Lake Norman Chiropractic

Personal Information

Name:_____
First Initial Last

Address:
_____
Street City State Zip

Home Phone: _____

Cell Phone: _____

Work Phone: _____Ext. _____

Email:_____

SSN: ____-___-_____ Date of Birth: ___/___/_____ Sex: ___

Occupation: _____ Employer: _____

Marital Status: □ Single □ Married □ Divorced □ Widowed

Spouse's Name/Number:
_____

Emergency Contact:
_____
Name Number Relationship

How will you be covering the cost of care?
□Self-Pay
□Insurance Carrier:_____ ID#:_____ Group#:_____
□Personal Injury: Attorney:_____ and/or Claim#:_____
□Other: _____

How were you referred to our office?
_____

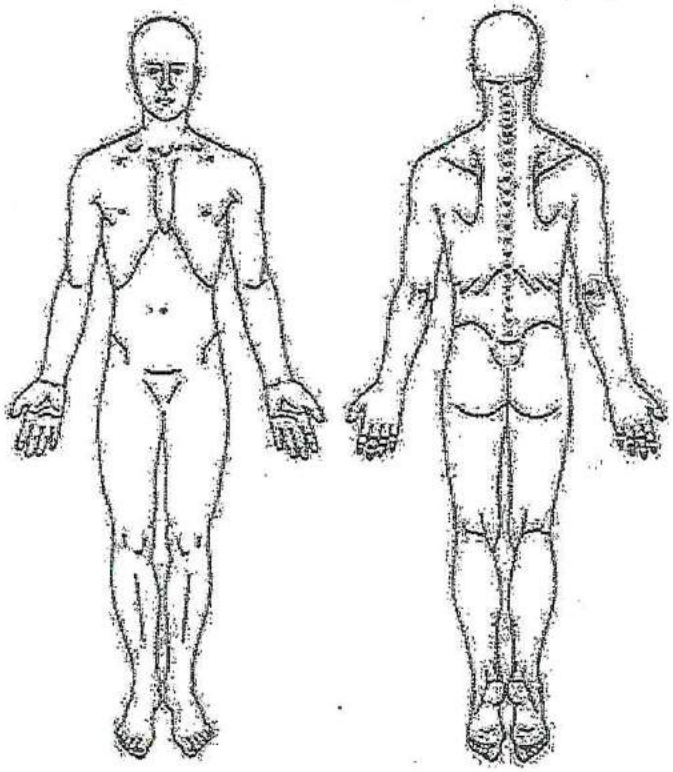
Health Questionnaire

Name:_____ Date:_____

A. Complaints:

Using the key below, indicate on the body diagram where you are experiencing your symptoms:

N = Numbness B = Burning S = Stabbing T = Tingling A = Aching



Describe your symptoms in order of severity, with worse symptoms being #1:

_____

_____

_____

When did your symptoms begin? Date: _____

How would you rate your pain today? (0 = No pain, 10 = worst pain ever)

0 1 2 3 4 5 6 7 8 9 10

Is your condition due to:

- □ An automobile accident?
- □ A work-related injury?
- □ Other: _____

How often do your symptoms occur?

□ Occasional □ Intermittent □ Frequent □ Constant □Other:_____

Is your complaint aggravated by any of the following?

□ Coughing □ Sneezing □ Bowel Movements □ Lifting
□ Bending □ Sitting □ Standing □ Walking
□ Reaching □ Neck Movement □ Driving □ Exercise
□ Other: _____

Is your complaint relieved by any of the following?

□ Rest □ Ice □ Heat □ Stretching □ Exercise
□ Sitting □ Standing □ Laying down □ Sleeping
□ Nothing □ Other: _____

Since your symptoms began, have there been any changes to the following:

□ Bowel Function: Onset Date:_____ Duration: _____
□ Bladder Function: Onset Date:_____ Duration: _____
□ Sexual Function: Onset Date:_____ Duration: _____

B. Review of Systems:
Are you presently suffering from, or have suffered from any of the following?

General: □ Fatigue □ Weakness □ Fever □ Sleep loss □ Chills
□ Weight Loss □ Night Sweats

Neurological: □ Headache □ Dizziness □ Fainting □ Convulsions □ Double Vision

Mouth/Throat: □ Sores □ Bleeding □ Enlarged Glands □ Loss of taste
□ Abnormal taste □ Change in smell □ Difficulty swallowing

Heart/Lungs: □ Cough □ Difficulty Breathing □ Swollen arms/legs
□ Blue discoloration □ Varicose veins □ Murmur □ Chest pain
□ Heaviness in legs with walking □ Heart Palpitations

Gastrointestinal: □ Decreased appetite □ Increased Appetite □ Vomiting
□ Abdominal pain □ Hemorrhoids □ Diarrhea □ Constipation

Genitourinary: □ Inability to hold urine □ Painful urination □ Bedwetting □ Impotence
□ Frequent Urination □ Irregular menstruation □ Painful menses
□ Prostate problems □ Loss of bowel/bladder control

Endocrine: □ Intolerance to heat □ Intolerance to cold □ Tremors □ Neck Lump
□ Sugar in urine □ Diabetes □ Constant fatigue

Psychological: □ Anxiety □ Depression □ Memory loss □ High stress
□ Mood swings □ Mental impairment □ Phobias

Are there any other symptoms not listed above that you are experiencing?
Please List: _____

Social History

Smoking:	□ Never	□ Occasional	□ Often: Packs/Day: _____
Alcohol:	□ Never	□ Occasional	□ Often: Drinks/Day: _____
Exercise:	□ Never	□ Occasional	□ Often
Caffeine Use:	□ Never	□ Occasional	□ Often

C. Medical History

Have you been to a Chiropractor before? ☐ Yes ☐ No

Do you have a family physician? ☐ Yes ☐ No

Physician's name/address: _____

Date of last physical exam: _____

Do you have any allergies and/or allergic reactions to medications?

☐ No ☐ Yes (Please list) _____

Please list any medications you are currently taking:

_____

_____

Women Only:

Are you or could you be pregnant at this time? ☐ Yes ☐ No

Do you regularly see an OB-GYN? ☐ Yes ☐ No

Please check any condition you currently have or have had in the past:

☐ Arthritis ☐ Diabetes ☐ Thyroid issues ☐ Cancer
☐ Scoliosis ☐ Epilepsy ☐ HIV/AIDS ☐ Heart trouble
☐ High Blood pressure ☐ Pacemaker ☐ Multiple Sclerosis (MS)
☐ Osteoporosis (DJD) ☐ Depression ☐ STI's
☐ Other: _____

To your knowledge, does your family history include any of the following conditions?

☐ Cancer ☐ Stroke ☐ Arthritis ☐ Diabetes ☐ Heart Disease
☐ High Blood Pressure ☐ Rheumatoid Arthritis ☐ Thyroid Issues ☐ Other:_____

Occupation Information – Activities of Daily Living

Job Type: ☐ Full Time ☐ Part Time ☐ Temporary ☐ Other: _____

Work Week: Hours/Day: 1 2 3 4 5 6 7 8 9 10 11 12 13+
(Circle one) Days/Week: 1 2 3 4 5 6 7

What activities does your job involve? (Mark all that apply)

☐ Sitting ☐ Typing ☐ Lifting – Weight_____ ☐ Walking
☐ Twisting ☐ Bending ☐ Reaching ☐ Stooping

What is your primary work position/location? (Mark one)

☐ Seated ☐ Standing ☐ Both equally

Is there anything not covered in the questionnaire that you feel is important for the doctor to know?

_____

_____

Lake Norman Chiropractic

Patient's Name: _____

THE PATIENT IDENTIFIED ABOVE AUTHORIZES LAKE NORMAN CHIROPRACTIC CENTER, P.A. TO USE AND/OR DISCLOSE PROTECTED HEALTH INFORMATION IN ACCORDANCE WITH THE FOLLOWING:

SPECIFIC AUTHORIZATIONS

I give permission to Lake Norman Chiropractic Center, P.A. to use my address, phone number, and clinical records to contact me with appointment reminders, missed appointment notifications, birthday cards, holiday-related cards, information about treatment alternatives or other health related information.

If Lake Norman Chiropractic Center, P.A. contacts me by phone, I give them permission to leave a phone message with a member of my household and/or my answering machine/voicemail.

I give Lake Norman Chiropractic Center, P.A. permission to treat me in an area where other patients are also being treated. I am aware that other persons in the office may overhear some of my protected health information during the course of care. Should I need to speak with the doctor at any time in private, the doctor will provide a room for these conversations.

I give Lake Norman Chiropractic Center, P.A. permission to use my first initial and last name on their internal referral board if and when I refer people to their office for evaluation and treatment.

By signing this form, you are giving Lake Norman Chiropractic Center, P.A. permission to use and disclose your protected health information in accordance with the directives listed above.

This notice is effective as of the date of the signed authorization. This authorization shall expire seven years after the date on which you last received services from Lake Norman Chiropractic Center, P.A.

RIGHT TO REVOKE AUTHORIZATION

You have the right to revoke this authorization, in writing, at any time. However, your written request to revoke this authorization is not effective to the extent that we have provided services or taken action in reliance on your authorization.

You may revoke this authorization by mailing or hand delivering a written notice to the privacy official of Lake Norman Chiropractic Center, P.A. The written notice must contain the following information:

- Your name, social security number, and date of birth
- A clear statement of your intent to revoke this authorization
- The date of your request
- Your signature

The revocation is not effective until it is received by our compliance/privacy officer.

This authorization is requested by Lake Norman Chiropractic Center, P.A. for its own use/disclosure of private health information.

You have the right to refuse to sign this authorization. If you refuse to sign, Lake Norman Chiropractic Center, P.A. will not refuse to provide treatment.

A COPY OF THE SIGNED AUTHORIZATION WILL BE PROVIDED TO YOU UPON REQUEST

Print Name: _____

Signature: _____

Date: _____

Signature of parent/guardian: _____

Relationship to patient: _____

Informed Consent Form

PATIENT NAME: _____ DATE: _____

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

The nature of the chiropractic adjustment

The primary treatment procedure used by Doctors of Chiropractic is spinal manipulative therapy. The doctor may use his/her hands or a mechanical instrument on your body in such a way as to create motion in joints. This procedure may cause an audible "pop" or "click"; similar to what you experience when you "crack" your knuckles. You may feel an increased sense of movement.

Analysis / Examination / Treatment

As part of the analysis, examination, and treatment, you are consenting to the following procedures in order for the doctor to make the most accurate diagnosis and provide the most effective treatment for your condition:

□Spinal Manipulative Therapy	□Radiographic Studies	□Heat Therapy
□Range of Motion Testing	□Palpation	□Cold Therapy
□Muscle Strength Testing	□Orthopedic Testing	□Vital Signs
□Therapeutic Ultrasound	□Postural Analysis	□Electrical Stimulation
□Mechanical Traction	□Neurological Testing	□Soft Tissue Massage

□ Other: _____

_____

The material risks inherent in chiropractic treatment

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 strains, cervical myelopathy, ligament sprains, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the upper cervical spine leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment, this is not uncommon. The doctor 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 the doctor's attention, it is your responsibility to inform him/her.

The probability of those risks occurring

Fractures are a rare occurrence and generally result from an underlying weakness of the bone which the doctor will check for during your history, the exam, and X-rays. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and estimated to occur between one in one million and one in five million neck adjustments. The other complications listed are 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/prescription drugs such as anti-inflammatory, muscle relaxers, and pain-killers
- Hospitalization
- Surgery
- Other manual therapies such as massage, acupuncture, or physical therapy

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

The risks and dangers to remaining untreated

Remaining untreated may allow for the formation of scar tissue and a loss of mobility. If left to progress, this could potentially lead to a cascade of pain reactions and further reduction of mobility causing more permanent changes to your joints and soft tissues. Over time this process may complicate future treatment making it more difficult and less effective as the damage builds up the longer it is postponed.

DO NOT SIGN THIS UNTIL YOU HAVE READ AND UNDERSTOOD THE ABOVE INFORMATION

PLEASE CHECK THE APPOPRIATE BOX AND SIGN BELOW

☐ **I have read or have had read to me the above explanation of the chiropractic adjustment and related treatment. I have discussed any questions/interpretations with the doctor and had them answered to my satisfaction. By signing below, I state that I have compared the risks and benefits involved in receiving chiropractic treatment and have decided that it is in my best interest to undergo the treatment recommended by the doctor. Having been informed of the procedures, risks, and benefits, I hereby give my consent to receive treatment.**

Date: _____ **Date:** _____

_____ _____

Patient's Name **Doctor's Name**

_____ _____

Patient's Signature **Doctor's Signature**

_____

Signature of Parent/Guardian (if a minor)

Lake Norman Chiropractic
Todd Abernathy, DC, CCSP
Daniel Zagst, DC

612 North Main St.
Mooresville, NC 28115

P: (704) 664 – 3455
F: (704) 664 – 2827

Lien

I hereby authorize and direct you, the insurance company, and/or my attorney, to pay directly to **Lake Norman Chiropractic Center, P.A.** such sums as may be due and owing this office for services rendered to me, both by reason of accident, illness and by reason of any other bills that are due this office, and to withhold such sums from any disability benefits, medical payment benefits, liability benefits, health and accident benefits, workmen's compensation benefits, or any other insurance benefits obligated reimburse me or from any settlement, judgement, or verdict, on my behalf as may be necessary to adequately protect said office. I hereby further give a lien to said office against any and all insurance named herein, and any and all proceeds of any settlement, judgement or verdict which may be paid to me as a result of the injuries or illness for which I have been treated by said office. This is to act as an assignment of my rights and benefits to the extent of the office's services provided. **I understand that I remain personally responsible for the total amounts due the office for their services.** I further understand and agree that this assignment, lien, and authorization does not contribute any consideration for the office to await payments and they may demand payment from me upon rendering services at their option. I authorize this office to release any information pertinent to my case to any insurance company or attorney to facilitate collection under this assignment, lien, and authorization. I agree that the above mentioned office be given power of attorney to endorse my name on any and all checks for payment of my doctor bill. I further understand and agree, that if this office must take any action to collect an outstanding balance on my account, I will be responsible for payment of and will reimburse this office for all cost of such collection efforts, including, but not limited to, all court costs and attorney fees. I fully understand that upon settlement, by signing this agreement and without exception, I cannot use G.S. 44.49, Supplement or G.S. 44.50. The above general statutes mention recoveries for personal injury. I acknowledge my acceptance by my signature, which is witnessed to waive use of the above general statutes. Please acknowledge this letter by signing below. 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 will require me to make payments on my current balance.

_____ _____

Patient or Guardian Signature **Date**

_____ _____

Witness **Date**

Automobile Crash Questionnaire

- **Vehicle you were in:**

- Vehicle Type (Circle One)
  Car Van Station Wagon Pickup Truck Bus
  Other_____

- Vehicle Size (Circle One)
  Subcompact Compact Mid-Size Full-Size Mini Light
  Other_____

- What was your location in the vehicle? (Circle One)
  Drive Front Passenger Left Rear Passenger Right Rear Passenger Center Rear Passenger

- What was the vehicle you were in doing? (Circle only ONE below to answer this question)
  - Vehicle stopped for: Traffic Light Intersection Stop Sign Traffic Pedestrian Turning Parked Other_____
  - Vehicle slowing down for: Traffic Light Intersection Stop Sign Traffic Pedestrian Turning Parking Other_____
  - Vehicle Moving: Slowly Moderately Fast Accelerating Other_____
  - Vehicle Doing something else:
    _____

- What damage did the vehicle you were in sustain: (Circle One)
  Minimal Moderate Extensive Totaled Unsure
  Other_____

- **Other Vehicles that were involved in the Accident**

- First Vehicle to strike you in Accident:
  - Vehicle Type: Car Van Station Wagon Pickup Truck Bus
    Other_____
  - Vehicle Size: Subcompact Compact Mid-Size Full-Size Mini
    Other_____
  - How did this vehicle strike the one you were in? (Circle One)
    Head On From Right From Left Rear-Ended Sideswiped on right/left
    Other_____
  - What damage did this vehicle sustain? (Circle One)
    Minimal Moderate Extensive Totaled Unsure
    Other_____

- Were traffic citations issued as a result of the accident? (Circle One)
  No citations issued Driver of other vehicle Driver of vehicle you were in You

Unsure

- **Additional Information about your Automobile Accident:**

_____
_____
_____
_____

ACCIDENT INJURY QUESTIONNAIRE

- Date of Injury: ___/___/___ Time of Injury: _____am/pm
- Hospital visit after accident/injury:
  - When did you go to the hospital?
    _____
  - Hospital Name:
    _____
  - Examined by Doctor:
    _____
  - Admitted? Y / N Date Discharged:
    _____
  - If x-rays were taken, of what body parts?
    _____
    _____
  - If a CAT Scan was performed, of what body parts?
    _____
    _____
  - If an MRI was performed, of what body parts?
    _____
    _____
  - What was the diagnosis given at the hospital?
    _____
    _____
    _____
  - What treatment was administered at the hospital?
    _____
  - When you were discharged from the hospital, were you told to follow up with anyone? Y / N
    If yes, then with who?
    _____
  - Was medication prescribed?

_____

- Following the accident/ injury
  - How much later did additional symptoms develop?

    _____

    _____
  - What additional symptoms developed?

    _____

    _____

    _____
  - Since your accident/injury have you suffered from any of the following? (Circle all that Apply)

    Blurred Vision Double Vision Reduced Vision Impaired Hearing Ringing in Ears Nausea Vomiting Chest Pain Difficulty Breathing Palpitations Constipation Diarrhea Frequent Urination Inability to hold urine Painful Urination
  - Additionally have you experienced any of the following? (Circle all that apply)

    Anxiety Depression Mood Swings Nervousness Poor Memory Tension Convulsions Dizziness Headaches Fainting Loss of balance Light Sensitivity Restlessness Fatigue Insomnia Weakness Reduced Appetite Weight gain Weight loss
  - Are you restricted in any of the following areas as a result of this accident/injury?

    Daily Living Occupational/Work Recreational Activities
  - Have you missed work due to this accident/injury? Y / N If yes, then how much?

    _____
  - Did you self-treat your symptoms? Y / N If yes, then how & with what?

    _____
  - Did you seek medical care elsewhere?

    _____
  - What is the reason for seeking today's consultation?

    _____

    _____
- Insurance / Attorney Information:
  - Have you contacted an insurance adjuster or representative regarding this claim? Y / N

    Company:

    _____

    _____

    Adjuster:

    _____

    _____

Claim Number:

_____

- Have you engaged the service of an attorney? Y / N
  Attorney:

  _____

  ___
  Address:

  _____

  ____
  City: _____ State: _____ Zip: _____ Phone:

  _____

- Have you filed an accident/injury report? Y / N
- Have you filed for insurance benefits? Y / N

Patient's or Guardian's Signature:

_____

Date: _____

Lake Norman 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:

- 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.

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

- 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.

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

- 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.

- 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:

- 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.
- 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.
- 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.
- 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.