FOUNDATION

Family Chiropractic

PERSONAL INJURY QUESTIONNAIRE

Legal Name _____ Name you go by _____ Date _____

Address _____ City _____ State _____ Zip _____

Age ____ Birthdate __/__/__ SS# _____-____-_____ Sex ( )F ( )M Email: _____

Home Phone _____ Work Phone _____ Cell Phone _____

Emergency Contact: _____ Phone Number: _____

Your Auto Insurance Information

Auto Ins. Co. _____ Claim # _____

Address _____ City _____ State _____ Zip _____

Adjuster's Name _____ Adjuster's Phone # _____ Ext. _____

Policy Holder's Name (if other than self)_____

Accident Details

Date of accident: _____ Time of day: _____ am/pm Were you struck from: *Behind Front Left Right*

Does car have a headrest? *( ) Yes ( ) No* Headrest height at impact? *Bottom of head Bottom of Neck Middle of head*

Number of people in vehicle:_____ Were you wearing a seat belt? *( ) Yes ( ) No* Were you: *Driver or Passenger?*

Were you in the *front seat* or *back seat*? Approx speed of your car:____ mph Approx speed of other car:___ mph

Were you knocked unconscious? *( ) Yes ( ) No If yes, for how long?* ____ Were the airbags deployed? *( ) Yes ( ) No*

Were the police notified? *( ) Yes ( ) No* Do you have an accident report? *( ) Yes ( ) No* *please provide a copy

Was a traffic violation issued? ( ) Yes ( ) No If yes, to whom: _____

Were there witnesses? If so, please name: _____

In your own words, please describe the accident:

_____

_____

_____

Did you have any physical complaints before the accident? ( ) Yes ( ) No
If yes, please describe: _____

Please describe how you felt:
During the accident _____

Immediately after the accident _____

Later that day _____

Have you been treated by another doctor since the accident? ( ) Yes ( ) No
If yes, please write down their names: _____

Since the injury occurred, are your symptoms ( ) improving ( ) getting worse ( ) the same

CHECK SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT:

( ) Headache	( ) Irritability	( ) Numbness in toes	( ) Flushed face	( ) Neck pain
( ) Chest pain	( ) Back Pain	( ) Shortness of breath	( ) Buzzing in ears	( ) Stiff neck
( ) Dizziness	( ) Fatigue	( ) Loss of balance	( ) Fainting	( ) Depression
( ) Diarrhea	( ) Heavy Head	( ) Memory Loss	( ) Loss of Taste	( ) Fever
( ) Cold Feet	( ) Cold Hands	( ) Ringing in ears	( )Constipation	( ) Loss of smell
( ) Nervousness		( ) Pin/Needles in legs		( )Difficulty breathing
( ) Numbness in fingers		( ) Pins/Needles in arms		( ) Upset stomach
( ) Light Sensitive Eyes		( ) Other _____	( ) Other _____	

Have you ever been involved in an accident before? ( ) Yes ( ) No
If yes, please describe, including dates and types of accidents as well as injuries suffered:
_____

Have you lost time from work as a result of this accident? ( ) Yes ( ) No
If yes, last day worked:

Type of Employment:_____ Place Of Employment: _____

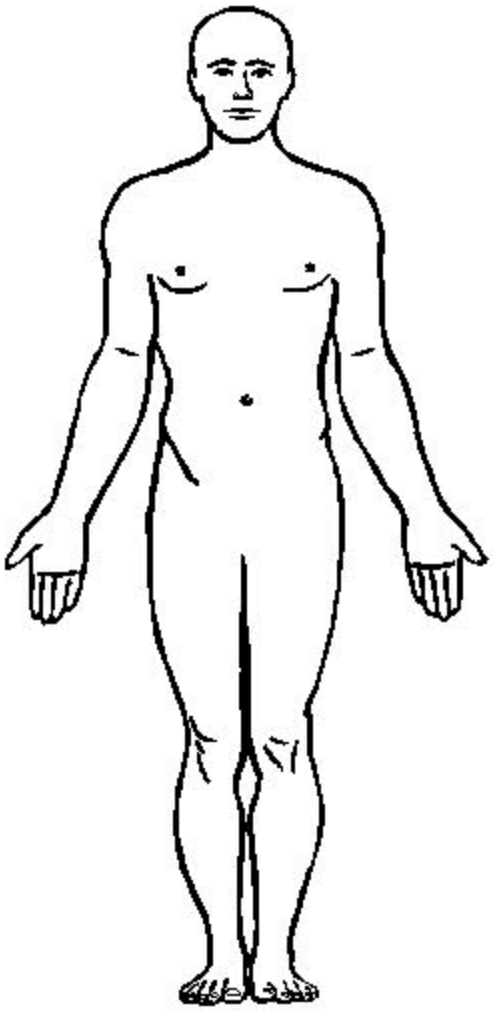
Did you notice any activity restrictions as a result of this injury? ( ) Yes ( ) No
If yes, please describe: _____

_____

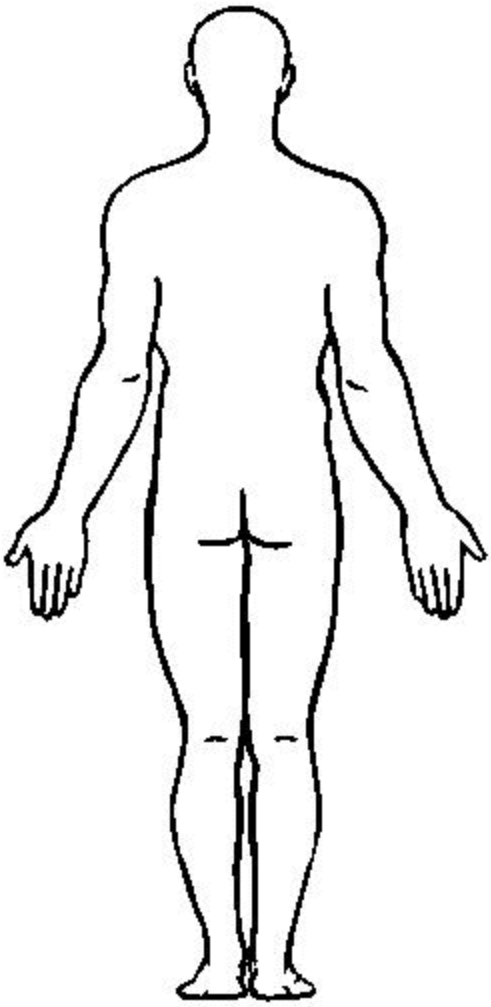
General Symptoms Sheet

Please use the following notations on the figures below to indicate the type and location of your symptoms, as it relates to the purpose of your visit today.

A = ACHE	G = STABBING	N = NUMBNESS
B = BURNING	M = SPASMS	T = TINGLING
P = PINS & NEEDLES	F = STIFFNESS	O = OTHER



FRONT



BACK

If you marked “O” for OTHER on any part, please explain below:

_____

_____

_____

_____

QUADRUPLE VISUAL ANALOGUE SCALE

Name _____ **Date** _____

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

NOTE: If you have more than one complaint, please answer each question for each Individual complaint and indicate which score is for which complaint.

EXAMPLE:

	HEADACHE				NECK						LOW BACK
No Pain	0	1	2	3	4	5	6	7	8	9	10 Worst Pain

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1. What is your pain RIGHT NOW?

No Pain	0	1	2	3	4	5	6	7	8	9	10 Worst Pain

2. What is your TYPICAL or AVERAGE pain?

No Pain	0	1	2	3	4	5	6	7	8	9	10 Worst Pain

3. What is your pain AT ITS BEST (How close to "0" does your pain get at its best)?

No Pain	0	1	2	3	4	5	6	7	8	9	10 Worst Pain

4. What is your pain AT ITS WORST (How close to "10" does your pain get at its worst)?

No Pain	0	1	2	3	4	5	6	7	8	9	10 Worst Pain

PERSONAL INJURY OFFICE POLICY

We would like to take this opportunity to welcome you to the office and assure you that you will receive the very best care available for your injury. In order to familiarize you with the financial policy of our office, we would like to explain how your medical bills will be handled. Please initial where indicated and sign below that you have read and understand this policy.

Responsibility for Accident

If you were involved in an auto accident, that you were responsible for, in your own vehicle, we will bill your medical portion of your car insurance policy (if available) for services rendered in our office. If you were a passenger in another vehicle, the car insurance company that insures that vehicle may be billed for the charges of your medical services. If another vehicle, other than the vehicle you traveled in, caused the accident, we will first bill your auto insurance for medical services rendered. If your car insurance policy does not include a medical pay portion, we will require that you sign a lien and obtain an attorney. By signing the lien we agree, as a courtesy to you, to defer payment of your medical bills until your settlement is received. If care is discontinued before your treatment plan is complete, payment of your account is due immediately. This office does not discount or reduce the amount of your balance based upon the outcome of your settlement.

_____

Your initials

Responsibility for Payment

If you already have an attorney, please provide the name and contact info on the sheet provided. Ask your attorney to send us a letter of representation. A release packet including your bills and records will be sent to your attorney after your release exam. If you do not plan to retain an attorney and are, instead, filing claims to an insurance company, you will need to contact the insurance company and provide us with all information for billing including name, contact information and claim number. No bills or copies of bills will be given to you until the attorney or insurance company has given us an indication that they will do everything possible to protect the interest of Foundation Family Chiropractic. As a courtesy to you, we will provide your insurance company and/or attorney with all the information they might need to negotiate and provide payment for any charges you incur in our office. However, all charges for services rendered in our office are charged directly to you and ultimately you are personally responsible for payment of these charges.

_____

Your initials

Cancellation & No-show Policy

Appointments you schedule are reserved especially for you. If you need to reschedule or cancel an appointment, we request and appreciate a minimum of 24-hours notice. If it is necessary to miss an appointment, we request that you make the appointment up, within 24 hours, if possible. Patients who miss 3 consecutive visits without calling this office will be discharged from care. Your claim will be closed out and bills submitted to the appropriate insurance company or the attorney listed on your patient intake form.

_____

Your initials

I hereby authorize and direct my attorney or insurance company to pay to Foundation Family Chiropractic such sums as may be due for chiropractic services rendered me by reason of the accident and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect and fully compensate Foundation Family Chiropractic . And I hereby further request that payment be made directly to Foundation Family Chiropractic which would otherwise be paid to myself, as the result of the treatment charges injured for the injuries in connection therewith. This is a direct assignment of my rights and benefits under this claim. I understand that I am directly and fully responsible for all medical bills submitted for services rendered me and that this agreement is made solely for the protection and in consideration Foundation Family Chiropractic for awaiting payment. And I further understand that such payments are not contingent on any settlement, judgment or verdict which I may eventually recover. Please acknowledge your agreement to this request by initialling above and signing below.

Date	**Patient's Name**	**Signature**	**Date of Injury**

Complete below if you are using an attorney

Foundation Family Chiropractic
455-A Old Trolley Road Summerville, SC 29485
843-851-2417 (phone) 843-875-3817 (fax)
EIN: 81-3609472

NOTICE OF LIEN

Letter of Protection / Irrevocable Assignment of Benefits

Patient's Name: _____If Minor, Guardian or Responsible Party: _____

Accident Date: _____ Attorney's Name: _____

Law Firm Name and Address: _____

Ph # _____ E-Mail _____

I, _____, do hereby authorize this office to furnish the above listed attorney with a full report of my examination, diagnosis, treatments, prognosis etc., in regard to the accident in which I was involved.

I hereby direct my attorney to withhold the full amount for the billed charges in connection to this accident. I hereby notify my attorney that I have a lien from the above provider's office in consideration of their willingness to treat me on credit without demand for payment at the time services are rendered. I instruct my attorney to pay for all services rendered directly to the provider, Foundation Family Chiropractic, within 14 days, of my case settlement. I understand that any settlement, verdict, or judgement cannot be distributed to me without first satisfying this lein.

I agree to promptly notify Foundation Family Chiropractic of any change or addition of attorney(s) used by me in connection with this accident, and I instruct my attorney to do the same and to promptly deliver a copy of this lien to any such substituted or added attorney(s). I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment but may declare the entire balance due and payable.

I Understand that the bills which I incur at Foundation Family Chiropractic are my responsibility. I acknowledge that this office will **not** bill to my health insurance companies but that I can submit bills myself for reimbursement, if any. I further agree that if the proceeds from the accident are not enough to satisfy my bill that Foundation Family Chiropractic reserves the right to pursue collection of any outstanding balance.

Date: _____ Patient or Legal Guardian Signature: _____

Date: _____ Staff/Witness Signature: _____

THE UNDERSIGNED ATTORNEY AND HIS/HER FIRM ACKNOWLEDGES AND HEREBY AGREES TO OBSERVE ALL THE TERMS ABOVE AND AGREES TO WITHHOLD SUCH SUMS FROM ANY SETTLEMENT, JUDGEMENT OR VERDICT, AS MAY BE NECESSARY TO ADEQUATELY PROTECT AND FULLY COMPENSATE THE FOUNDATION FAMILY CHIROPRACTIC. ATTORNEY FURTHER AGREES TO PAY FOUNDATION FAMILY CHIROPRACTIC DIRECTLY OUT OF THE PROCEEDS FROM THE SETTLEMENT AND NOT AFTER DISTRIBUTION TO THE PATIENT. ATTORNEY AGREES TO MAKE PAYMENT DIRECTLY TO FOUNDATION FAMILY CHIROPRACTIC.

Date: _____ Attorney's Signature: _____

Attorney: Please sign/date and return one copy to this office and retain a copy for your records.

Complete if you are NOT using an attorney and are filing directly to an insurance company

Foundation Family Chiropractic
455-A Old Trolley Road Summerville, SC 29485
843-851-2417 (phone) 843-875-3817 (fax)
EIN: 81-3609472

Insurance / Assignment of Benefits

Patient's Name: _____If Minor, Guardian or Responsible Party: _____

Accident Date: _____

Liability Info

Your Health Insurance Name: _____ Policy # _____

(Please provide this office with a copy of your health insurance card)

OR

Your Auto Insurance Name: _____ Policy # _____

(Please provide this office with a copy of your auto insurance card)

Your Auto Insurance Agent or Adjustor's Name: _____

Your Auto Insurance Agent or Adjustor's Ph # _____

Claim # for this accident: _____

Name of responsible party: _____ Their ph # _____

Responsible Party's Auto Insurance Name: _____ Policy # _____

Their Auto Insurance Agent or Adjustor's Name: _____

Their Auto Insurance Agent or Adjustor's Ph # _____

Claim # for this accident: _____

I, _____, do hereby authorize this office to furnish the above listed insurance company, with a full report of my examination, diagnosis, treatments, prognosis etc., in regard to the accident in which I was involved.
I hereby direct the insurance company to withhold the full amount for the billed charges in connection to this accident. I hereby notify the insurance company that I have a lien from the above provider's office in consideration of their willingness to treat me on credit without demand for payment at the time services are rendered. I instruct the insurance company to pay for all services rendered directly to the provider, Foundation Family Chiropractic. I understand that any settlement, verdict, or judgement cannot be distributed to me without first satisfying this lein. I clearly understand that the bills which I incur at Foundation Family Chiropractic are my responsibility.

Date: _____ Patient or Legal Guardian Signature: _____

Date: _____ Staff/Witness Signature: _____

Foundation Family Chiropractic

Medical Information Release Form
HIPPA Release Form

Name: _____ Date of Birth: _____
Print Name

Release of Information:

[ ] I authorize the release of information including the diagnosis, records, examination rendered to me as well as financial obligations and claims information. This information may be released to:

[ ] Spouse_____
[ ] Child(ren)_____
[ ] Other _____
[ ] Information is not to be released to anyone.

The Release of Information will remain in effect until terminated by me in writing.

Phone and Text Messages:

Please call [ ] my home [ ] my work [ ] my mobile number:_____

If unable to reach me:
[ ] you may leave a detailed message
[ ] please leave a message asking me to return your call
[ ]_____

The best time to reach me is (day)_____ between (time)_____

Signature of patient or guardian: _____ Date: _____

Foundation Family Chiropractic

Summerville
455 Trolley Rd Ste A 270
Summerville, SC 29485
843-851-2417

St George
903 Dukes St Ste 1
St George, SC 29477
843-560-8445

Mt Pleasant
1300 Hospital Dr Ste
Mt Pleasant, SC 29464
843-614-3226

Foundation Family Chiropractic

455-A Old Trolley Road~Summerville~SC~29485

CHIROPRACTIC INFORMED CONSENT TO TREAT

I hereby consent to the performance of chiropractic procedures, including spinal manipulations (adjustments), various modes of physiotherapy, diagnostic x-rays, and any supportive therapies on me (or the patient named below, for whom I am legally responsible) by the doctor(s) of Foundation Family Chiropractic and/or other licensed chiropractors who now or in the future treat me while employed by or serving as a fill in chiropractor.

I understand that chiropractic, like all forms of health care treatments, holds certain risks. While the risk is often minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and strokes, which occur at a rate of 1 in 2 million people, have been associated with chiropractic adjustments. I do not expect the doctor to be able to anticipate all risks and complications. I wish to rely on the doctor's judgment and expertise during the course of my treatment based upon the facts then known and in my best interest.

I have read, or have had read to me, the above consent. By signing below, I agree to chiropractic treatment as recommended by the doctor. I intend this consent form to cover the entire course of treatment for my present condition(s) and for any future condition(s) for which I seek treatment.

Print Patient's Name _____ **Patient Signature** _____ **Date** _____

Below to be completed by the patient's representative, if necessary (Patient is a minor or is incapable of completing form)

Print Representative's Name _____ **Representative's Signature** _____ **Relationship to patient** _____

NOTICE OF PRIVACY PRACTICE

I have read the Patient Privacy Notice, included with this paperwork and also located in the notebook in the waiting room. I understand my rights as well as the practice's duty to protect my health information and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this Notice of Privacy Practice at any time in the future and will make the new provisions effective for all information that it maintains past and present. I am aware that a more comprehensive version of this "Notice" is available to me and copies are kept in the waiting room and at the front desk. At this time, I do not have any questions about my rights or any of the information I have received.

Print Patient's Name _____ **Patient Signature** _____ **Date** _____

Below to be completed by patient's representative, if necessary (Patient is a minor or is incapable of completing form)

Print Representative's Name _____ **Representative's Signature** _____ **Relationship to patient** _____