BODY REVIVE CHIROPRACTIC

4132 Katella ave suite 102 Los Alamitos, CA 90720
Phone: (562) 596-9677 Fax: (562) 795-6630
eMail: info@bodyrevivechiropractic.com

PATIENT INTAKE - CAR ACCIDENT

Patient's Name: (Last) ____________ (First) ____________ (Sex): ☐ M ☐ F

Today's Date: __________ Patient's Age: __________ Date of Birth: __________

Address: ____________ City: __________ Zip:__________

eMail Address : ____________ Cell Phone #: (____) __________

Social Security No #: ______ - ______ -______ Employer: __________ Job Description: __________

Emergency Contact: __________Emergency Contact Phone #: (____) __________ Relation:

History of the accident / injury:

Date of accident: __________ City of accident: __________ Police Report Taken: ☐ YES ☐ NO

Your Vehicle Information: Year__________ Make: __________ Model: __________

At-Fault Vehicle Information: Year__________ Make: __________ Model: __________

Please describe the accident / injury: ____________

____

____

____

____

Have you lost time from work as a result of this accident: ☐ YES ☐ NO

If yes, give dates and details: ____________

Health Insurance Information:

DO YOU HAVE HEALTH INSURANCE? ☐ YES ☐ NO

NAME OF INSURANCE COMPANY: ____________ POLICY #: ____________

DETAILS OF THE INJURY

TYPE OF INJURY: AUTO VS. AUTO: ☐ SLIP and FALL: ☐ WORK INJURY: ☐ HOME: ☐

1. **Where was your vehicle struck?:**

   FRONT: ☐ REAR: ☐ DRIVERS SIDE: ☐ PASSENGER SIDE: ☐

2. **Were you the:**

   DRIVER: ☐ PASSENGER: ☐ BACK RIGHT: ☐ BACK LEFT: ☐

   PEDESTRIAN: ☐ OTHER: ☐ ______________________________

3. **Were you:**

   UNPREPARED: ☐ HOLDING STEERING WHEEL: ☐ WALKING: ☐ STANDING: ☐

   SITTING: ☐ LOOKING LEFT: ☐ LOOKING RIGHT: ☐ TURNED BACKWARDS: ☐

   WEARING SEAT BELT: ☐ STEPPING HARD ON BRAKES: ☐ BRACING: ☐

4. **Upon impact, did you feel:**

   FORCEFUL JOLT AND JARRING: YES: ☐ NO: ☐

   THRUST SIDE TO SIDE YES: ☐ NO: ☐

   THROWN FORWARD AND BACKWARDS: YES: ☐ NO: ☐

5. **Were you rendered unconscious?**

   YES: ☐ NO: ☐ If yes, how long?: ____________________

6. **Did any part of your body strike something within the vehicle?** YES: ☐ NO: ☐

   If so, what and where?______________________________

7. **Following the accident, how did you feel?:**

   NERVOUS: ☐ CONFUSED: ☐ SHAKY: ☐ DIZZY: ☐

   LIGHT HEADED: ☐ SHOCKED: ☐ SCARED: ☐ NAUSEATED: ☐

8. **Who assisted you at the scene of the accident?:**

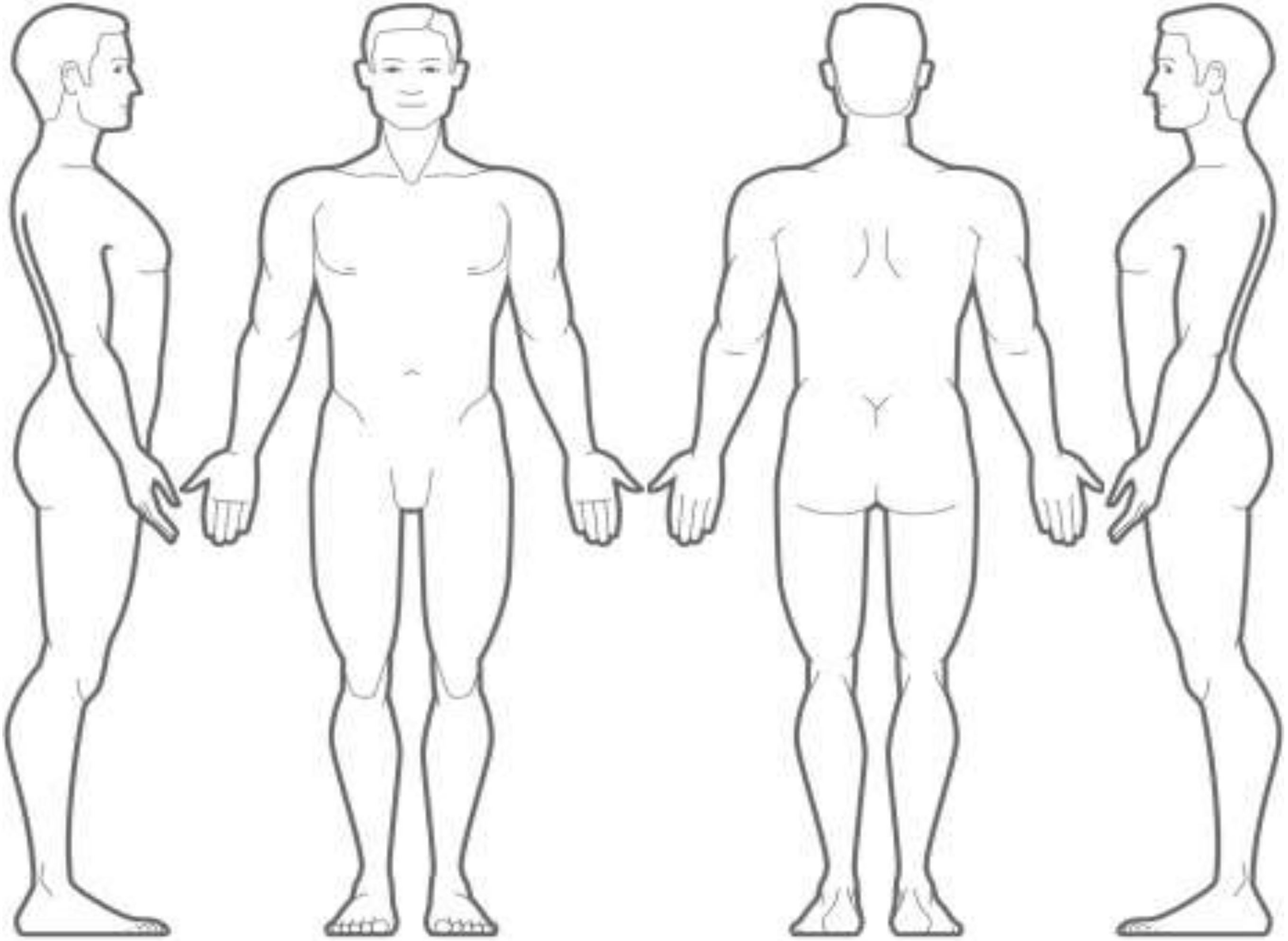
   POLICE: YES: ☐ NO: ☐ PARAMEDICS: YES: ☐ NO: ☐

   GOOD SAMARITAN: YES: ☐ NO: ☐ OTHER: YES: ☐ NO: ☐

9. **After the accident did you go?**

   HOME: ☐ HOSPITAL: ☐ FAMILY DOCTOR: ☐ OTHER: ☐

PRESENT COMPLAINTS
RELATED TO THIS ACCIDENT ONLY!



PLEASE SHADE IN AREAS OF PAIN OR SYMPTOMS

Please list hospitals / doctors you saw prior to coming to this office, related to THIS accident:

Name of doctor / hosptial? ________________________ City: ______________Date of visit: ______________________

How did you get to the hospital? (Circle all that apply) **Ambulance** **Helicopter** **I drove myself** **Someone else drove me**

What type of treatment did you receive? (Circle all that apply) **X-rays** **CAT scan** **MRI scan** **Injection** **Medication**

PRE-EXISTING INJURIES

1. **Do you have any pre-existing pain that is not related to this accident / injury?** Yes: ☐ No: ☐

   If yes, describe:____

   If yes, was your pre-existing pain worsened by this recent accident / injury? Yes: ☐ No: ☐

2. **Have you ever been involved in an accident, fall, or injury that has caused you pain?** Yes: ☐ No: ☐

   If yes, describe:____

   If yes, did the pain from the prior injury resolve completely prior to the recent accident / injury? Yes: ☐ No: ☐

REPORTED MEDICAL HISTORY

Do you smoke cigarettes? Yes: ☐ No: ☐ If yes, for how many years? _____ How many per day? _____

Do you drink alcohol? Yes: ☐ No: ☐ ☐ Socially ☐ 1 drinks/day ☐ 2 drinks/day ☐ > 2 drinks/day

Female Only: Are you pregnant? Yes: ☐ No: ☐ Due Date:________ Date of Last Menstrual Period:________
Is there any chance you might be pregnant? Yes: ☐ No: ☐

FAMILY MEDICAL HISTORY

	Age	Health Problems	Age at Death	Cause of Death
Mother				
Father				

SURGICAL HISTORY

Type of Surgery	Date Performed

MEDICAL CONDITIONS

List Medical Conditions You Have	How Long Have You Had This Condition	Doctor Treating This Condition

MEDICATIONS

List Medications You Are Taking	Reason for Taking	Prescribing Doctor
☐ See Attached Medication List		

MARITAL STATUS

Single		Married		Divorced		Widow/er	

Assignment of Benefits, Release of Information, Payment Agreement, HIPAA Guidelines

I understand that payment is due at the time of service unless other arrangements have been made. I understand that Body revive chiropractic & Alamitos back pain center will be filing my insurance company / adjusters / attorney on my behalf. I agree to have the benefits from my insurance assigned to Alamitos back pain center. I permit Body Revive Chiropractic &Alamitos back pain center to release any information deemed necessary to any insurance or third party, within the guidelines of HIPAA (Health Insurance Portability & Accountability Act of 1996) I agree that I am responsible for full payment of this account & any court costs and attorney fees associated with the collection of this account.

____ ____________________

Signature of Patient (Parent or Guardian if under 18) **Date**

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INFORMED CONSENT TO CHIROPRACTIC CARE

Please read this entire document prior to signing it. It is important that you understand the information contained in this document. After reading, please ask the doctor questions before you sign if anything in unclear.

The nature of the chiropractic adjustment
The primary treatment used by doctors 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, manual therapy, massage therapy, machine assisted massage and manual therapies, palpation, vital signs, range of motion testing, orthopedic testing, neurological testing, muscle strength testing, postural analysis testing, ultrasound, hot/cold therapy, muscle stimulation, and / or radiographic studies.

The 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, nerve 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. 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 the doctor.

The probability of those risks occurring
Fractures are rare occurrences and generally result from some underlying weakness of the bone which we check for during the taking of your history and during examination. Stroke and /or arterial dissection caused by chiropractic manipulation of the neck has been the subject of ongoing medical research and debate. The most current research on the topic is inconclusive as to a specific incident of this complication occurring. If there is a causal relationship at all it is extremely rare and remote. Unfortunately, there is no recognized screening procedure to identify patients with neck pain who are at risk of arterial stroke.

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 the doctor 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 risk. I hereby give my consent to that treatment.

Patient Full Name: ________________________________

Patient Signature: ________________________________ Date: ______________

Parent Signature if aforementioned is a minor: ________________ Date: ______________

Doctor Signature: ________________________________ Date: ______________

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HIPAA Medical Authorization Form

I hereby authorize Alamitos back pain center to release all existing medical records and information regarding the above-referenced patient's medical care, treatment, physical/medical condition, and medical expenses revealed by your observation or treatment of past, present and future to or its representative, or the bearer hereof, or the bearer of any photo static, PDF or Xerox copy hereof.

I understand that this authorization includes information regarding the diagnosis and treatment of any and all conditions described to any provider during the course of treatment at Alamitos back pain center. It may also include outside medical records containing x-ray reports, laboratory reports, CT scan reports, MRI scans, EEG's, EKG's, sonograms, arteriograms, fetal monitor strips, discharge summaries, photographs surgery consent forms, informed consent forms regarding family planning, admission and discharge records, operation records, doctor and nurses notes, prescriptions, medical and any correspondence/memoranda and billing information. It also includes, to the extent such records currently exist and are in your possession,
insurance records, including Medicare/Medicaid and other public assistance claims, applications, statements, eligibility material, claims or claim disputes, resolutions and payments, medical records provided as evidence of services provided, and any other document or things pertaining to services furnished under Title XVII of the Social Security Act or other forms of
public assistance (federal, state, local, etc). This listing is not meant to be exclusive.

I, the undersigned individual, am on notice that:

(1) Initiating this request for disclosure of protected health information, and any disclosure of the same pursuant hereto is at the request of the
individual.

(2) Any health care provider disclosing the above requested information may not condition treatment, payment, enrollment, or eligibility for benefits on whether the individual signs this authorization.

(3) This authorization can be revoked through written notice to Body Revive Chiropractic & Alamitos back pain center or to the individual above listed entities, except to the extent that action has been taken in reliance on this authorization. The undersigned is aware of the potential that protected health information
disclosed pursuant to this authorization is subject to re-disclosure in a manner that will not be protected by HIPAA regulations.

(4) A photocopy of this authorization shall be considered as effective and valid as the original.

I have carefully read and understand the above and do herein expressly and voluntarily authorize the disclosure of the above information about, or medical records of the person listed above.

Patient Full Name: ___________________________________

Patient date of birth: _________________

Parent Signature: _________________ **Date: _______________**

This authorization is designed to be in compliance with the Health Insurance Portability and Accountability Act ("HIPAA") 45 CFR Parts 160 and 164.

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NOTICE OF DOCTOR'S LIEN

I, the undersigned, hereby authorize Body Revive Chiropractic & Alamitos back pain center to furnish you, my attorney, with a full report of his examination, diagnosis, treatment, prognosis, etc., of myself regarding the accident in which I was recently involved.

I hereby authorize and direct you, my attorney, to pay directly to said doctor such sums as may be due and owing to him for medical services rendered me both by reason of this accident, and/or by reason of any other bills that are due to his office and adequately protect said the doctor. And I hereby further give a lien on my case to said doctor against any and all proceeds of my settlement, judgment, or verdict which may be paid to you, my attorney, or myself, as the result of injuries for which I have been treated or injuries connected therewith. Additionally, I direct you, my attorney, to disclose any and all case information to said doctor if requested by the doctor, as to facilitate billing, payment, and settlement of my patient account.

I agree never to rescind this document, and that rescission will not be honored by my attorney. I hereby instruct that in the event another attorney is substituted in this matter and that the new attorney honor this lien as inherent to the settlement and enforceable upon the case as if it were executed by him.

I fully understand that I am directly and fully responsible to said doctor for services rendered to me, and that this agreement is made solely for said doctor's additional protection and in consideration of him awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment, or verdict by which I may eventually recover said fee.

Please acknowledge this letter by signing and returning it to the doctor's office. 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.

Dated Signed: ___________ **Patient's Signature:** ______________________
(Parent, if patient is a minor)

Date of Accident: ___________ **Patient's Name:** ______________________

The undersigned, being attorney of record for the above patient does hereby agree to observe all of the terms of the above and agrees to withhold such sums from any settlement, judgment, or verdict as may be necessary to adequately protect said doctor above named. Attorney further agrees that in the event this lien is litigated, that the prevailing party will be awarded attorney fees and costs. Additionally, attorney agrees and understands that in the event that the settlement amount for this case is insufficient to pay all medical providers in full, a pro-rata reduction with a detailed breakdown of expenses will be sent to the doctor for the doctor's consideration.

Attorney Name: ___________ **Attorney's Signature:** ______________________

____

______________________ **Date :** __________________

Please sign, date, and return to Doctor's office as soon as possible.

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ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California and federal law, and not by a lawsuit or resort to court process except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: All Claims Must be Arbitrated: It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the health care provider including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and the health care provider and/or other licensed health care providers or preceptorship interns who now or in the future treat the patient while employed by, working or associated with or serving as a back-up for the health care provider, including those working at the health care provider's clinic or office or any other clinic or office whether signatories to this form or not. All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the health care provider, and/or the health' care provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees, or other expenses incurred by a party for such party's own benefit. Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator. The parties consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder, any existing court action against such additional person or entity shall be stayed pending arbitration. The parties agree that provisions of the California Medical Injury Compensation Reform Act shall apply to disputes within this arbitration agreement, including, but not limited to, sections establishing the right to introduce evidence of any amount payable as a benefit to the patient as allowed by law (Civil Code 3333.1), the limitation on recovery for non-economic losses (Civil Code 3333.2), and the right to have a judgment for future damages conformed to periodic payments (CCP 667.7). The parties further agree that the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this Arbitration Agreement.

Article 4: General Provision: All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the health care provider within 30 days of signature and if not revoked will govern all professional services received by the patient and all other disputes between the parties.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment) patient should initial here. Effective as of the date of first professional services. If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this Arbitration Agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT, YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION, AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 'I OF THIS CONTRACT.

DATE:________________ **PATIENT SIGNATURE:________________________________**