PERSONAL INJURY REFERENCE SHEET

VITALITY
CHIROPRACTIC & WELLNESS

DATE OF INJURY ___-___-_____

TODAY'S DATE: _____

INSURANCE COMPANY NAME _____

INSURANCE COMPANY ADJUSTER _____

CLAIM # _____

IS YOUR CLAIM OPEN OR CLOSED? _____

DO YOU HAVE AN ATTORNEY (YES OR NO)?_____

ATTORNEY PHONE NUMBER: _____

DO YOU HAVE HEALTH INSURANCE (YES OR NO)? _____

HAVE YOU HAD IMAGING? _____

HAVE YOU SEEN ANY OTHER PROVIDER FOR THIS CONDITION YES OR NO)? _____

MOTOR VEHICLE CRASH FORM

Patient Name:_____ Today's Date:_____

Date of Injury:_____ Time of Injury _____ ☐ AM ☐ PM

City where crash occurred:_____Was the street wet or dry? ☐Wet☐Dry

Street (location) where crash occurred:_____

What is the estimated damage to your vehicle? $_____

Who made the damage estimates on your vehicle? _____

Who owns the vehicle you were involved in: _____

☐ Yes ☐ No Did the police come to the accident scene and make a report?

☐ Yes ☐ No Were you cited by the police? If yes, name of officer:_____

Describe how the crash happened:

_____

_____

_____

_____

COLLISION DESCRIPTION-TYPE(Check all that apply to the crash you were involved in)

☐ Single-car crash	☐ Two-vehicle crash	☐ Three or more vehicles
☐ Rear-end crash	☐ Side crash	☐ Rollover
☐ Head-on crash	☐ Hit guard rail, tree, or object	☐ Ran off the road

☐Other (Describe): _____

INDICATE YOUR SEATING POSITION

☐ Driver ☐ Front Passenger ☐ Left Rear Passenger ☐ Right Rear Passenger

DESCRIBE THE VEHICLE YOU WERE IN:

Make, Model and Year:_____

☐ Small-sized car	☐ Mid-sized car	☐ Large-sized car
☐ Pick-up truck	☐ Van	☐ Sport Utility Vehicle
☐ 2 Door Vehicle	☐ 4 Door Vehicle	☐ Large truck,bus or semi-
☐ Sedan	☐ Hatchback	☐ Stationwagon

☐ Other(Describe):_____

DESCRIBE THE OTHER VEHICLE:

Model, Make and Year:_____ ☐ Unknown

☐ Small car ☐ Mid-sized car ☐ Van

☐ Pick-up truck/SUV ☐ Full sized car ☐ Large truck, bus or semi

AT THE TIME OF IMPACT YOUR VEHICLE WAS:

☐ Slowing down ☐ Gaining speed

☐ Stopped ☐ Moving at steady speed

AT THE TIME OF IMPACT OF THE OTHER VEHICLE WAS:

☐ Slowing down ☐ Gaining Speed ☐ Unknown speed

☐ Stopped ☐ Moving at steady speed ☐ Other:_____

DURING AND AFTER THE CRASH, YOUR VEHICLE:

☐ Kept going straight, not hitting anything ☐ Spun around, not hitting anything

☐ Kept going straight, hitting car in front ☐ Spun around, hitting another car

☐ Was hit by another vehicle ☐ Spun around, hitting other object

INDICATE IF YOUR BODY HIT SOMETHING OR WAS HIT BY ANY OF THE FOLLOWING: Please draw lines from the body regions on the left to match the right side.

BODY REGION	OBJECT YOU HAD CONTACT WITH
Head	Windshield
Face	Side Window
Shoulder	Side Door
Arm/Hand	Dashboard
Front chest wall	Knee bolster/glove compartment
Side chest wall	Seatbelt
Hip/Abdomen	Frame of car near windows
Knee	Roof of vehicle
Leg	Another occupant/animal
Foot	Other

CHECK IF ANY OF THE FOLLOWING VEHICLE PARTS BROKE, BENT OR WERE DAMAGED IN YOUR CAR:

☐ Windshield ☐ Seat frame ☐ Knee bolster

☐ Steering wheel ☐ Side-rear window ☐ Other

☐ Dashboard ☐ Mirror ☐ Other

ALL TYPES OF COLLISIONS: Indicate those relevant to your case.

YES	NO	
☐	☐	Did any of the front or side structures, such as the side door, dashboard, or floorboard of your car dent inward during the crash?
☐	☐	Did the side door touch your body during the crash?
☐	☐	Did your body slide under the seatbelt?
☐	☐	Was the door(s) of your vehicle damaged to the point where you could not open the door?
☐	☐	Did an airbag deploy in your vehicle during the crash?
☐	☐	Were you intoxicated(alcohol) at the time of crash?
☐	☐	Were you wearing a seatbelt?
		If yes, does your seatbelt have a: ☐ Lap & Shoulder strap ☐ Lap belt only
☐	☐	Indicate if you had any portion of your seatbelt positioned behind your back or shoulder?
☐	☐	Were you holding onto the steering wheel(driver only) at the time of impact?

If yes, Indicate where each had was positiones(Use time clock face as your reference point.

Left hand: ☐ Not on wheel ☐ Yes, hand at _____ o' clock ☐ Hand elsewhere

Right hand: ☐ Not on wheel ☐ Yes, hand at _____ o' clock ☐ Hand elsewhere

REAR-END COLLISIONS ONLY: Answer this section only if hit from rear.

Describe your vehicle's head restraint system:

☐ Movable/adjustable head restraint ☐ Fixed, non-moveable head restraint

☐ No headrests in my vehicle ☐ Bench seat in your vehicle w/o head restraint

Please indicate how your head restraint was positioned at the time of crash(if present):

☐ At the top of the back of your head ☐ Midway height of the back of your head

☐ Lower height of the back of your head ☐ Located at the level of your neck

☐ Level of your shoulder blades

OTHER FACTORS

YES	NO	
☐	☐	Did you body(chest,breast,knee,face,head) hit the roof of your vehicle, hit the steering wheel, dash, or other structures within your vehicle? If yes, indicate what happened:_____
☐	☐	Did your car separate away from the striking vehicle after the crash? If yes, you are indicating that after the crash your car was pushed away from the striking vehicle and your vehicle did not stay attached. If yes, indicate your estimate of the distance between vehicles after the crash:_____ feet.

VITALITY
CHIROPRACTIC & WELLNESS

PATIENT INTAKE FORM

Patient's Name: _____ Date of Birth: _____
(LAST, FIRST, MIDDLE INITIAL)

Patient's Guardian Name (if applicable): _____

Address: _____

Phone: _____ Email: _____ Gender: M / F

Primary Healthcare Provider and/or Clinic: _____

Please tell us who you were referred by so we may thank them:

☐ Physician: _____ ☐ Other (friend/family/patient): _____

Marital status? (Please check most current status)
☐ Single
☐ Married
☐ Living with Significant Other
☐ Divorced/Separated
☐ Widowed

Are you being seen for:
☐ Motor Vehicle Accident
☐ Workers Compensation

What is your race?
(Defined by the federal government; please check one)
☐ Asian or Pacific Islander
☐ Black/African American
☐ Hispanic
☐ American Indian or Alaskan Native
☐ White
☐ Other _____

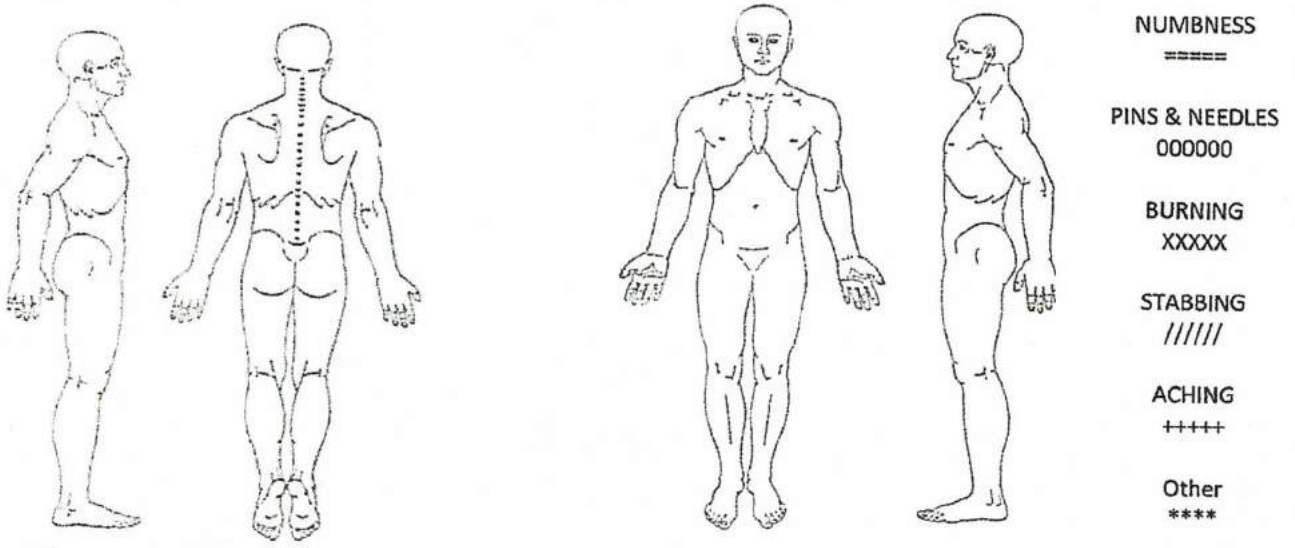
What is the reason for your visit today? _____

Was there a triggering event? _____

How long have you had the problem? _____

What do you want your treatment to accomplish? _____

Please indicate where you have pain or other symptoms below:



Please list any significant traumas or injuries you have had: _____

Patient/Guardian Signature _____ **Date** _____

PATIENT REVIEW OF SYSTEMS

Please check the **"Current"** box for all conditions that you are now experiencing and mark the **"Past"** box for any condition or symptom(s) experienced previously. Please do not write in the spaces marked **"Clinician's Notes Only"**.

	Current	Past	Clinician's Notes Only Please do not write in this space.
GENERAL			
Fever			
Sweats			
Chills			
Fatigue			
Weight loss/gain			
Sleep disturbance			
Change in routine			
HEAD			
Headache			
Dizziness			
Head trauma			
Fainting			
Blacking out			
EYES			
Change in vision			
Glasses/Contacts			
Blurry/double vision			
Cataracts			
Sensitive to light			
Flashes in vision			
Spots in vision			
EARS			
Ringing in ears			
Frequent infection			
Hearing loss			
Drainage			
Ear pain			
NOSE			
Post nasal drip			
Nosebleeds			
Sinus problems			
MOUTH			
Bleeding gums			
Cold sores			
Dentures			
Trouble Swallowing			
Sore throat			
Jaw pain			
Changes in taste			
Swelling			
Hoarseness			
Last dental appt _____			
MEDICAL			
Substance abuse			
Hospitalization			
Psychiatric care			
Surgeries_____			
Last chest x-ray (for those over age 55) _____			

	Current	Past	Clinician's Notes Only Please do not write in this space.
LUNGS			
Difficulty breathing			
Asthma			
Pneumonia			
Wheezing			
Persistent cough			
Coughing up phlegm			
Coughing up blood			
Tuberculosis			
CARDIO VASCULAR			
Chest pain			
Palpitations			
Ankle swelling			
Cold/hot feet or hands			
Discolored foot/hand			
Leg cramps/calf pain			
Varicose veins			
High/l ow blood pressure			
G-I SYSTEM			
Gas			
Heartburn/Indigestion			
Ulcers			
Vomiting/Nausea			
Abdominal pain			
Diarrhea/constipation			
Blood in stool			
Hemorrhoids			
Gall bladder disease			
Liver disease			
Colonoscopy			
G-U SYSTEM			
Difficulty urinating			
Pain urinating			
Blood in urine			
Incontinence			
Foul odor of urine			
Increase/decreased urination			
Urinary infection			
Genital infection			
Kidney stones			
Last prostate exam (males) _____			
Last PSA (males) _____			
Last testicular exam (males)_____			
MEDICATION			
Prescription medications			(please bring)
OTC medication			(please bring)
Vitamins			(please bring)
Herbs			
Drug allergies_____			

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	Current	Past	Clinician's Notes Only Please do not write in this space.
PSYCHOLOGIC			
Excessive Stress			
Depression			
Anxiety			
Mood swings			
SKIN			
Rash			
Bruising			
Hair loss			
Brittle nails			
Changes in moles			
Itching/peeling			
NEUROLOGIC			
Seizures/Epilepsy			
Strokes			
Tingling/numbness			
Weakness			
Difficulty walking			
Poor coordination			
MUSCLE/BONE			
Osteoporosis			
Joint pain			
Stiffness			
Muscle ache			
Arthritis			
Deformity			
Bone pain			
Dislocations			
Fractures (please list):			
LABORATORY			
Last fasting blood glucose _____ (date)			
Last cholesterol _____ (date)			
VACCINATIONS (if age >60 y/o)			
Flu			
Varicella			
Pneumonia			
Tetanus			
FAMILY HISTORY (immediate family members)			
Cancer			
Alcoholism			
Depression			
Epilepsy			
Alzheimer's			
Heart Disease			
Other _____			

	Current	Past	Clinician's Notes Only Please do not write in this space.
NECK			
Masses			
Swelling			
Stiffness			
SOCIAL			
Consume alcohol			
Consume caffeine			
Tobacco use			
Recreational drugs			
Exercise	Y	N	
Safe at home	Y	N	
Guns at home	Y	N	
Seat belts used	Y	N	
Text while driving	Y	N	
Hobbies _____			
Drink _____ glasses water/day			
Sleep _____ hours/night			
Occupation _____			
OB GYN (females)			
Pregnancy			
Breast cancer			
Lumps in breast			
Nipple discharge			
PMS			
Irregular periods			
Hot flashes			
Menopause			
Menstrual cramps			
Age period began _____			
Last breast exam _____			
Last PAP _____			
Last mammogram _____			
PAST MEDICAL HISTORY			
Allergies			
Hypertension			
Diabetes			
Cancer/Tumor			
Anemia			
Other _____			

Patient Name _____ **Date** _____

Patient Signature _____

Clinician's Name _____

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The Keele STarT Back Screening Tool

Patient name: _____ Date: _____

Thinking about the **last 2 weeks** tick your response to the following questions:

		Disagree 0	Agree 1
1	My back pain has **spread down my leg(s)** at some time in the last 2 weeks	☐	☐
2	I have had pain in the **shoulder** or **neck** at some time in the last 2 weeks	☐	☐
3	I have only **walked short distances** because of my back pain	☐	☐
4	In the last 2 weeks, I have **dressed more slowly** than usual because of back pain	☐	☐
5	It's not really safe for a person with a condition like mine to be physically active	☐	☐
6	**Worrying thoughts** have been going through my mind a lot of the time	☐	☐
7	I feel that **my back pain is terrible** and **it's never going to get any better**	☐	☐
8	In general I have **not enjoyed** all the things I used to enjoy	☐	☐

9. Overall, how **bothersome** has your back pain been in the **last 2 weeks**?

Not at all	Slightly	Moderately	Very much	Extremely
☐	☐	☐	☐	☐
0	0	0	1	1

Total score (all 9): _____ **Sub Score (Q5-9):** _____

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Funded by Arthritis Research UK

List Your Pains/Complaints From Most Severe (Problem #1) To Least

Today, you have the following physical complaints:	Location Of Problem #1	Location Of Problem #2	Location Of Problem #3	Location Of Problem #4
Is this complaint: Sharp, Dull, Achy, Throbbing, Numb, Shooting, or Other (explain)?	☐ Sharp ☐ Dull ☐ Achy ☐ Throbbing ☐ Numb ☐ Tingle ☐ Electric/Shooting	☐ Sharp ☐ Dull ☐ Achy ☐ Throbbing ☐ Numb ☐ Tingle ☐ Electric/Shooting	☐ Sharp ☐ Dull ☐ Achy ☐ Throbbing ☐ Numb ☐ Tingle ☐ Electric/Shooting	☐ Sharp ☐ Dull ☐ Achy ☐ Throbbing ☐ Numb ☐ Tingle ☐ Electric/Shooting
How long have you had this?				
Since it began is it getting:	☐ Better ☐ Same ☐ Worse	☐ Better ☐ Same ☐ Worse	☐ Better ☐ Same ☐ Worse	☐ Better ☐ Same ☐ Worse
What makes it better?				
What makes it worse?				
On a scale of 0-10 rate your discomfort:	0 1 2 3 4 5 6 7 8 9 10 10 = Excruciating 0 = No Discomfort	0 1 2 3 4 5 6 7 8 9 10 10 = Excruciating 0 = No Discomfort	0 1 2 3 4 5 6 7 8 9 10 10 = Excruciating 0 = No Discomfort	0 1 2 3 4 5 6 7 8 9 10 10 = Excruciating 0 = No Discomfort
How have you taken care of this, and how has it worked?				
This issue is affecting my:	☐ Job o Childcare ☐ Marriage/Sex ☐ Sports/Hobbies ☐ Finances ☐ Bowel/Bladder ☐ Digestion	☐ Job o Childcare ☐ Marriage/Sex ☐ Sports/Hobbies ☐ Finances ☐ Bowel/Bladder ☐ Digestion	☐ Job o Childcare ☐ Marriage/Sex ☐ Sports/Hobbies ☐ Finances ☐ Bowel/Bladder ☐ Digestion	☐ Job o Childcare ☐ Marriage/Sex ☐ Sports/Hobbies ☐ Finances ☐ Bowel/Bladder ☐ Digestion
Helping this issue would increase my quality of life by:	☐ 10-30% ☐ 40-75% ☐ 80-100%	☐ 10-30% ☐ 40-75% ☐ 80-100%	☐ 10-30% ☐ 40-75% ☐ 80-100%	☐ 10-30% ☐ 40-75% ☐ 80-100%

People see us for different reasons. Some come for relief of pain, some to correct the cause, and others to prevent future ailments. Your doctor will weigh your needs and desires when recommending your health program. Please check the type of care desired so that we may be guided by your wishes.

☐ **Relief** ☐ **Correction of the cause** ☐ **Prevention** ☐ **Let the doctor choose for me**

Have you experienced any of the following symptoms associated with your reason for visiting us today? Check all that any/all that apply:

- Double vision
- Dizziness
- Sudden numbness/weakness of face, arms or legs
- Difficulty speaking
- Difficulty walking due to poor coordination
- Vomiting/queasiness
- Involuntary, rapid eye movements
- Loss of bowel/bladder function
- Pain that wakes you up at night
- Excessive weight loss/gain within the past 6 months
- Blood in urine or bowel
- Night sweats
- Pain that doesn't increase/decrease with changes in position
- Deep, aching pain

What type of chiropractic care are you interested in? Check all that apply:

- Structural spinal adjustments
- Neurological/instrument assisted adjustments
- Nutrition counseling
- Whole food supplementation
- Plantar Fasciitis relief
- Instrument assisted soft tissue mobilization
- Pre-pregnancy planning
- Detoxification/weight-loss
- Ayurveda
- Other: _____

What kind of chiropractic care have you received in the past?
Check all that apply:

- Structural spinal adjustments
- Neurological spinal adjustments
- Nutrition counseling
- Whole Food Supplementation
- E-stim
- Instrument Assisted Soft tissue mobilization
- Exercises/Stretching
- Muscle taping
- Therapeutic ultrasound
- Lumbar decompression therapy

How was your last chiropractic experience? _____
What would you change? _____
What would you keep the same? _____

Name:_____ Date_____ Score (X2)_____

Neck Pain

This form is to be completed by patients being seen for neck pain. This questionnaire is designed to enable us to understand how much your **neck pain** has affected your ability to manage everyday activities. Please answer each Section by circling the ONE CHOICE that most applies to you. We realize that you may feel that more than one statement may relate to you, but please just circle the one choice which closely describes your problem right now.

Pain intensity

⓪ I have no pain at the moment.
① The pain is very mild at the moment.
②The pain is moderate and does not vary much.
③ The pain is fairly severe at the moment.
④The pain is severe but comes and goes
⑤The pain is severe and does not vary much.

Personal care (washing, dressing, etc.)

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 manage most of my personal care.
④ I need help every day in most aspects of self care.
⑤ I do not get dressed, 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 but I can manage light to medium weights if they are conveniently positioned.
④ I can lift only very light weights.
⑤ I cannot lift or carry anything at all.

Reading

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

Headache

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

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Concentration

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

Work

⓪ I can do as much work as I want to.
① I can only do my usual work, but no more.
② I can 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.

Driving

⓪ I can drive my car without neck pain.
① I can drive my car as long as I want with slight pain in my neck.
② I can drive my car as long as I want with moderate pain in my neck.
③ I cannot drive my car as long as I want because of moderate pain in my neck.
④ I can hardly drive my car at all because of severe pain in my neck.
⑤ I have no social life because of pain.

Sleeping

⓪ My sleep is never disturbed by pain.
① My sleep is occasionally disturbed by pain.
② Because of pain I have less than 6 hours sleep.
③ Because of pain I have less than 4 hours sleep.
④ Because of pain I have less than 2 hours sleep.
⑤ Pain prevents me from sleeping at all.

Recreation

⓪ I am able engage in all recreational activities with no pain in my neck at all.
① I am able engage in all recreational activities with some pain in my neck.
② I am able engage in most, but not all recreational activities because of pain in my neck.
③ I am able engage in a few of my usual recreational activities because of pain in my neck.
④ Pain restricts me to short necessary journeys under 30 minutes.
⑤ I cannot do any recreational activities all

Name:_____ Date_____ Score (X2)_____

Low Back Oswestry 2.1a

This form is to be completed for patients being seen for back pain. This questionnaire is designed to give us information as to how your back (or leg) trouble affects your ability to manage in everyday life. Please answer every section. Mark one number only in each section that most closely describes you today.

Pain intensity

⓪ I have no pain at the moment.
① The pain is very mild at the moment.
② The pain is moderate at the moment.
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.

Personal care (washing, dressing, etc.)

⓪ I can look after myself normally without causing extra pain.
① I can look after myself normally but it is very painful.
② It is painful to look after myself and I am slow and careful.
③ I need some help but manage most of my personal care.
④ I need help every day in most aspects of self care.
⑤ I do not get dressed, 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 gives 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 but I can manage light to medium weights if they are conveniently positioned.
④ I can lift only very light weights.
⑤ I cannot lift or carry anything at all.

Walking

⓪ Pain does not prevent me walking any distance.
① Pain prevents me walking more than one mile.
② Pain prevents me walking more than a quarter of a mile.
③ Pain prevents me walking more than 100 yards.
④ I can only walk using a stick or crutches.
⑤ I am in bed most of the time and have to crawl to the toilet.

Sitting

⓪ I can sit in any chair as long as I like.
① I can sit in my favorite chair as long as I like.
② Pain prevents me from sitting for more than 1 hour.
③ Pain prevents me from sitting for more than half an hour.
④ Pain prevents me from sitting for more than 10 minutes.
⑤ Pain prevents me from sitting at all.

Standing

⓪ I can stand as long as I want without extra pain.
① I can stand as long as I want but it gives me extra pain.
② Pain prevents me from standing for more than 1 hour.
③ Pain prevents me from standing for more than half an hour.
④ Pain prevents me from standing for more than 10 minutes.
⑤ Pain prevents me from standing at all.

Sleeping

⓪ My sleep is never disturbed by pain.
① My sleep is occasionally disturbed by pain.
② Because of pain I have less than 6 hours sleep.
③ Because of pain I have less than 4 hours sleep.
④ Because of pain I have less than 2 hours sleep.
⑤ Pain prevents me from sleeping at all.

Sex life (if applicable)

⓪ My sex life is normal and causes no extra pain.
① My sex life is normal but causes some extra pain.
② My sex life is nearly normal but is very painful.
③ My sex life is severely restricted by pain.
④ My sex life is nearly absent because of pain.
⑤ Pain prevents any sex life at all.

Social life

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

Travelling

⓪ I can travel anywhere without pain.
① I can travel anywhere but it gives extra pain.
② Pain is bad but I manage journeys over two hours.
③ Pain restricts me to journeys of less than one hour.
④ Pain restricts me to short necessary journeys under 30 minutes.
⑤ Pain prevents me from travelling except to receive treatment.

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VITALITY CHIROPRACTIC & WELLNESS

CHIROPRACTIC INFORMED CONSENT

I hereby give my consent to the performance of diagnostic tests and procedures and chiropractic treatment or management of my condition(s).

Initials: _____ **Date:** _____

Chiropractic treatment or management of conditions almost always includes the chiropractic adjustment, a specific type of joint manipulation. Like most health care procedures, the chiropractic adjustment carries with it some risks. Unlike many such procedures, the serious risks associated with the chiropractic adjustment are extremely rare. **Following are the known risks:**
Temporary soreness or increased symptoms or pain It is not uncommon for patients to experience temporary soreness or increased symptoms or pain after the first few treatments.

Dizziness, nausea, flushing These symptoms are relatively rare. It is important to notify the chiropractor if you experience these symptoms during or after your care.

Fractures When patients have underlying conditions that weaken bones, like osteoporosis, they may be susceptible to fracture. It is important to notify your chiropractor if you have been diagnosed with a bone weakening disease or condition. If your chiropractor detects any such condition while you are under care, you will be informed and your treatment plan will be modified to minimize risk of fracture.

Disc herniation or prolapse Spinal disc conditions like bulges or herniations may worsen even with chiropractic care. It is important to notify your chiropractor if symptoms change or worsen.

Stroke A certain extremely rare type of stroke has been associated with chiropractic care. Although there is an association between this type of stroke and chiropractic visits, there is also an association between this type of stroke and primary care medical visits. According to the most recent research, there is no evidence of excess risk of stroke associated with chiropractic care. The increased occurrence of this type of stroke associated with both chiropractic and medical visits is likely explained by patients with neck pain and headache consulting both doctors of chiropractic and primary care medical doctors before or during their stroke.

Other risks associated with chiropractic treatment include rare burns from physiotherapy devices that produce heat.

Bruising Instrument assisted soft tissue manipulation may result in temporary soreness or bruising.

I understand that the practice of chiropractic, like the practice of all healing arts, is not an exact science, and I acknowledge that no guarantee can be given as to the results or outcome of my care.

• PATIENT PLEASE REVIEW • PRINT & SIGN NAME •

I have read or had read to me this informed consent document. I have discussed or been given the opportunity to discuss any questions or concerns with my chiropractor and have had these answered to my satisfaction prior to my signing this informed consent document. I have made my decision voluntarily and freely.

PATIENT'S NAME (Print)_____ DATE OF BIRTH_____

_____ _____ _____ _____

(PATIENT | GUARDIAN SIGNATURE) (DATE) (TRANSLATOR | INTERPRETER SIGNATURE) (DATE)
(if applicable)

CLINICIAN ONLY

Based on my personal observation and the patient's history, I conclude that throughout the informed consent process the patient was:

☐ OF LEGAL AGE ☐ APPEARS UNIMPAIRED ☐ CONSENT GIVEN THROUGH GUARDIAN ☐ INTERN PRESENT - INITIALS_____
☐ ORIENTED X3 ☐ FLUENT IN ENGLISH ☐ ASSISTED BY A TRANSLATOR OR INTERPRETER ☐ INTERN NOT PRESENT

_____, D.C. _____

(D.C. SIGNATURE) (DATE)

PATIENT FINANCIAL ACKNOWLEDGEMENT

Please read thoroughly. Initial your acknowledgement, then sign and print your name and date. Thank you.

☐ **ASSIGNMENT OF BENEFITS**

I assign all benefits payable to me for my care at Vitality Chiropractic & Wellness #833 55104.I understand that this health care facility will be paid directly by the insurance company or other payer. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is considered as valid as the original.

☐ **GUARANTEE OF PAYMENT**

I guarantee payment of all charges incurred for treatment in accordance with the rates and terms of this health care facility.

☐ **CANCELLATION POLICY**

To maintain our excellence in customer service, we require a 24-hour cancellation notification for our acupuncture, massage, naturopath, nutrition, and Oriental medicine appointments. Please notify the clinic within 24 hours to avoid a charge for the missed appointment.

SIGNATURE (PATIENT|GUARDIAN) _____ **PRINT NAME** _____ **DATE** _____

Office Use Only

United Health Care	Medica	Preferred One	Landmark/CCMI (Health Partners, Cigna, Patient Choice)	Medicare	Medical Assistance	Select Care	BCBS	Other

☐ CHIROPRACTIC

1. Deductible/co-insurance? _____
2. Is there a co-pay? $_____
3. Limit on visits or services? _____

- ☐ 992XX (Examination)
- ☐ 97110 (Therapeutic exercise)
- ☐ 97112 (NMS re-education)
- ☐ EXTRA SPINAL MANIPULATION
- ☐ LABORATORY
- ☐ Orthotics _____ # per year
- ☐ Orthotics NOT verified
- ☐ Radiology non-spinal
- ☐ Radiology-spinal
- ☐ STRAPPING
- ☐ 97010 (Hot/cold packs)
- ☐ 97032 (EMS Attended)
- ☐ 97035 (Ultrasound)
- ☐ S8948 (Cold laser)
- ☐ 97012 (Mechanical Traction)

☐ ACUPUNCTURE

1. Deductible/co-insurance? _____
2. Co-pay? $_____
3. Limit on visits or services? _____
4. Authorization/Precertification needed?___

☐ ACUPUNCTURE BENEFITS NOT VERIFIED

☐ ACUPUNCTURE NOT A BENEFIT ON THIS PLAN

☐ NURSE PRACTITIONER

1. Deductible/co-insurance? _____
2. Co-pay? $_____

BASED ON THE INFORMATION PROVIDED BY THE HEALTH INSURANCE PLAN, SERVICES CHECKED ABOVE ARE NOT COVERED.

PAYMENT POLICY

VITALITY
CHIROPRACTIC & WELLNESS

Thank you, for choosing our office to meet your health care needs. In choosing to use your group health insurance to meet your financial obligation with our office, you must clearly understand and agree to the guidelines listed below. If you have any questions regarding our policy, please do not hesitate to speak with our accounts receivable administrator.

1. You will be considered a cash patient until our office qualifies and accepts your insurance coverage. We will verify your chiropractic benefits within 72 working hours of your first visit. These benefits will be reviewed with you so that you have a clear understanding of what your financial obligation will be at each visit.
2. Many of our patients are covered by health insurance. Due to extreme variations in insurance policy coverage, we encourage our patients to check with their insurance company or employer to determine their specific coverage. This includes the participating provider list and out of network payment schedule.
3. **You must pay all deductibles and co-pays in full at the time of visit** unless prior authorization was given and a payment policy was agreed upon by a mutual payment plan agreement.
4. If your plan requires a referral from your primary care doctor or precertification prior to your visit and you fail to obtain, you will be responsible for full payment of that visit at time of services are rendered.
5. If we do not participate with your insurance plan, you are responsible for full payment of your visit, even if it exceeds the insurance's determination of "usual and customary allowance" for the procedure performed.
6. If your insurance policy requires a treatment plan be submitted for continued care, Vitality Chiropractic & Wellness will do this on your behalf. As a result of their review they may impose restrictions on the number of visits the time allotted for your care with our office, you will be responsible or any visits that exceed the imposed restriction. If an appeal process is appropriate we will help you with appealing the decision to the appropriate parties.
7. If you are restricted to a number of visits or maximum dollar limitation allowed per year imposed by your insurance plan, you will be responsible for payment of any visits over that allowance.
8. We can not accept responsibility for collecting an insurance claim after 60 days or negotiating a disputed claim. Insurance policies are a contract between you, your employer and the insurance carrier. You are ultimately responsible for payment on your account. If you have a dispute with how your insurance company processed a claim, you are responsible to contact them directly to resolve the dispute.
9. If your insurance is terminated or there is any change in your plan, it is your responsibility to notify us immediately.
10. Infrequently insurers or patients submit payments in excess of the required amount. When we receive mistaken payments or large over payments, we attempt to make a good faith effort to refund the reimbursement or apply the over payment to future billings. Certain credit balances will not be refunded due to administrative burden.

Credit balances equal to the value of an adjustment ($48) will neither be automatically refunded to the patient or any third party payor if after any reasonable attempt, administrative burdens makes it to difficult to continue to process the refund. Patient disclaims and right, title or interest to the knowingly and voluntarily waives and legal demand to the foregoing credit balance, which shall not constitute unclaimed or abandoned property in the possession of a holder as defined in the Unclaimed Property Act, 72 P.S. §1301.1 and §1301.10(1).

11. I hereby agree that in consideration of the services rendered I understand that any portion that is not covered by my insurance will be responsibility. This consent and agreement will remain in effect as long as the patient remains active in our practice.
12. There is a $25 cancellation fee for any missed regular appointments with less than 24 hour notice.
13. Vitality Chiropractic & Wellness reserves the right to discontinue care if unpaid balances exceed the cost of 2 visits. Any unpaid balance may be sent to collections if left unpaid for greater than 30 days.

I have read and agree to the financial policy of Vitality Chiropractic & Wellness, Dr. Shilpa S. Parikh, DC & Dr. Anthony C. Heaverlo at 393 Dunlap Street North Suite #833 Saint Paul, Minnesota 55104.

PATIENT/ GUARANTOR SIGNATURE _____

_____
PRINT NAME

_____
DATE

WITNESS SIGNATURE _____

_____
PRINT NAME

_____
DATE