the right to restrict disclosure of information to your commercial health insurance plan regarding services or products that you paid for in full, out-of-pocket and we will abide by that request unless we are legally obligated to do so.

We are not required to agree to any other requested restriction. If we agree, we will follow your request unless the information is needed to a) give you emergency treatment, b) report to the Department of Health and Human Services, or c) the disclosure is described in the "Uses and Disclosures That Are Required or Permitted by Law" section. To request a restriction, you must have your request in writing to the Practice's Privacy Officer. You must tell us: a) what information you want to limit, b) whether you want to limit use or disclosure or both and c) to whom you want the limits to apply. Either you or we can terminate restrictions at a later date.

Right to Receive Confidential Communications – You have the right to request that we communicate your PHI in a certain way or at a certain place. For example, you can ask that we only contact you by mail or at work. If you want to request confidential communications you must do so in writing to our Practice's Privacy Officer and explain how or where you can be contacted. You do not need to give us a reason for your request. We will accommodate all reasonable requests.

Right to Inspect and Copy – You have the right to inspect and request copies of your information. I understand that a clinical summary report is created after each visit for the purpose of EHR and is available for my review. At this time, I am asking Kuchmaner Chiropractic to save these electronically for me and not print them out after each visit. I understand that, upon request, these reports are available to be printed or emailed to me for review.

To inspect or copy your information, you may either complete an Authorization to Release/Obtain Information form or write a letter of request, stating the type of information to be released, the date(s) of service being requested, the purpose of the request, and whether you wish to review the record or receive copies of the requested information in your preferred format. We will abide by your request in the format you have requested, if we are able to do so. If we cannot provide your records to you in the requested format, we will attempt to provide them in an alternative format that you agree to. You may also request that your records be sent to another person that you have designated in writing. Direct this request to the Practice's Privacy Officer. You may be charged a fee for the cost of copying, mailing or other expenses related with your request.

We may deny your request to inspect and copy information in a few limited situations. If you request is denied, you may ask for our decision to be reviewed. The Practice will choose a licensed health care professional to review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of that review.

Right to Amend – If you feel that your PHI is incorrect, you have the right to ask us to amend it, for as long as the information is maintained by us. To request an amendment, you must submit your request in writing to the Practice's Privacy Officer. You must provide a reason for the amendment.

We may deny your request for an amendment if it is not in writing or does not include a reason for wanting the amendment. We also may deny your request if the information: a) was not created by us, unless the person or entity that created the information is no longer available to amend the information, b) is not part of the information maintained by the Practice, c) is not information that you would be permitted to inspect and copy or d) is accurate and complete.

If your request is granted the Practice will make the appropriate changes and inform you and others, as needed or required. If we deny your request, we will explain the denial in writing to you and explain any further steps you may wish to take.

Right to an Accounting of Disclosures – You have the right to request an accounting of disclosures. This is a list of certain disclosures we have made regarding your PHI. To request an accounting of disclosures, you must write to the Practice's Privacy Officer. Your request must state a time period for the disclosures. The time period may be for up to six years prior to the date on which you request the list, but may not include disclosures made before April 14, 2003.

There is no charge for the first list we provide to you in any 12-month period. For additional lists, we may charge you for the cost of providing the list. If there will be a charge, we will notify you of the cost in advance. You may withdraw or change your request to avoid or reduce the fee.

Certain types of disclosures are not included in such an accounting. These include disclosures made for treatment, payment or healthcare operations; disclosures made to you or for our facility directory; disclosures made with your authorization; disclosures for national security or intelligence purposes or to correctional institutions or law enforcement officials in some circumstances.

Right to a Paper Copy of this Notice – You have the right to receive a paper copy of this Notice of Privacy Practices, even if you have agreed to receive this Notice electronically. You may request a paper copy of this Notice at any time.

Right to File a Complaint – You have the right to complain to the Practice or to the United States Secretary of Health and Human Services (as provided by the Privacy Rule) if you believe your privacy rights have been violated. To file a complaint with the Practice, you must contact the Practice's Privacy Officer. To file a complaint with the United States Secretary of Health and Human Services, you may write to: Office for Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Washington, DC 20201. All complaints must be in writing. To obtain more information about your privacy rights or if you have questions about your privacy rights you may contact the Practice's Privacy Officer as follows: V.A. Kuchmaner, DC – 10922 South Tryon St. Suite B, Charlotte, NC 28273: 704-588-3433 - We encourage your feedback and we will not retaliate against you in any way for the filing of a complaint. The Practice reserves the right to change this Notice and make the revised Notice effective for all health information that we had at the time, and any information we create or receive in the future. We will distribute any revised Notice to you prior to implementation. I acknowledge receipt of a copy of this Notice, and my understanding and my agreement to its terms.

Patient Signature: _____ Date: _____

Informed Consent to Treatment

I hereby request and consent to the performance of chiropractic adjustments (also known as spinal manipulations) and other chiropractic procedures, including various modes of physical therapeutic modalities and diagnostic X-rays on me (or on the patient named below, for whom I am legally responsible) by V.A. Kuchmaner, D.C. and/or other licensed doctors of chiropractic who now or in the future work at Kuchmaner Chiropractic.

I have had an opportunity to discuss with the doctor of chiropractic named above and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed. I understand that the type of treatment used in this office is a low force treatment that helps reduce the possibility of the below risks but the information is provided so that I may make an informed decision.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some possible risks to treatment, including but not limited to fractures, disc injuries, VBA, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient Name Printed _____ Patient Signature _____

Date _____ Parent/Guardian's Signature _____

DO NOT WRITE BELOW THIS LINE

Patient Accepted? YES NO Doctor's Signature _____

KUCHMANER CHIROPRACTIC

ASSIGNMENT OF BENEFITS/LIEN

To any insurance company with coverage applicable to my claim(s) and to any attorney representing me:

In consideration of Kuchmaner Chiropractic's willingness to treat me on credit without demand of payment at the time services are rendered, I hereby agree and stipulate as follows:

I irrevocably assign to Kuchmaner Chiropractic any proceeds and compensation that I am or may become entitled to receive as a results of injuries or illness on _____, to the extent of the chiropractic services rendered. I make this agreement without prejudice to any rights I may have to prosecute legal claims against any party who may be liable for my injuries or my illness, but I hereby authorize and instruct you to pay directly to Kuchmaner Chiropractic, from any disability benefits, judgments, settlements or other proceeds of any kind that would otherwise by payable to me, such sums are due or may become due to Kuchmaner Chiropractic for its services rendered.

I appoint Kuchmaner Chiropractic as my attorney in fact to affix my name as an endorsement upon the reverse of any check or draft in which I named payee and to deposit said check or draft and apply the proceeds to any unpaid balance I may have with Kuchmaner Chiropractic.

I acknowledge that I remain personally liable for the total amount due to Kuchmaner Chiropractic for services rendered, including the balance remaining after the application of insurance payments and settlements or judgment proceeds. If Kuchmaner Chiropractic is required to take legal action to recover any unpaid balance on my account, I will reimburse Kuchmaner Chiropractic for its cost of recovery, including reasonable attorney fees.

I authorize Kuchmaner Chiropractic to release to any insurer with applicable coverage or to my attorney any information regarding my injury, illness or treatment as may be necessary to facilitate collection under this assignment and waiver.

_____
Patient

_____
Date

_____
Witness

NOTICE OF LIEN

Pursuant to N.C.G.S. 44-49 and 44-50, Kuchmaner Chiropractic herby asserts and gives notice of a lien upon any sums recovered in damages for personal injury in any civil action and also upon all funds paid to the above-named patient in compensation for or settlement of injuries sustained, whether in litigation or otherwise.

Kuchmaner Chiropractic hereby requests that if its claims are not paid in full from the foregoing proceeds, a full disclosure and accounting of proceeds in conformity with N.C.G.S. 44-50.1 Kuchmaner Chiropractic agrees to be bound by any confidentiality agreements regarding the contents of the accounting.

KUCHMANER CHIROPRACTIC

By:_____

VICTOR KUCHMANER D.C.
10922 S. TRYON ST; SUITE B
CHARLOTTE, NC 28273
PHONE: 704-5883433- FAX: 704-588-3459

Victor A. Kuchmaner, DC
Kuchmaner Chiropractic

10922 S. Tryon St
Suite B
Charlotte, NC 28273
Telephone: (704) 588-3433
Fax: (704) 588-3459

Medpay Information

A lot of people have benefits (MEDPAY) included in their automobile policies and do not even realize it. Our office highly recommends that you use your Medpay coverage, if you have it, in the event that you've been in an automobile accident, regardless of who is at fault.

Here are three reasons why we recommend filing your Medpay.

1. **Medpay is similar to health insurance.** Using it does not cause your rates to increase. If your rates do increase, it's not because you filed your Medpay, it's most likely because a) it was determined that you were at fault, b) you received the police citation or ticket, or C) you've been involved in numerous reported auto accidents within a brief period of time and therefore are now considered to be "high risk."
2. **Filing your Medpay does not relieve the other party from having to pay in full for your loss.** On the contrary, by filing your Medpay, when you collect from the other driver's liability insurance, a greater amount of the settlement will go directly to you because your bill at our office may be paid in full. If the other driver's liability insurance refuses to make payments to you for whatever reason, filing your Medpay will help insure that you are not stuck with all of the medical bills.
3. **If you have Medpay coverage and choose not to file it, then you are paying for an option, but not receiving any benefit.**

To file your Medpay, simply call your auto insurance company and make a separate Medpay claim. Once you have a phone number and claim number for your Medpay coverage, bring it into us and we will take care of filing it to your auto insurance company.

Name _____ Date _____