Knewtson Health Group

Personal Injury New Patient Information

Last Name _____ First Name_____ MI _____

If child under 18 name of parent or guardian _____

Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Work Phone _____

Cell Phone _____Driver's License # _____

Social Security Number _____Email_____

Date of Birth_____

Sex: M F Marital Status: Single Married Divorced Widowed

Employer _____ Type of work _____

Spouse's Name _____ Spouse's Employer _____

Automobile Accident Please note that Minnesota is a No Fault state so you will need to file this claim with your auto insurance carrier and give us your auto insurance carrier information.

Workers' Compensation If you have not done so already, please notify your employer immediately. Your employer will give you the insurance carrier information.

Insurance Company _____Phone Number_____

Claim Mailing Address _____

City _____ State _____ Zip Code_____

Date of Injury _____ Adjuster's Name _____

Policy Number _____ Claim Number _____

Attorney's Name _____Phone Number _____

Address_____

City _____ State _____ Zip Code _____

Release and Assignment of Benefits

I authorize the release of any information necessary to process my claims and assign and request payment be made directly to my health care provider.

Patient/Guardian Signature _____Date _____

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Knewtson Health Group

Injury Report

An accident or trauma of any kind can cause you to have spinal nerve stress, also known as vertebral subluxations. Subluxations can affect you body structure and in turn your physical and emotional health. Every accident victim needs a spinal checkup by a doctor of chiropractic.

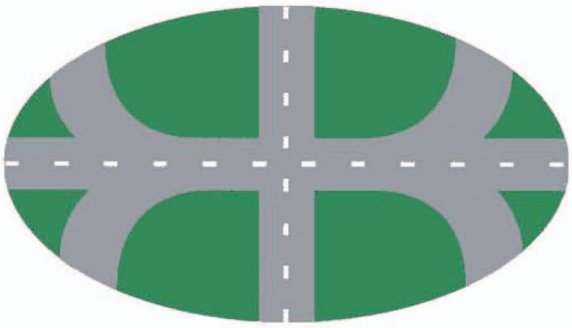
Please indicate the type of accident you were involved in:
O Work O Sport O Auto O Personal Injury O Other_____

Date of accident_____Time_____Location_____

Please explain how you were injured. Be as detailed as possible. If it was an auto accident, please mention the speed of the vehicles, where your car was hit, the damage that was done, the weather conditions and your state of mind/health at the time of the accident. Let us know if you need more paper.

_____
_____
_____
_____

Please illustrate the accident with all involved vehicles (if applicable) below.



I was O driving O a passenger in a_____
(type of vehicle)

on a_____. The other vehicle was a_____.
(i.e. street or highway) (type of vehicle)

I was	**O in front, left**	**O in front, right**	**O in back. left**	**O in back, right**
	O wearing seat belt	**O air bag deployed**	**O struck headrest**	
	O facing front	**O turned**		

Were other people in the car?	**O No**	**O Yes**
If yes, were they hurt?	**O No**	**O Yes**
Were police notified?	**O No**	**O Yes**

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Injury Report

Where were you taken after the accident and who cared for you? _____

_____

_____

Were X-rays, MRI or other tests done? O Yes O No
If yes, please list. _____

_____

What treatment was given? _____
Are you receiving care from other health professionals? _____
If yes, please give name, specialty and contact information. _____

_____

_____

Injuries From The Accident
As a result of your accident, did you have any of the following: *(please check all that apply)*
O Broken Bones O Dislocations O Head Injuries O Surgery O Concussion
If yes to any of the above, please describe. _____

_____

Were you knocked unconscious? O No O Yes If yes, for how long? _____
Please use the illustrations below to show where you are experiencing symptoms.

Front _____

_____

_____

_____

_____

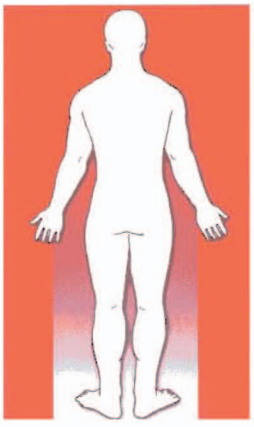
Back _____

_____

_____

_____

_____



As a result of this accident, do you have any of the following: *(please check all that apply)*

O Dizziness	O Stiff Neck	O Buzzing/Ringing in Ear
O Memory Loss	O Nausea	O Disturbed Sleep
O Tension	O Numb Feet	O Arm/Shoulder Pain
O Upset Stomach	O Blurred Vision	O Numb Hands/Fingers
O Back Stiffness	O Neck Pain	O Shortness of Breath
O Headache	O Jaw Problems	O Forgetfulness
O Irritability	O Back Pain	O Fatigue
O Chest Pain	O Leg Pain	Other _____

Is there anything else you'd like us to know? _____

_____

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Knewtson Health Group

Patient Consent

TO OUR PATIENTS: Please read and sign the form below. Ask questions if there is something you do not understand.

Please check to indicate approval:

____ **RELEASE OF MEDICAL RECORDS FOR MY MEDICAL CARE OR AS REQUIRED BY LAW:**
-to health care providers directly involved in my care.
-to State, Federal and accrediting bodies for required reporting data and/or surveys for compliance.
-for purposes of my care and for business operations.
Note: Records are not automatically sent to your physician. They must be requested.

____ **ASSIGNMENT OF BENEFITS/BILL MY INSURANCE:**
-I authorize Knewtson Health Group to send my bills for my medical care and treatment to my insurance company and/or Medicare or Medicaid for payment, to the extent my insurance company and/or Medicare or Medicaid id required to pay the bill under terms of my insurance policy or by law.
-I request that my insurance company and/or Medicare or Medicaid pay Knewtson Health Group and the providers who are involved in my treatment.
-I consent to the release of my medical records by Knewtson Health Group to my insurance company and/or Medicare or Medicaid (and organizations working on their behalf) if necessary in order for my bills to be paid.
-I agree to pay for charges not covered by my insurance.
-I understand that if I do not check this box Knewtson Health Group will send a bill directly to me for payment.

____ **RELEASE OF MEDICAL RECORDS FOR MEDICAL OR SCIENTIFIC RESEARCH:**
-I agree that my records may be used by Knewtson Health Group for medical or scientific study.
-No information which can identify me as a patient or participant in any such study will be shared.
-I may revoke this in writing at any time.

By signing this form, I consent and authorize my medical health provider to assess and treat me. I understand that my provider is available to explain the purpose of treatment, and that I have the right to refuse recommended treatment. I understand I have the right to revoke this consent, in writing, at any time except where Knewtson Health Group has already made disclosures in reliance to the consent.

I consent to the treatment(s) provided by this clinic. I understand that my condition may necessitate modifications from time to time due to the type of treatment(s) rendered and the portions of my body that may need to be examined. I understand and consent to clinic staff providing me with verbal descriptions, when there are changes to my exam(s) and treatment(s), consent to the clinic staff providing said treatment(s) and exam(s) and hereby consent to any similar subsequent treatment(s) or exam(s). If I do not consent, I will immediately inform clinic staff. There are times when individuals other than staff may see me receive treatment at the clinic or overhear discussions of my condition or insurance. I consent to others perceiving these interactions at the clinic. If additional privacy is required, I will inform the clinic staff.

SIGNATURE OF PATIENT OR AUTHORIZED REPRESENTATIVE_____

PRINT NAME_____**DATE**_____

IF AUTHORIZED REPRESENTATIVE, RELATIONSHIP TO PATIENT_____

REASON PATIENT UNABLE TO SIGN_____

Check only if applicable (one-time acknowledgement)

_____**I acknowledge that I have been offered a copy of Knewtson Health Group's Privacy Practices Information. If I would like a copy in the future, I will ask for one.**

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Knewtson Health Group

Authorization and Notice of Doctor's Lien

Patient's Name: _____

Patient's Attorney: _____

Insurance Company: _____

Date of Injury: _____

I authorize and direct you, my attorney, and my insurance carrier, to pay directly to Knewtson Health Group such sums as may be due and owing the clinic for medical services rendered me by reason of this accident and by reason of any other bills that are due the clinic and to withhold such sums from my portion of any settlement, judgment or verdict as may be necessary to adequately protect the clinic. I further give a lien on my case to said clinic against my portion of any and all proceeds of the first available settlement, judgment or verdict which my be paid to you, my attorney, or myself as the result of the injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to Knewtson Health Group for all medical benefits, including major medical, submitted by the clinic for services rendered me and that this agreement is made solely for this clinic's additional protection and in consideration of the clinic's awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may recover said fee.

Patient's Name: _____

Address: _____

Signed: _____ **Date** _____

ACKNOWLEDGEMENT OF ATTORNEY

The undersigned, being the attorney of record for the above patient, does hereby agree to observe all terms of the above and agrees to withhold such sums from patient's portion of the first available settlement, judgment or verdict as necessary to adequately protect Knewtson Health Group.

Dated _____ **Attorney's Signature** _____

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