Axelson CHIROPRACTIC & REHAB

WELCOME SHEET

PATIENT INFO

Patient Name _____

What Do You Prefer To Be Called? _____

Address _____

City/State/Zip _____

Home Phone (_____) _____

Cell Phone (_____) _____

Work Phone (_____) _____ Ext _____

Email: _____

Birthday: _____ Sex: ☐Male ☐Female

Marital Status: ☐Single ☐Married ☐Divorced ☐Separated

☐Child ☐Widowed SS# _____

Referred By: ☐Print Ad ☐Internet ☐Website ☐Phonebook

☐Attorney ☐Doctor ☐Event _____

☐Friend/Family _____

☐Other _____

INSURANCE INFO

Primary Ins Co _____

Name of Insured _____

Insured's Relationship to Patient: ☐Self

☐Spouse ☐Parent ☐Child ☐Other

Insured's Birthday _____

Insured's Employer _____

Secondary Ins Co _____

SOCIAL HISTORY

Employment Status: ☐Full-Time ☐Part-Time ☐Retired ☐Student ☐Homemaker ☐Unemployed

Employer / School _____

Occupation _____ How Long? _____

What Do You Do Most of the Day at Work?

☐Sit ☐Stand ☐Light Labor ☐Heavy Labor ☐Other _____

Check Any of the Following in Which You Participate in Regularly:

☐Gardening ☐Bicycling ☐Swimming ☐Running ☐Weight Lifting

☐Aerobics/Cardio ☐Golf ☐Other _____

How Often Do You Participate? ☐2-3x's/Week ☐1x/Week ☐1-2x's/Month ☐Other_____

How much sleep do you get per night? ☐ 5 or Less ☐ 6-8 ☐ 8-10 ☐ 10 or More

Rate your sleep: No/Poor Sleep 0 1 2 3 4 5 6 7 8 9 10 Wake-up Fully Rested

List your major Stressors: _____

What are your Health Goals? _____

APPOINTMENT REMINDER

Would you like to receive appointment reminders? □ Yes (Circle one): Email / Text □ No

Email _____

Cell Phone # _____ Cell Phone Provider: AT&T/Verizon/Sprint/US Cellular/_____

When would you like reminder sent? (Circle one): 30 min / 45 min / 1 hr / 2 hrs / 4 hrs / 1 day / 2 days prior

REASON FOR VISIT

Reason for today's visit: Primary Complaint _____

Other Complaints _____

When did condition begin? _____ The discomfort is: □ getting worse □ constant □ comes & goes

Describe the discomfort: □ Sharp □ Shooting □ Aching □ Throbbing □ Burning □ Stiff □ Other _____

Does it interfere with Daily Activities: □ Sleep □ Walking/Running □ Sitting □ Standing □ Lifting
□ Work □ Social Activities □ Personal Care □ Other _____.

Please rate your discomfort at its worst: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst pain)

Please rate your discomfort at its best: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst pain)

Have you had this or a similar condition in the past? Y / N Explain _____

_____

What treatment have you already received for your condition?

□ None □ Medication □ Surgery □ Physical Therapy □ Chiropractic □ Other _____

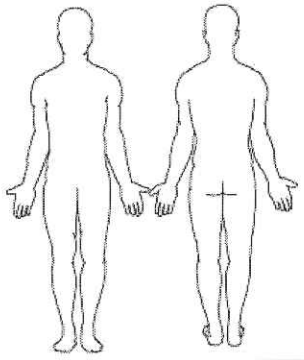
Were you satisfied with the results of your treatment? Y / N Explain _____

DESCRIBE THE DISCOMFORT

Please mark the diagram below by placing the appropriate symbol at the site of discomfort.

Symptom:	Symbol:
Numbness	NNN
Pins & Needles	PPP
Burning	BBB
Aching	AAA
Stabbing	SSS

◯ Circle any other area not represented by a symbol.



HEALTH HISTORY

Do you have or have you had any of the following: □ Heart Attack/Stroke □ Pacemaker □ Heart Surgery
□ High/Low BP □ Difficulty Breathing □ Alcohol/Drug Abuse □ Diabetes □ Cancer
□ Arthritis □ Seizures/Fainting □ Artificial Joints □ HIV/AIDS □ Psychiatric Problems

Other serious medical conditions not listed above _____

List any surgeries (& dates) not listed above _____

Do you have any scars from surgeries/procedures? Y / N Where? _____

Do you wear: □ Heel Lifts □Orthotics □Inner Soles □ Arch Supports □ Other _____

List any allergies or skin sensitivities _____

Are you on any special diet? Y / N (Explain)_____

Who is your Medical Doctor? _____ Phone _____

IN CASE OF EMERGENCY

In case of emergency, whom should we contact? _____

Relationship: _____ Phone _____

* I authorize the staff to perform any necessary services needed during diagnosis & treatment.
* I authorize the provider to release any information required to process insurance claims.
* I acknowledge that this form was completed correctly to the best of my knowledge.
* I understand it is my responsibility to inform this office of any changes to the information I have provided.

Patient Signature _____ Date _____

Axelson
CHIROPRACTIC & REHAB

GENERAL RELEASE OF MEDICAL RECORDS

Patient's Name (printed) _____ **DOB:** _____

I hereby request and authorize: _____

Phone: _____ Fax: _____

to disclose my protected health information as indicated below:

Description of information to be disclosed*

_____ X-Ray Images/Reports _____ MRI Images/Reports

_____ OTHER _____

***Please send the most recent record unless otherwise specified**
A photocopy of this authorization will be accepted with the same authority as the original.

Reason for requested use or disclosure: continuance of care

This information is to be disclosed to: Axelson Chiropractic & Rehab
Address: 901 Newman Road
New Bern, NC 28562
Phone: 252-633-3334
Fax: 252-637-4483

TO BE READ AND SIGNED BY PATIENT

I understand the following:

a. I may revoke this authorization at any time by providing written notice to the practice.
b. I may not be able to revoke this authorization if the practice has already taken action utilizing this authorization or if the authorization was obtained as a condition of obtaining insurance coverage.
c. The practice will not determine treatment or payment based on my signing this authorization.
d. No one has pressured me to sign this authorization.
e. The information disclosed in this authorization may be subject to re-disclosure by the practice and no longer protected by federal law.
f. I acknowledge that I have had an opportunity to review this authorization and understand the intent and the use.
g. I have right to request a copy of this authorization.

Patient's Signature: _____ **Date** _____

***This authorization shall be in force and effect until one year from date signed**

Axelson
CHIROPRACTIC & REHAB

PERSONAL INJURY QUESTIONNAIRE

(Please use additional paper and attach should you need more space.)

Name:_____ Phone: _____

Address: _____ City: _____

State: _____ Zip: _____ Email:_____

Birthday: _____ Sex: ( ) F ( ) M SS#: _____

Employer's Name: _____ Phone: _____

INSURANCE INFORMATION (YOUR MEDPAY AND RESPONSIBLE PARTY INFO)

Your Auto Ins Co:_____ Phone:_____

Claim #: _____ Agent's Name: _____

Liability (At Fault) Auto Ins Co: _____ Phone: _____

Claim #: _____ Adjuster's Name: _____

ATTORNEY INFORMATION

Name: _____ Phone: _____

Address: _____ City/State/Zip:_____

Were there any witnesses? ( )No ( )Yes If so, please list:_____

NATURE OF ACCIDENT:

1. Date of Accident: _____ Time of Day Accident Occurred :_____
2. What type of accident was this? ( ) Motor Vehicle Accident ( ) Work Related Accident
3. Where did the accident occur? _____
4. In your own words, please describe the accident (use the back of this page if more space is needed):

_____

_____

_____

_____

If this is a work related accident, you may skip questions 5-11. Please continue to question #12.

5. Were you the: ( ) Driver Passenger: ( ) Front Seat ( ) Back Seat Drivers Side ( ) Back Seat Passengers Side
6. Were you struck from: ( ) Behind ( ) Front ( ) Left side ( ) Right side?
7. Your vehicle type (Circle One): Car / Pick-up / Van / SUV / Bus / Heavy Transport Vehicle / Other _____
8. Other vehicle involved (Circle): Car / Pick-up / Van / SUV / Bus / Heavy Transport Vehicle / Other _____
9. Were you wearing a seat-belt? ( ) Yes ( ) No Were airbags deployed? ( ) Yes ( ) No
10. Did any part of your body strike any object (steering wheel, dash, etc.)? ( ) Yes ( ) No

    If yes, please explain _____
11. Approximate speed of your car: _____mph. Other car: _____mph.
12. Were you knocked unconscious? ( ) Yes ( ) No If yes, for how long? _____
13. Were police notified? ( ) Yes ( ) No
14. Please describe how you felt:
    a) DURING the accident: _____
    b) IMMEDIATELY AFTER the accident: _____

c) LATER THAT DAY: _____

d) THE NEXT DAY: _____

15. What are your PRESENT complaints and symptoms?

_____

_____

16. Are your symptoms: ( ) Constant ( ) They Come & Go

17. Were you evaluation/treated at the hospital/urgent care after the accident? ( ) Yes ( ) No

18. If Yes, where? _____

19. Were you transported by ambulance? ( ) Yes ( ) No

20. Have you been treated by another doctor since the accident? ( ) Yes ( ) No

If yes, please list doctor's name _____ phone ( )_____

21. What type of treatment did you receive? ( ) X-Rays ( ) Medications ( ) Other _____

22. Since this injury occurred, are your symptoms: ( ) Improving ( ) Getting Worse ( ) Same

23. CHECK SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT:

☐ Headache(s)	☐ Irritability	☐ Nervousness	☐ Heavy Depression	☐ Tension
☐ Neck Pain/Stiffness	☐ Dizziness	☐ Blurred Vision	☐ Ears Ring/Buzz	☐ Loss of Balance
☐ Chest Pain	☐ Shortness of Breath	☐ Fatigue	☐ Fainting	☐ Stomach Upset
☐ Back Pain/Stiffness	☐ Tingling in Legs	☐ Tingling in Arms	☐ Diarrhea/Constipation	☐ Loss of Smell/Taste
☐ Difficulty Sleeping	☐ Numb Feet/Toes	☐ Numb Hands/Fingers	☐ Fever ☐ Cold Sweats	☐ Loss of Memory

24. Symptoms Other Than Listed Above:_____

25. Are there any activities that are uncomfortable or painful to perform since the accident? ( ) Yes ( ) No

If yes, please explain _____

_____

26. Have you lost time from work as a result of this accident? ( ) Yes ( ) No

If yes, please explain: _____

27. Do you notice any activity restrictions as a result of this injury? ( ) Yes ( ) No

If yes, please describe in detail: _____

_____

28. Do you have any congenital (from birth) factors, or previous illnesses which relate to this problem? ( ) Yes ( ) No

If yes, please explain _____

29. Have you ever been involved in an accident before? ( ) Yes ( ) No

If yes, please describe, including date(s) and type(s) of accidents as well as injury/injuries received:

_____

_____

30. Other pertinent information:

_____

_____

To any insurance company with coverage applicable to my claim(s) and to any attorney representing me:

ASSIGNMENT OF BENEFITS

IN CONSIDERATION of the willingness of AXELSON CHIROPRACTIC to treat me on credit without demand for payment at the time services are rendered, I hereby agree and stipulate as follows:

I irrevocably assign to AXELSON CHIROPRACTIC any proceeds or compensation that I am or may become entitled to receive as a result of injuries that occurred on _____ to the extent of the chiropractic services rendered. I make this agreement without prejudice to any rights I may have to prosecute legal claims against any party who may be liable for my injuries, but I hereby authorize and instruct you to pay directly to AXELSON CHIROPRACTIC, from any disability benefits, medical payments (MEDPAY) benefits, liability benefits, health and accident benefits, workers compensation benefits, judgments, settlements, or proceeds of any kind that would otherwise be payable to me, such sums as are due to AXELSON CHIROPRACTIC for its services rendered.

I appoint AXELSON CHIROPRACTIC as my attorney in fact to affix my name as an endorsement upon the reverse of any check or draft upon which I am a named payee and to deposit said check or draft and apply the proceeds to any unpaid balance I may have with AXELSON CHIROPRACTIC.

I authorize AXELSON CHIROPRACTIC to release to any insurer with applicable coverage or to my attorney or successor attorney any information regarding my injuries, prior medical history, or treatment as may be necessary to facilitate collection of proceeds under this agreement.

I acknowledge that I remain personally liable for the total amount due to AXELSON CHIROPRACTIC for services rendered, including any balance remaining after the application of insurance payments and settlement or judgment proceeds. If AXELSON CHIROPRACTIC is required to take legal action against me to recover any unpaid balance on my account, I agree to reimburse AXELSON CHIROPRACTIC for its costs of recovery, including reasonable attorney's fees.

I further agree this assignment of benefits (AOB) cannot be revoked and the right to receive payment cannot be transferred to any other party or re-asserted by my in any way.

_____
Patient

_____
Date

_____
Witness

NOTICE OF LIEN

Pursuant to N.C.G.S. 44-49 and 44-50, AXELSON CHIROPRACTIC hereby asserts and gives notice of a lien upon any sums recovered for personal injury in any civil action and also upon all funds paid to the above-named patient in compensation for or settlement of injuries sustained, whether in litigation or otherwise.

AXELSON CHIROPRACTIC hereby requests that if its claim is not paid in full from the foregoing proceeds, a full disclosure and accounting of proceeds be provided in conformity with N.C.G.S. 44-50.1. AXELSON CHIROPRACTIC agrees to be bound by any confidentiality agreements regarding the contents of the accounting.

Axelson Chiropractic By: _____ Date: _____

Axelson
CHIROPRACTIC & REHAB

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:

1. 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.

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

3. 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.

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

5. 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.

4. 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:

1. 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.
2. 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.
3. 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.
4. 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.

Axelson
CHIROPRACTIC & REHAB

901 Newman Road
New Bern, NC 28562
252-633-3334

Consent to use PHI

Acknowledgement for Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of your Protected Health Information (PHI)

Axelson Chiropractic may use or may disclose my PHI to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office. _____ Patient Initials

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your PHI may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office.

I have received a copy of the Notice of Patient Privacy Policy. _____ Patient Initials

Requesting a Restriction on the Use or Disclosure of Your Information

You may request a restriction on the use or disclosure of your PHI. This office may or may not agree to restrict the use or disclosure of your PHI. If we agree to your request, the restriction will be binding with this office. Use or disclosure of PHI in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Notice of Treatment

Axelson Chiropractic has private treatment rooms and an open therapy room. I consent to treatment & authorize the staff to perform any necessary services needed during diagnosis and treatment. _____ Patient Initials

I understand that I am required to make payment for all services rendered at the time of visit (whether covered or non-covered by insurance) and I am ultimately responsible for my account. _____ Patient Initials

Revocation of Consent

You may revoke this consent to the use and disclosure of your PHI. This must be done in writing. Any use or disclosure that had occurred prior to the date on which your revocation of consent is received will not be affected.

Authorized Disclosure of PHI

I authorize the following person(s) to access my PHI (please list their name and their relationship to you):

Name _____ Relationship to patient _____

Name _____ Relationship to patient _____

Name _____ Relationship to patient _____

*This authorization will be valid for five years from the date signed unless revoked in writing or when a new authorization form is completed and signed. At that time, the updated authorization will replace this one.

_____ _____
Patient or Legally Authorized Individual Signature Date

_____ _____
Print Patient's Full Name Date of Birth

_____ _____
Witness Signature Date