O'DONAHUE CHIROPRACTIC

HIPAA Compliant Authorization for Release of Patient Information

Section I- Patient Information

Patient Name:_____Date:_____

Patient Address:_____Phone:_____

Date of Birth:_____SS#:_____Email:_____

Section II- Authorization for Release of Patient Information

I hereby authorize the use or disclosure of my identifiable health information as described below. I understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment; receive payment; or eligibility for benefits unless allowed by law. I, or my authorized representative, hereby authorize _____

And their respective employees, agents and subcontractors to disclose my Personal Health Information (PHI) and Insurance Record to:

O'Donahue Chiropractic
915 E. Firetower Road, Suite 104
Winterville, NC 28590
Phone: (252) 756-0837 Fax: (252) 756-7718
OC0013@OC0013.direct.chirotouch.md ***(encrypted email)***

Section III- Specific Information to be Released

- ✓ All Medical Records- Entire Medical Record including patient histories, office notes, radiology reports (x-ray & CT scan), MRI reports and photo static copies or excerpts of all records and any other information that relates to examination, treatment, x-ray finding or opinions concerning my accident, injury or illness. This excludes actual radiographic/MRI images.
- ✓ X-Ray/Radiology Reports
- ○ Billing Records with CPT Codes
- ○ Summary of Treatment
- ✓ Service Date/s for Record Request:_____

Section IV- Reason for Release of Information

- ○ At My Request (only the patient can check this circle)
- ✓ For My Healthcare
- ○ For Payment/Insurance
- ○ For Employment Purposes
- ○ Other:_____

Section V- Revocation Rights, Release and Signature

I understand that chiropractic physicians in North Carolina are required to maintain my records for at least six years and that records more than six years old may have been destroyed as permitted by law. I further

understand that health care providers are permitted to charge a photocopying fee for paper records in the amount of $.75 per page for the first 25 pages, $.50 per page for pages 26-100, and $.25 per page for each page in excess of 100 pages, with a minimum fee of $10.00. I further understand that, in addition to the foregoing photocopying fees for paper records, chiropractic physicians are permitted to charge a reasonable fee for duplication of x-ray images or the preparation of a summary of x-ray findings in lieu of duplicate images. I further understand that there is no cost for the transmission of patient records by email, but there may be actual production costs for the transfer of electronic patient records to storage media involving hardware such as DVD's and flash drives.

I further understand that if these records contain any information from previous providers or information about:

- HIV/AIDS status
- Cancer Diagnosis
- Drug/Alcohol Abuse
- Sexually Transmitted Disease

I am hereby authorizing disclosure of this information. I understand that unless earlier revoked, this authorization will expire:

- 1 year after the date signed
  - ➢ I may revoke this authorization at any time by notifying O'Donahue Chiropractic in writing, but if I do, it will not have any effect on any actions O'Donahue Chiropractic took before it received revocation.

By signing below, I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information (PHI). By signing this form, I am confirming that it accurately reflects my wishes. In addition, I have kept a copy of this form for my records.

[redacted] _____ [redacted] _____

Signature of Patient (or Patient Representative) Date

[redacted] _____ _____

Printed Name of Patient (or Patient Representative) Date

_____

*Representative's Authority to Sign for Patient

*If an Authorized Representative is making this request, please provide your information above and attach certifying documentation of your status as authorized representative, such as Power of Attorney or Guardianship papers.

MED-PAY INFORMATION

Many people have medical benefits (Med-Pay) covered under their auto insurance policy and they don't even realize it. Our office highly recommends that you use your Med-Pay coverage in the event you've been injured in an automobile accident, *regardless of who is at fault.* Even if you don't have Med-Pay coverage on your own personal auto insurance policy, it may be available to you under the policy of the driver of the car you were in. Our office will be glad to file the Med-Pay for you and submit the bills and notes directly to the Med-Pay company on your behalf. Here are 3 reasons why we recommend that we file your Med-Pay:

1.) Med-Pay is similar to Health Insurance.

Med-Pay is usually a limited dollar amount of coverage for medical bills for each person who was in the vehicle at the time of accident. *Using it does not cause your rates to increase. If your insurance premium rate increases it is most likely because:

a) It was determined that you were at fault for the accident,
b) You received a 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 Med-Pay does not relieve the other party from having to pay in full for your loss.

If the other driver's Liability insurance refuses to make payment to you for the medical bills you ensued from the accident, filing your Med-Pay will help to insure that you are not stuck with all the medical bills. Furthermore, if Liability and Med-Pay both pay on your medical bills, you are more likely to receive a refund.

3.) If you have Med-Pay coverage and choose not to use it, then you are paying for an option, but not receiving the benefit.

To determine if you have Med-Pay coverage, call your auto insurance carrier and ask if you have Medical Payments available to you on your policy. Tell them you would like to open a Med-Pay claim, and be sure to find out how much is available to you under your coverage.

If you do not have Med-Pay Coverage, and someone else was the driver of the vehicle you were in, it is possible that the driver may have Med-Pay. In order to file Med-Pay in this case, you must obtain the driver's auto insurance policy information and open a claim with the insurance company.

- If you have any questions about Med-Pay, please do not hesitate to ask our friendly staff.

O'Donahue Chiropractic

Dr. James O'Donahue
915 E. Firetower Rd. Ste 104
Winterville, NC 28590
P: 252-756-0837
F: 252-756-7718
dro@odonahuechiropractic.com

Personal Injury Office Policy

Our office would like to take a moment to familiarize you with the office policy for billing personal injury accounts. The information we are requesting will enable us to help you in filing your medical bills accordingly and in a prompt manner; thus allowing you to concentrate on getting better faster. If you have any questions after reviewing this information, please do not hesitate to ask.

*Please initial which option(s) you are choosing to file. You may choose more than one. :

_____**Attorney**
Our office will forward all necessary information, including a notarized lien, bills and records to the attorney whom you have chosen to represent you for this accident.

- Provide us with the name of the firm/attorney and a telephone number

_____**Liability Payment Benefits** (*Individual At Fault*)
Our office will submit a notarized lien, bills and records directly to the liability company after your treatment at our office is complete. This is the insurance company of the person who was at fault for the accident. If you were at fault: see Med-Pay Coverage.

- Report the accident and your injuries to the Liability Carrier
- Provide us with the Adjusters name, Phone number and Claim number
- Provide us with the official Accident Report

_____**Medical Payment Coverage** (*Your Automobile Coverage*)
Our office will submit a notarized assignment of benefits, bills and records directly to the med-pay company. This is a benefit available to you under your personal auto insurance policy *or* the car owner's auto insurance policy. *See our *pink* Med-Pay information sheet if you have questions about this coverage.

- Report your injuries to the Insurance Company
- Provide us with the Adjusters name, Phone number and Claim number
- Provide us with the official Accident Report

Please understand that we are treating *your condition* sustained in the automobile accident, we are not treating *your liability claim*. As a courtesy to you, our office will hold our bill, and we will not expect payment at the time of service. In accordance with this policy, we will file your claim in the terms outlined above. The purpose of the lien/assignment of benefits is to ensure that payment for our services will be directed to our office. However, please be aware that there is no guarantee of payment and any outstanding balance is your responsibility. After your claim(s) have been settled, any overpayments, (credits), on your account will be mailed directly to you. **At no time while your account has an outstanding balance will you be given a copy of any medical records or bills.** This policy is in place for the protection of O'Donahue Chiropractic interests. If you do not agree with these terms we will be glad to treat you on a cash patient basis or discuss another form of payment.

I have Read, Understand, and Agree to this Policy

_____ _____

Patient/Guardian Signature Date

Patient Introduction Card

Pt. No. _____ Date: _____

Full Name: _____
First Middle Last Suffix

Address: _____
Street City State Zip

Home: _____ Work: _____ Cell: _____

Email: _____ Date of Birth: _____ Sex: Male Female

Status: Married Single Divorced Other: _____ Social Security #: _____

Occupation: _____ Employer: _____

*Emergency Contact- Name & Phone #: _____

Health Insurance Authorization to File: *Please complete the information below & present your card(s) to our staff*

Primary Insurance Company: _____ Subscriber's Name: _____

Subscriber's Date of Birth: _____ Do you have a Secondary Insurance?: YES NO

Is your visit today a result of a work or auto accident injury? Yes No Major Complaint: _____

Privacy Practices Preferences:

I authorize being contacted for appointment & practice reminders and closings, as well as health related information or promotions about O'Donahue Chiropractic. Please review our Notice of Privacy Practices for PHI for more information.

- Please choose *preferred* method of contact: Telephone/Voicemail Email Text

Have you had previous Chiropractic care? YES NO *If Yes, Doctor's Name? _____

Who (or what) can we thank for referring you? _____

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

_____ _____

Patient/Patient Representative Signature Date

REASON FOR VISIT

What is the date of your scheduled appointment? ____ / ____ / _____

How long have you had this complaint?

- ⌐ Less than 5 days (Acute)
- ⌐ Between 5-30 days (Sub Acute)
- ⌐ More than 30 days (Chronic)

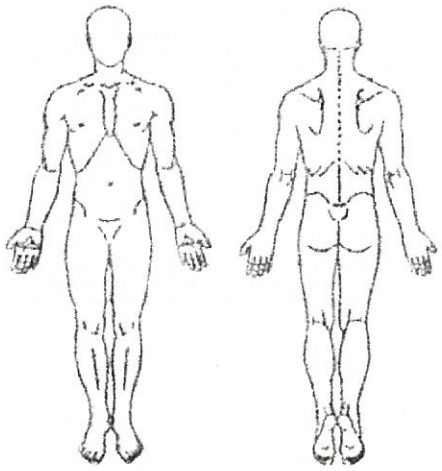
What caused this condition? _____

What is the date this condition began? (Skip if due to accident) ____ / ____ / _____

What terms describe your discomfort best? (aching, burning, tingling, etc.) _____

On the body diagrams to the right, please indicate your areas of symptoms by drawing in the appropriate symbols.

P - pain
N - numbness
W - weakness
S - shooting
A - aching



On a scale of 1 to 10, with 10 being the most severe, how would you rate your current level of discomfort?

None *Unbearable*

0 1 2 3 4 5 6 7 8 9 10

How often do you feel this discomfort? ⌐ Constant ⌐ Frequent ⌐ Occasional ⌐ Intermittent

How has this complaint changed since the onset? ⌐ Worsened ⌐ Remained the same ⌐ Improved

What activity is most significantly affected by this discomfort? (Explain) _____

_____

What treatment have you received for this condition up to now? _____

_____

What aggravates this condition? _____

What improves this condition or gives you relief? _____

Have other health care provider(s) performed tests related to this condition? _____

_____

Have you ever had any previous episodes of this condition? _____

_____

CURRENT HEALTH

Other than the information already provided, do you have additional health concerns involving any of the following?

Muscles, Bones, or Joints ⌐ No ⌐ Yes Explain: _____

Nerves, Headaches, Dizziness, or Emotional ⌐ No ⌐ Yes Explain: _____

Head, Eyes, Ears, Nose or Throat ⌐ No ⌐ Yes Explain: _____

Heart, Blood Pressure, or Circulation ⌐ No ⌐ Yes Explain: _____

Shortness of Breath, Coughing, Asthma or Lung Condition ⌐ No ⌐ Yes Explain: _____

Stomach, Bowels or Digestive Conditions ⌐ No ⌐ Yes Explain: _____

Genital, Bladder, or Urinary Conditions ⌐ No ⌐ Yes Explain: _____

Diabetes, Thyroid or Glandular Conditions ⌐ No ⌐ Yes Explain: _____

Skin or Bleeding Conditions ⌐ No ⌐ Yes Explain: _____

Allergies or Sensitivities ⌐ No ⌐ Yes Explain: _____

PERSONAL AND FAMILY HISTORY

Have you had any surgical procedures? ⌐ No ⌐ Yes **Explain:** _____

Are there any past illnesses or conditions we should be aware of? ⌐ No ⌐ Yes **Explain:** _____

Do you have a past history of accidents or trauma? ⌐ No ⌐ Yes **Explain:** _____

Are there any past illnesses or conditions we should be aware of? ⌐ No ⌐ Yes **Explain:** _____

Are you presently taking any medication? ⌐ No ⌐ Yes **Explain:** _____

Do you have a past family illness history, such as diabetes, cancer, hypertension, and progressive neurological diseases that we should be aware of? ⌐ No ⌐ Yes **Explain:** _____

WORK AND SOCIAL HABITS

Current work habits: select all that apply

⌐ Permanently fully disabled
⌐ Permanently partially disabled
⌐ Cannot work due to current condition
⌐ Full-time (20-40+ hours/week)
⌐ Part-time (1-19 hours/week)
⌐ Retired ⌐ Student ⌐ Homemaker ⌐ Unemployed

Personal social habits: select all that apply

⌐ Smoke or use tobacco products
⌐ Drink alcohol
⌐ Drink caffeine
⌐ Use recreational drugs
⌐ Other, to be discussed with doctor

Present exercise habits: select all that apply

⌐ No current exercises
⌐ Exercise daily
⌐ Exercise 3+ times per week
⌐ Cannot return to exercise due to current condition

Diet and nutrition habits: select all that apply

⌐ Vegan or vegetarian
⌐ Daily supplements
⌐ Other

Neck Index

ACN Group, Inc. Form NI-100

ACN Group, Inc. Use Only rev 3/27/2003

FOR Neck Pain Only

This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ I have no pain at the moment.
① The pain is very mild at the moment.
② The pain comes and goes and is moderate.
③ The pain is fairly severe at the moment.
④ The pain is very severe at the moment.
⑤ The pain is the worst imaginable at the moment.

Sleeping

⓪ I have no trouble sleeping.
① My sleep is slightly disturbed (less than 1 hour sleepless).
② My sleep is mildly disturbed (1-2 hours sleepless).
③ My sleep is moderately disturbed (2-3 hours sleepless).
④ My sleep is greatly disturbed (3-5 hours sleepless).
⑤ My sleep is completely disturbed (5-7 hours sleepless).

Reading

⓪ I can read as much as I want with no neck pain.
① I can read as much as I want with slight neck pain.
② I can read as much as I want with moderate neck pain.
③ I cannot read as much as I want because of moderate neck pain.
④ I can hardly read at all because of severe neck pain.
⑤ I cannot read at all because of neck pain.

Concentration

⓪ I can concentrate fully when I want with no difficulty.
① I can concentrate fully when I want with slight difficulty.
② I have a fair degree of difficulty concentrating when I want.
③ I have a lot of difficulty concentrating when I want.
④ I have a great deal of difficulty concentrating when I want.
⑤ I cannot concentrate at all.

Work

⓪ I can do as much work as I want.
① I can only do my usual work but no more.
② I can only do most of my usual work but no more.
③ I cannot do my usual work.
④ I can hardly do any work at all.
⑤ I cannot do any work at all.

Personal Care

⓪ I can look after myself normally without causing extra pain.
① I can look after myself normally but it causes extra pain.
② It is painful to look after myself and I am slow and careful.
③ I need some help but I manage most of my personal care.
④ I need help every day in most aspects of self care.
⑤ I do not get dressed, I wash with difficulty and stay in bed.

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
③ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
④ I can only lift very light weights.
⑤ I cannot lift or carry anything at all.

Driving

⓪ I can drive my car without any neck pain.
① I can drive my car as long as I want with slight neck pain.
② I can drive my car as long as I want with moderate neck pain.
③ I cannot drive my car as long as I want because of moderate neck pain.
④ I can hardly drive at all because of severe neck pain.
⑤ I cannot drive my car at all because of neck pain.

Recreation

⓪ I am able to engage in all my recreation activities without neck pain.
① I am able to engage in all my usual recreation activities with some neck pain.
② I am able to engage in most but not all my usual recreation activities because of neck pain.
③ I am only able to engage in a few of my usual recreation activities because of neck pain.
④ I can hardly do any recreation activities because of neck pain.
⑤ I cannot do any recreation activities at all.

Headaches

⓪ I have no headaches at all.
① I have slight headaches which come infrequently.
② I have moderate headaches which come infrequently.
③ I have moderate headaches which come frequently.
④ I have severe headaches which come frequently.
⑤ I have headaches almost all the time.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Neck Index Score

Back Index

ACN Group, Inc. Form BI-100

ACN Group, Inc. Use Only rev 3/27/2003

For Back Pain Only

This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ The pain comes and goes and is very mild.
① The pain is mild and does not vary much.
② The pain comes and goes and is moderate.
③ The pain is moderate and does not vary much.
④ The pain comes and goes and is very severe.
⑤ The pain is very severe and does not vary much.

Sleeping

⓪ I get no pain in bed.
① I get pain in bed but it does not prevent me from sleeping well.
② Because of pain my normal sleep is reduced by less than 25%.
③ Because of pain my normal sleep is reduced by less than 50%.
④ Because of pain my normal sleep is reduced by less than 75%.
⑤ Pain prevents me from sleeping at all.

Sitting

⓪ I can sit in any chair as long as I like.
① I can only sit in my favorite chair as long as I like.
② Pain prevents me from sitting more than 1 hour.
③ Pain prevents me from sitting more than 1/2 hour.
④ Pain prevents me from sitting more than 10 minutes.
⑤ I avoid sitting because it increases pain immediately.

Standing

⓪ I can stand as long as I want without pain.
① I have some pain while standing but it does not increase with time.
② I cannot stand for longer than 1 hour without increasing pain.
③ I cannot stand for longer than 1/2 hour without increasing pain.
④ I cannot stand for longer than 10 minutes without increasing pain.
⑤ I avoid standing because it increases pain immediately.

Walking

⓪ I have no pain while walking.
① I have some pain while walking but it doesn't increase with distance.
② I cannot walk more than 1 mile without increasing pain.
③ I cannot walk more than 1/2 mile without increasing pain.
④ I cannot walk more than 1/4 mile without increasing pain.
⑤ I cannot walk at all without increasing pain.

Personal Care

⓪ I do not have to change my way of washing or dressing in order to avoid pain.
① I do not normally change my way of washing or dressing even though it causes some pain.
② Washing and dressing increases the pain but I manage not to change my way of doing it.
③ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
④ Because of the pain I am unable to do some washing and dressing without help.
⑤ Because of the pain I am unable to do any washing and dressing without help.

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor.
③ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
④ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
⑤ I can only lift very light weights.

Traveling

⓪ I get no pain while traveling.
① I get some pain while traveling but none of my usual forms of travel make it worse.
② I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
③ I get extra pain while traveling which causes me to seek alternate forms of travel.
④ Pain restricts all forms of travel except that done while lying down.
⑤ Pain restricts all forms of travel.

Social Life

⓪ My social life is normal and gives me no extra pain.
① My social life is normal but increases the degree of pain.
② Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
③ Pain has restricted my social life and I do not go out very often.
④ Pain has restricted my social life to my home.
⑤ I have hardly any social life because of the pain.

Changing degree of pain

⓪ My pain is rapidly getting better.
① My pain fluctuates but overall is definitely getting better.
② My pain seems to be getting better but improvement is slow.
③ My pain is neither getting better or worse.
④ My pain is gradually worsening.
⑤ My pain is rapidly worsening.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Back Index Score

O'Donahue Chiropractic
INFORMED CONSENT FORM

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. In anything is unclear, please ask questions before you sign.

The nature of the chiropractic adjustment
The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis / Examination / Treatment
As a part of the analysis, examination, and treatment, you are consenting to the following procedures:

___ spinal manipulative therapy
___ range of motion testing
___ muscle strength testing
___ hot/cold therapy
___ radiographic studies
___ palpation
___ orthopedic testing
___ postural analysis
___ Electrical Stim
___ mechanical traction
___ vital signs
___ basic neurological testing
___ Other (please explain)_____
_____

The material risks inherent in chiropractic adjustment
As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

The probability of those risks occurring
Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the taking of your history and during examination and X-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

The availability and nature of other treatment options
Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers
- Hospitalization
- Surgery

If you chose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated
Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.
I have read or have had read to me the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Dr. James O'Donahue and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

_____	_____	_____
Patient Name (Please Print)	Patient/Representative Signature	Date
Dr. James O'Donahue	_____	_____
Doctor's Name (Please Print)	Doctor's Signature	Date

O'Donahue Chiropractic
915 E. Firetower Rd., Suite 104
Winterville, NC 28590

Electronic Health Records Intake Form

In compliance with requirements for the government EHR incentive program

First Name:_____ **Last Name:**_____

Email address: _____@_____

DOB: ___/___/_____ **Gender (Circle one):** Male / Female **Preferred Language:** _____

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

Smoking Start Date (Optional): _____

CMS requires providers to report both race and ethnicity

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) / Native Hawaiian or Pacific Islander / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? (Please include regularly used over the counter medications)

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

Patient Signature: _____ Date: _____

For office use only

Height: _____ Weight:_____ Blood Pressure:_____/_____

O'DONAHUE CHIROPRACTIC
ACKNOWLEDGMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for seven years.

List below the names and relationship of people to whom you authorize the Practice to release your Protected Health Information (PHI):

_____	_____
_____	_____
_____	_____
_____	_____
Patient Name (please print)	*Representative Name*
_____	_____
Patient/Representative Signature	*Date*

Automobile Accident Questionnaire

Patient Name:_____ Date:_____

1. What date & time did the accident occur?:_____/_____/_____ at_____AM or PM
2. Please explain in detail what happened (in your own words):_____

   _____

   _____
3. The vehicle you were in was struck from which direction? (circle one):

   Behind Front Driver's Side Passenger's Side
4. You were heading in which direction? (circle one):

   North South East West on _____ Street/Highway
5. You were (circle one): Driver Front Seat Passenger Back Seat Passenger Pedestrian
6. Did you have your seat belt on? Yes No
7. Did your head strike the windshield? or another object? Yes No Other object:_____
   - If yes, were you knocked unconscious? Yes No
     - If yes, for how long?_____
8. Where did you go after the accident?
   - Were you transported by Ambulance to the hospital after the accident? Yes No
     - If yes, we would like to request the records from the hospital. See our release form.
   - *If not*, where were you transported to:_____
     - And how did you get there: Drove Self Another Car Other:_____
9. What was the total number of people in your vehicle:_____
10. Was law enforcement notified of the accident? Yes No
    - If yes, did you receive an Exchange Slip? Yes No
    - Please use it to complete the information requested below.
    - Please provide the Exchange Slip to our staff so that we can make a copy for your file.
11. Have you filed a claim with the Liability and/or Medical Payments Insurance Company? Yes No
    - Which?:_____
    - We will need all applicable claim information, please complete the information below or provide staff with a copy of your personal claim records. *We will also need a copy of the *official accident report.*
12. Liability Claim Information:
    - Insurance Company Name:_____
    - Injury Adjuster's Name:_____
    - Injury Adjuster's Phone#:_____ Fax#:_____
    - Claim #:_____
13. Medical Payments Claim Information:
    - Insurance Company Name:_____
    - MedPay Adjuster's Name:_____
    - Medpay Adjuster's Phone#:_____ Fax#:_____
    - Claim #:_____

O'Donahue Chiropractic

Election Not to File Health Insurance Claims

(Personal Injury/Accident)

The chiropractor(s) at this clinic are participating ("in-network") providers for your health benefit plan. As participating providers, we are obligated to file claims for reimbursement with your plan for all covered services provided to you UNLESS you instruct us in writing not to file.

You have indicated that rather than using your own health insurance, you wish to consider seeking payment from other third-party payors such as the at-fault driver's liability insurance. To help you make an informed decision, please carefully review the following information.

If you elect NOT to file claims on your health insurance:

1. The clinic will rely on your decision and extend credit to you for the cost of care based on the assumption that your bill will be paid by sources other than your health insurance. You will be required to assign to the clinic the right to receive monies paid by liability insurers, medical payments insurers or other third-party payors to the extent necessary to satisfy your bill.

2. You will not be required to pay co-payments/co-insurance and/or deductibles that would normally be required by your health benefit plan.

3. The cost of your treatment will be billed at the clinic's usual rates rather than the discounted rates that routinely apply to services covered by your health benefit plan.

4. If the combined payments received from other sources do not fully satisfy your bill, you may be personally liable for any unpaid balance.

5. None of the charges for your treatment will be applied towards satisfying the annual deductibles associated with your health benefit plan.

If you elect TO file claims on your health insurance:

1. Your health insurance should pay the cost of *covered* services associated with this accident/injury EXCEPT FOR copayments, co-insurance and/or deductibles, which you will be expected to pay directly to the clinic at the time services are rendered.

2. You will be responsible for paying to the clinic the cost of any *non-covered* services you elect to receive, and your payment will be due at the time services are rendered.

3. If your health benefit plan initially pays the clinic for your treatment and later determines that it is not legally responsible for payment, the plan administrator may require the clinic to refund to the plan all or part of the payments received. If that happens, you will become responsible for reimbursing the clinic the amount it was required to refund.

4. Your health benefit plan requires the clinic to submit claims in a timely fashion and while timely filing requirements vary, most plans require claims to be filed within 3-6 months from date of service. If your action or inaction causes a claim to be submitted late, the claim could be denied, and you would be responsible for paying this clinic for those services which were denied.

Election not to file health insurance claims:

1. By my signature below, I attest that I have read and understand the above information regarding the options available to me and have been given an opportunity to ask questions and to have those questions answered.
2. I hereby instruct the clinic not to file claims on my health insurance for services associated with this accident/injury, and I authorize the clinic to seek payment from, and send my treatment records to, other third-party payors who are potential sources of payment.
3. I understand that the clinic is relying on my decision not to file health insurance claims, and that with regards to claims related to this accident/injury, this decision is irrevocable.
4. I understand that no subsequent action on my part shall impair the clinic's right to bill and receive payments from third-party payors; subject only to any contractual obligation the clinic may have to my health benefit plan.

_____	_____
Printed Name of Patient	**Printed** Clinic Representative
_____	_____
Signature of Patient (or parent/legal guardian, as applicable)	Signature of Clinic Representative
_____	_____
Date:	Date:

A complete copy of this executed agreement must be maintained in the patient's health care record, and a copy must be provided to the patient.

O'DonahueChiropractic
Adjust Your Life.

915 E. Firetower Rd. Ste 104
Winterville, NC 28590
Tel: 252.756.0837
Fax: 252.756.7718
ODonahueChiropractic.com

NOTICE OF DOCTORS LIEN

Date:

Attn:

Address:

Re:
Date of Accident:
Claim#:

To Whom It May Concern:

THIS IS TO INFORM YOU THAT WE HAVE TREATED/EXAMINED THIS PATIENT FOR INJURIES SUSTAINED IN THIS ACCIDENT. PURSUANT TO N.C.G.S. s44-49 AND –50, THIS OFFICE HEREBY GIVES NOTICE OF A LIEN UPON ALL FUNDS PAID TO ANY PERSON IN COMPENSATION FOR OR SETTLEMENT OF THE SAID INJURIES, WHETHER IN LITIGATION OR OTHERWISE, WITH RESPECT TO THE BALANCE DUE THIS DOCTOR FOR SERVICES RENDERED.

THE ITEMIZED BILL FOR SERVICES PROVIDED TO THIS PATIENT WILL BE FORWARDED TO YOU FOLLOWING THE CONCLUSION OF TREATMENT.

Sincerely,

James M. O'Donahue, B.A., B.S., D.C.

_____ _____ _____
Patient Name Patient Signature Date

I,_____ a, Notary Public for Pitt County, NC, do hereby certify that

_____ personally appeared before me this day and acknowledged the due execution

of the foregoing instrument. Witness my hand and official seal, this the _____ day of _____,20_____.

_____
Notary Public

My commission expires:_____ {Official Seal}

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

ASSIGNMENT OF BENEFITS

IN CONSIDERATION of the willingness of O'Donahue Chiropractic, P.C. to treat me on credit without demand for payment at the time services are rendered, I hereby agree and stipulate as follows:

I irrevocably assign to O'Donahue Chiropractic, P.C. any proceeds or compensation that I am or may become entitled to receive as a result of injuries that occurred 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, but I hereby authorize and instruct you to pay directly to O'Donahue Chiropractic, P.C. from any disability benefits, medical payments benefits, liability benefits, health and accident benefits, workers compensation benefits, judgments, settlements, or proceeds of any kind that would otherwise be payable to me, such sums as are due to O'Donahue Chiropractic, P.C. for its services rendered.

I appoint O'Donahue Chiropractic, P.C. as my attorney in fact to affix my name as an endorsement upon the reverse of any check or draft upon which I am a named payee and to deposit said check or draft and apply the proceeds to any unpaid balance I may have with O'Donahue Chiropractic, P.C.

I authorize O'Donahue Chiropractic, P.C. to release to any insurer with applicable coverage or to my attorney or successor attorney any information regarding my injuries, prior medical history, or treatment as may be necessary to facilitate collection of proceeds under this assignment.

I acknowledge that I remain personally liable for the total amount due to O'Donahue Chiropractic, P.C. for services rendered, including any balance remaining after the application of insurance payments and settlement or judgment proceeds. If O'Donahue Chiropractic, P.C. is required to take legal action against me to recover any unpaid balance on my account, I agree to reimburse O'Donahue Chiropractic, P.C. for its costs of recovery, including reasonable attorney's fees.

I further agree this assignment of benefits (AOB) cannot be revoked and the right to receive payment cannot be transferred to any other party or re-asserted by me in any way.

_____ _____ _____

Patient Signature Date Claim#

NOTICE OF LIEN

Pursuant to N.C.G.S. 44-49 and 44-50, O'Donahue Chiropractic, P.C. hereby 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.

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

O'Donahue Chiropractic, P.C.
James O'Donahue, D.C.
915 E. Firetower Rd. Suite 104
Winterville, NC 28590
(252) 756-0837 Fax (252) 756-7718

I,_____ a, Notary Public for Pitt County, NC, do hereby certify that _____

personally appeared before me this day and acknowledged the due execution of the foregoing instrument. Witness my hand and

official seal, this the _____ day of _____,20_____.

_____ {Official Seal}

Notary Public

My commission expires:_____