Motor Vehicle Accident Information

Last Name:	Social Security no.:
First Name:	Middle:

General Information

Date of Accident:			
Location (circle one)	**Driver**		
	Passenger	Location (circle one)	Front / Middle / Rear
		Position (circle one)	Left / Middle / Right

Work from Left to Right and Circle One

Patients Vehicle	**Type :**	Car / Van / Pickup / Truck / Bus / SUV / M. Cycle / Other:
	Size :	Mini / Sub Comp / compact / Mid Size / Full Size
	Action :	Stopped / Slowing / Acceleration / Cruising
	Speed : (MPH**)**	
	Time of Accident:	Day Light / Dawn / Dusk / Dark
	Road Condition :	Dry / Damp / Wet / Snow / Ice
	Visibility :	Good / Fair / Poor

Enter impact Information for up to three Vehicles or Objects

Impact Information: Vehicle or Object (I)

(Select one) ☐ **Vehicle** ☐ **Object**	**Name Object :**	
	Vehicle Type :	Car / Van / Pickup / Truck / Bus / SUV / M. Cycle / Other:
	Size :	Mini / Sub Comp / compact / Mid Size / Full Size
	Damage to Veh.:	Minimal / Moderate / Extensive / Totaled / Unsure
Impact Location		

Impact Information: Vehicle or Object (II)

(Select one) ☐ **Vehicle** ☐ **Object**	**Name Object :**	
	Vehicle Type :	Car / Van / Pickup / Truck / Bus / SUV / M. Cycle / Other:
	Size :	Mini / Sub Comp / compact / Mid Size / Full Size
	Damage to Veh.:	Minimal / Moderate / Extensive / Totaled / Unsure
Impact Location		

Impact Information: Vehicle or Object (III)

(Select one) ☐ **Vehicle** ☐ **Object**	**Name Object :**	
	Vehicle Type :	Car / Van / Pickup / Truck / Bus / SUV / M. Cycle / Other:
	Size :	Mini / Sub Comp / compact / Mid Size / Full Size
	Damage to Veh.:	Minimal / Moderate / Extensive / Totaled / Unsure
Impact Location		

During Impact Information:

Seat Belt?	☐ Yes	☐ No	Brakes Applied ?	☐ Yes	☐ No
Air Bag Deployed?	☐ Yes	☐ No	Seat Broken ?	☐ Yes	☐ No
Seat Back position Changed?	☐ Yes	☐ No			

Head Rest : (Circle one)	Low / Mid / High / None
Prepare for Accident: (Circle One)	Un-expected / Expected / Expected and Braced
Body Position : (Circle one)	Straight / Rotated Left / Rotated Right / Unsure / Other:
Body Thrown?	☐ Yes / ☐ No
Direction of Throw :(Circle One)	Backwards / Forward / Outside / Unsure / Other:

(Circle One)

Head Position :	Straight / Rotated Left / Rotated Right / Forward / Unsure / Other:
Head Motion :	Forward Backwards / Backwards Forward / Right Left / Left Right / Unsure / Other:

Body Impact (Indicate any parts of your body that were struck during the impact)

☐ Head	☐ Upper Back	☐ Right hand	☐ Lower Back
☐ Left Shoulder	☐ Left Leg	☐ Mid Torso	☐ Right Foot
☐ Left Arm	☐ Right Leg	☐ Mid Back	☐ Left Foot
☐ Left Elbow	☐ Right Shoulder	☐ Right Knee	☐ Other :
☐ Left hand	☐ Right Arm	☐ Left Knee	
☐ Upper Front Torso	☐ Right Elbow	☐ Lower Front Torso	

After Accident Information:

Immediately After Accident:	☐ Dizzy/dazed ☐ Upset ☐ Weak ☐ Nervous ☐ Headache ☐ Disoriented ☐ Unconscious ☐/Other:

Pain (Indicate if you experienced any pain immediately following the accident)

☐ Head	☐ Left foot	☐ Right foot	☐ Left Knee
☐ Left Hand	☐ Left Shoulder	☐ Right Shoulder	☐ Right knee
☐ Right Arm	☐ Left Elbow	☐ Left Arm	☐ Other :
☐ Upper Front Torso	☐ Mid Torso	☐ Right elbow	
☐ Upper Back	☐ Mid back	☐ Lower Front Torso	
☐ Left Leg	☐ Right Leg	☐ Lower Back	

Numbness:	☐Left Hand ☐ Right Hand ☐ Left Leg ☐ Right Leg ☐ Left Upper Arm ☐ Right Upper Arm ☐ Left Foot ☐ Right Foot ☐ Other:

Medical Information (Did you get medical care for this accident before coming to our office)

Medical Care?	☐ Yes	☐ No

Time of care	Next day / At time of Accident / Later that Day / Days Later: (Specify)
Transported	Drove Self / Ambulance / Other
Went To	Orthopedic / Chiropractor / Neurologist / Family Doc / ER / Other:(Specify)
Admitted to Hospital?	☐ Yes ☐ No Days Spent in Hospital:
Test:	☐ X-ray ☐ Lab Work ☐ MRI ☐ CT Scan ☐ Other:(Specify)
Treatment:	☐ Ice Pack ☐ Hot Pack ☐ None ☐ Cervical Collar ☐ Medication ☐ Other:(Specify)

Previous Injuries

Previous Injuries / Accidents	☐ No ☐ Yes, Specify:
Residual pain from Previous Injuries/Accidents	☐ No ☐ Yes, Specify:

Later Symptoms (Please note any symptoms that started after the accident occurred)

Head	☐ Headache ☐ Dizziness ☐ Blurred Vision ☐ Light Headedness ☐ Loss of Vision ☐ Fainting ☐ Loss of Memory ☐ Pain in ear ☐ Double Vision ☐ Other Specify:
Neck (with Movement)	☐ Pain in Neck ☐ Forward ☐ Backward ☐ Turn Left ☐ Popping in Neck ☐ Muscle Spasms ☐ Turn Right ☐ Bend Left ☐ bend Right ☐ Other Specify:
Shoulders	☐ Pain in Shoulder joint ☐ Tension in shoulders ☐ Muscle Spasms in Shoulder ☐ Pain across shoulder ☐ Cant raise arms above [ ] Above shoulder level [ ] Over head ☐ Other Specify:
Arms and Hands	☐ Pain in Fingers ☐ Numbness in Left Arm ☐ Hands Cold ☐ Pin & needles in hands ☐ Numbness in Right Arm ☐ Loss of Grip Strength ☐ Pin & needles in fingers ☐ Swollen joints in Fingers ☐ Other Specify:
Chest	☐ Chest pain ☐ Pain Around Ribs ☐ Shortness of Breadth ☐ Breast Pain ☐ Other Specify:
Abdomen	☐ Nervous Stomach ☐ Nausea ☐ Diarrhea ☐ Gas ☐ Constipation ☐ Other Specify:
Mid back	☐ Sharp Stabbing ☐ Mid pain back ☐ Pain From front to back ☐ Dull Ache ☐ Pain in Kidney Area ☐ Muscle Spasms ☐ Pain between shoulders ☐ Other Specify:
Lower Back	☐ Low Back Pain Low back pain is worse when ☐ Working ☐ Lifting ☐ Stooping ☐ Standing ☐ Sitting ☐ Bending ☐ Coughing ☐ Lying Down ☐ Muscle Spasms ☐ Other Specify:
Hips, Legs & Feet	☐ Pain in Buttocks ☐ Pain and needles in Legs ☐ Pain down leg ☐ Pain in hip joint ☐ Feet feel Cold ☐ Swollen Feet ☐ Numbness in Toes ☐ Numbness of Leg ☐ Knee pain ☐ Leg cramps ☐ Cramps in Feet ☐ Other Specify:
General	☐ Nervousness ☐ Fatigue ☐ Irritable ☐ Depressed ☐ Generally Feel Rundown ☐ Prostate Pain/Swelling ☐ Difficulty Urinating ☐ Night Urination ☐ Cramping ☐ Irregularity Loss of Sleep : [_____] hrs per night Loss of weight : [_____] lbs Gain weight : [_____] lbs Other:

Signature: _____ Date: _____

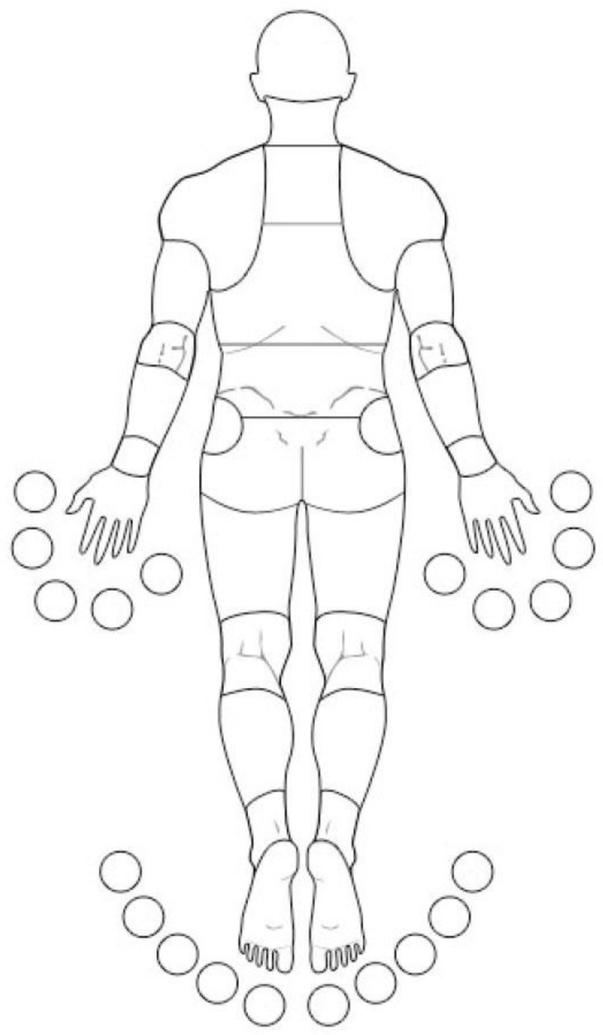
All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

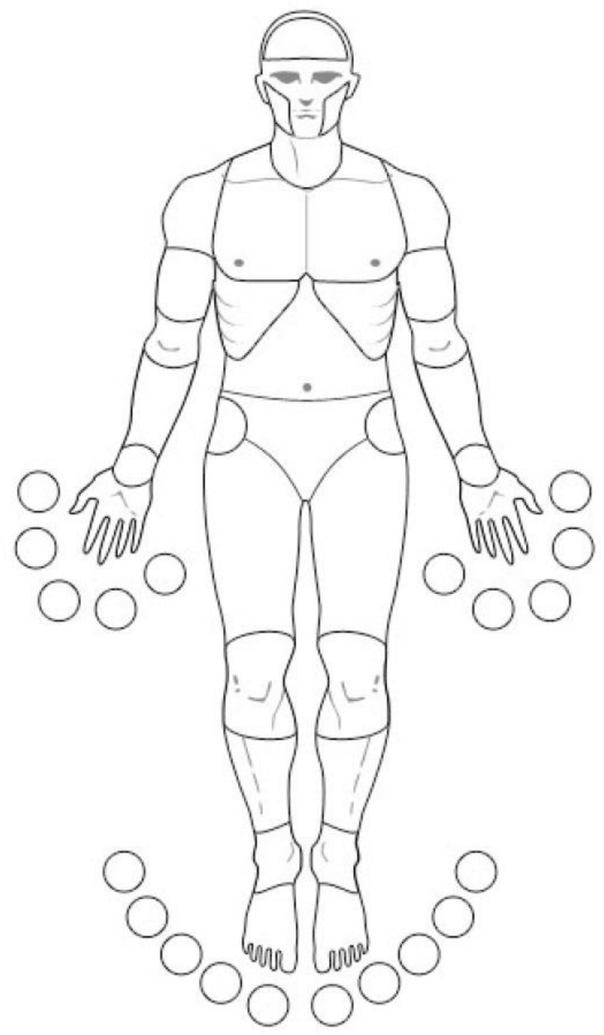
HEALTH

Patient's Name: _____ Date: _____

Please indicate the current complaints you are experiencing by marking the areas on the image below and providing details using the sections that follow.

1. headaches
2. Neck
3. Upper back
4. Mid Back
5. Lower Back
6. Hip
7. Buttock
8. Shoulder
9. Arm
10. Elbow
11. Forearm
12. Wrist
13. Hand
14. Fingers
15. Leg
16. Knee
17. Calf
18. Shin
19. Ankle
20. Foot
21. Toes
22. Chest
23. Ribs
24. Abdomen
25. Pelvis/Groin





HEADACHES	
Location	☐ Left ☐ Right ☐ Both ☐ Center
Specifics	☐ Frontal ☐ Coronal ☐ Occipital ☐ Parietal ☐ Temporal ☐ Throughout
Pain Ratings	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 (Excruciating)
Frequency	☐ Infrequent < 25% ☐ Occasional 25% to 50% ☐ Frequent 50% to 75% ☐ Constant > 75%
Pain/Severity	☐ No Pain ☐ Pain ☐ Numbness ☐ Tingling / ☐ Mild ☐ Moderate ☐ Severe
Associated with	☐ Dizziness ☐ Nausea ☐ Visual Problems ☐ Ringing/Buzzing ears ☐ Bright light ☐ Sensitivity ☐ Loss of balance
Radiates to	☐ Neck ☐ Right Eye ☐ Left Eye ☐ Right Ear ☐ Left Ear ☐ Right Jaw ☐ Left Jaw
Described as	☐ Aching ☐ Dull ☐ Sharp ☐ Stabbing ☐ Throbbing
At it's worst	☐ Morning ☐ Afternoon ☐ Evening ☐ Night After Activities: ☐ Light ☐ Moderate
What makes it better?	☐ Medication ☐ Lying Down ☐ Standing ☐ Sitting ☐ Stretching ☐ Range of Motion ☐ Nothing
What makes it worse?	☐ Bright lights ☐ Housework ☐ Loud noises ☐ Neck movements ☐ Watching T.V. ☐ Reading ☐ Working

Comments:_____

_____

NECK	
Location	☐ Right Front ☐ Left Front ☐ Right Back ☐ Left Back ☐ Center
Pain Ratings	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 (Excruciating)
Frequency	☐ Infrequent < 25% ☐ Occasional 25% to 50% ☐ Frequent 50% to 75% ☐ Constant > 75%
Pain/Severity	☐ No Pain ☐ Pain ☐ Numbness ☐ Tingling / ☐ Mild ☐ Moderate ☐ Severe
Associated with	☐ Numbness ☐ Tingling ☐ Increased sensitivity ☐ Stiffness ☐ Tightness ☐ ROM
Radiates to	☐ Head ☐ Forehead ☐ Back of head ☐ Right side of head ☐ Left side of head ☐ Both sides of head ☐ Right shoulder blade ☐ Left shoulder blade ☐ Right shoulder ☐ Left shoulder ☐ Right arm ☐ Left arm ☐ Right forearm ☐ Left forearm ☐ Right hand ☐ Left hand ☐ Right fingers ☐ Left fingers
Described as	☐ Aching ☐ Dull ☐ Sharp ☐ Stabbing ☐ Throbbing
At it's worst	☐ Morning ☐ Afternoon ☐ Evening ☐ Night ☐ Light Activities ☐ Moderate Activities
What makes it better?	☐ Medication ☐ Lying Down ☐ Standing ☐ Sitting ☐ Stretching ☐ Range of Motion ☐ Nothing
What makes it worse?	☐ Neck Movement ☐ Sneezing ☐ Prolonged Sitting ☐ Prolonged Standing ☐ Walking

Comments:_____

_____

MID BACK	
Location	☐ Left ☐ Right ☐ Both ☐ Center
Pain Ratings	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 (Excruciating)
Frequency	☐ Infrequent < 25% ☐ Occasional 25% to 50% ☐ Frequent 50% to 75% ☐ Constant > 75%
Pain/Severity	☐ No Pain ☐ Pain ☐ Numbness ☐ Tingling / ☐ Mild ☐ Moderate ☐ Severe
Associated with	☐ Numbness ☐ Tingling ☐ Increased sensitivity ☐ Tightness ☐ Stiffness ☐ Decreased ROM
Radiates to	☐ Neck ☐ Right Ribs ☐ Left Ribs ☐ Lower back
Described as	☐ Aching ☐ Dull ☐ Sharp ☐ Stabbing ☐ Throbbing
At it's worst	☐ Morning ☐ Afternoon ☐ Evening ☐ During Night ☐ Light Activities ☐ Moderate Activity
What makes it better?	☐ Medication ☐ Lying Down ☐ Standing ☐ Sitting ☐ Stretching ☐ Range of Motion ☐ Nothing
What makes it worse?	☐ Upper body movement ☐ Lifting ☐ Working ☐ Sneezing ☐ Housework ☐ Coughing ☐ Bending Prolonged: ☐ Sitting ☐ Standing ☐ Walking

Comments: _____

_____

LOWER BACK	
Location	☐ Left ☐ Right ☐ Both ☐ Center
Pain Ratings	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 (Excruciating)
Frequency	☐ Infrequent < 25% ☐ Occasional 25% to 50% ☐ Frequent 50% to 75% ☐ Constant > 75%
Pain/Severity	☐ No Pain ☐ Pain ☐ Numbness ☐ Tingling / ☐ Mild ☐ Moderate ☐ Severe
Associated with	☐ Numbness ☐ Tingling ☐ Increased sensitivity ☐ Tightness ☐ Stiffness ☐ ROM
Radiates to	☐ Right Upper back ☐ Left Upper back ☐ Right Buttock ☐ Left Buttock ☐ Both Buttocks ☐ Right Hip ☐ Left Hip ☐ Right Thigh ☐ Left Thigh ☐ Right Calf ☐ Left Calf ☐ Right Foot ☐ Left Foot ☐ Right Toes ☐ Left Toes
Described as	☐ Aching ☐ Dull ☐ Sharp ☐ Stabbing ☐ Throbbing
At it's worst	☐ Morning ☐ Afternoon ☐ Evening ☐ Night After Activities: ☐ Light ☐ Moderate
What makes it better?	☐ Medication ☐ Lying Down ☐ Standing ☐ Sitting ☐ Stretching ☐ Range of Motion ☐ Nothing
What makes it worse?	☐ Range of motion ☐ Lifting ☐ Bending ☐ Lying down ☐ Working ☐ Housework ☐ Coughing. ☐ Sneezing Prolonged: ☐ Sitting ☐ Standing ☐ Walking

Comments: _____

_____

ARM OR LEG (circle one)	
Location	☐ Right Arm/Leg ☐ Left Arm/Leg ☐ Both Arms/Legs
Pain Ratings	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 (Excruciating)
Frequency	☐ Infrequent < 25% ☐ Occasional 25% to 50% ☐ Frequent 50% to 75% ☐ Constant > 75%
Pain/Severity	☐ No Pain ☐ Pain ☐ Numbness ☐ Tingling / ☐ Mild ☐ Moderate ☐ Severe
Associated with	☐ Numbness ☐ Bruises/Abrasions ☐ Tingling ☐ Increased sensitivity ☐ Weakness
Radiates to	☐ Right Shoulder/thigh ☐ Left Shoulder/thigh ☐ Right Elbow ☐ Left Elbow ☐ Right Forearm/Calf ☐ Left Forearm/Calf ☐ Right Hand/Foot ☐ Left Hand/Foot ☐ Right Fingers/Toes ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ Left Fingers/Toes ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
Described as	☐ Aching ☐ Dull ☐ Sharp ☐ Stabbing ☐ Throbbing
At it's worst	☐ Afternoon ☐ Evening ☐ Light Activities ☐ Moderate Activities ☐ Morning
What makes it better?	☐ Medication ☐ Lying Down ☐ Standing ☐ Sitting ☐ Stretching ☐ Range of Motion ☐ Nothing
What makes it worse?	☐ Movement ☐ Housework ☐ Lifting ☐ Driving ☐ Working

Comments: _____

_____

Other Area of Complaint		
Location		☐ Left ☐ Right ☐ Both ☐ Center
Pain Ratings		☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 (Excruciating)
Frequency		☐ Infrequent < 25% ☐ Occasional 25% to 50% ☐ Frequent 50% to 75% ☐ Constant > 75%
Pain Type		☐ No Pain ☐ Pain ☐ Numbness ☐ Tingling ☐ Muscle Spasms ☐ Burning
Severity		☐ Mild ☐ Mild to Moderate ☐ Moderate ☐ Moderate to Severe ☐ Severe
What makes it better?		☐ Medication ☐ Lying Down ☐ Standing ☐ Sitting ☐ Stretching ☐ Range of Motion ☐ Nothing
What makes it worse?		☐ Movements ☐ Bending ☐ Twisting ☐ Weight Bearing ☐ Movements ☐ Neck flexion ☐ Sneezing ☐ Sitting ☐ Standing ☐ Walking ☐ Chewing ☐ Yawning ☐ Opening mouth ☐ Closing mouth ☐ Range of motion ☐ pushing/pulling ☐ Lifting ☐ Bright lights ☐ Loud Noises ☐ Watching T.V. ☐ Reading ☐ Working ☐ Driving ☐ Housework
Does the pain radiate to any other locations?	Upper Body	☐ Head ☐ Forehead ☐ Back of head ☐ Right side of head ☐ Left side of head ☐ Neck ☐ Right Ear ☐ Left Ear ☐ Right Eye ☐ Left Eye ☐ Face ☐ Right Jaw ☐ Left Jaw ☐ Right Upper back ☐ Left Upper back ☐ Right Shoulder ☐ Left Shoulder ☐ Right Chest ☐ Left Chest ☐ Right Ribs ☐ Left Ribs
	Mid Body	☐ Right Mid back ☐ Left Mid back ☐ Right Lower back ☐ Left Lower back ☐ Right Hip ☐ Left Hip ☐ Right Buttock ☐ Left Buttock ☐ Groin ☐ Right Arm ☐ Left Arm ☐ Right forearm ☐ Left forearm ☐ Right hand ☐ Left hand ☐ Right fingers ☐ Left fingers
	Lower Body	☐ Right Thigh ☐ Left Thigh ☐ Right Knee ☐ Left Knee ☐ Right Calf ☐ Left Calf ☐ Right Toes ☐ Left Toes ☐ Right Foot ☐ Left Foot ☐ Right Toes ☐ Left Toes
Described as		☐ Aching ☐ Dull ☐ Sharp ☐ Stabbing ☐ Throbbing
At it's worst		☐ Morning ☐ Afternoon ☐ Evening ☐ Night After Activities: ☐ Light ☐Moderate
Associated with		☐ Dizziness ☐ Nausea ☐ Visual Problems ☐ Ringing/Buzzing ears ☐ Bright light ☐ Sensitivity ☐ Loss of balance
Comments		

OTHER COMPLAINTS:

☐ Balance loss ☐ Fatigue ☐ Irritability ☐ Memory loss ☐ Nervousness ☐ Tension ☐ Shortness of breath

_____

Patient's Signature

Medical History Information

Last Name:		❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one)
First Name:	Middle:			Single / Mar / Div / Sep / Widow
Email:		Birth date:	Age:	Sex:
Address:	City:		State:	
ZIP Code:	Social Security No.:	Home Phone:		
Occupation:	Employer:	Phone:	Cell phone:	

Medical Care Information

Do You Have a Family Doctor?: ☐ No ☐ Yes, Name of Doctor:			
Address:	City:	State:	ZIP Code:
Date of last Visit: / /	Date of last exam: / /		
Have You Had Chiropractic Care In The Past? ☐ No ☐ Yes, Name of Chiropractor:			
Address:	City:	State:	ZIP Code:
Date of last Visit: / /	Date of last exam: / /		
Have you had surgeries in the last 5 Years: ☐ Yes ☐ No	If yes, Last Surgery Date:		
Reason for Surgery:			

Present illness /Conditions:

☐ AIDS	☐ Cancer	☐ Heart Problem	☐ Multiple Sclerosis	☐ Spinal Disc Disease	
☐ Allergies	☐ Cirrhosis/hepatitis	☐ High blood pressure	☐ Pacemaker	☐ Currently Pregnant Due Date:	☐ Taking Birth Control
☐ Anemia	☐ Diabetes	☐ HIV/ARC	☐ Prostate trouble	☐ Tuberculosis	☐ Date of Last Cycle
☐ Arthritis	☐ Dislocated joints	☐ Kidney trouble	☐ Rheumatic fever	☐ Thyroid trouble	☐ Ulcer
☐ Asthma	☐ Diverticulitis	☐ Low Blood Pressure	☐ Scoliosis	☐ Epilepsy	☐ Polio
☐ Bone fracture	☐ Hay Fever	☐ Mental/ Emotional Difficulty	☐ Sinus trouble	☐ STD'S	☐
Other:					

Family History of illness:

☐ AIDS	☐ Cancer	☐ Multiple Sclerosis	☐ Spinal Disc Disease	☐ STD'S	
☐ Allergies	☐ Bone fracture	☐ Heart Problem	☐ Low Blood Pressure	☐ Sinus trouble	☐ Ulcer
☐ Anemia	☐ Cirrhosis/hepatitis	☐ HIV/ARC	☐ Mental/ Emotional Difficulty	☐ Epilepsy	☐ Polio
☐ Arthritis	☐ Diabetes	☐ High blood pressure	☐ Prostate trouble	☐ Thyroid trouble	☐ Scoliosis
☐ Asthma	☐ Dislocated joints	☐ Kidney trouble	☐ Rheumatic fever	☐ Tuberculosis	☐ Diverticulitus
Other:					

Type of Cancer:	☐ Breast ☐ Lung ☐ Other:
Social History:	

Alcohol? ☐ No ☐ Yes Drinks per week?	Cigarettes? ☐ No ☐ Yes Packs per day?	Caffeine? ☐ No ☐ Yes Drinks per day?	Exercise? ☐ No ☐ Yes Hours per week? (circle one) Light / Moderate / Strenuous
Misc.:			

Signature: _____ Date: _____

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

IN CASE OF EMERGENCY

Please Contact:

Name	Phone Number	Relationship to patient

INFORMED CONSENT TO TREATMENT AND CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays on me or on the patient named below for whom I am legally responsible for by the Doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working for, or associated with, or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below, or any other office or clinic.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel regarding the nature and purpose of chiropractic adjustments and procedures.

I understand and am informed that as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations, and sprains. I do expect the doctor to exercise judgment during the course of the procedure which the doctor feels, at the time, based upon the facts known, is in my best interest.

I have read, or have had read to me, the above consent. I have also had the opportunity to discuss or ask questions about its content, and by signing below, I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present conditions and for any conditions in the future for which I seek treatment.

SIGNATURE _____ DATE _____

*I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release information required to process insurance claims.
*I understand the above information and guarantee this form was completed correctly and to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my medical status.

SIGNATURE _____ DATE _____

By my initials _____, I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance unpaid by the insurance company.

*Our policy requires payment in full for all services rendered at the time of the visit unless other arrangements are made with the office manager. **How will you be paying for today's visit?**
_____CASH _____CHECK _____CREDIT CARD _____GIFT CERT. _____ACCIDENT

DIAGNOSTIC IMAGING CONSULTANTS

Rudy N. Heiser, DC, MS, DACBR, Richard A. Leverone, DC, DACBR, **FICC**
Terry Sandman, DC, **MPH,** DACBR, A. Scott Thorpe, DC. DACBR

REFERRING DR.: LONG CHIROPRACTIC & REHAB CTR. **DR. LISA LONG**
4282 W. Linebaugh Ave., Tampa, FL 33624-5241
PH: (813) 930-6112 Fax: (813) 930-6332
Films/Date Exposed _____ ***Medical History*** _____

Please print and complete form with patient's signature

Patient Name _____ Date of Birth _____ Sex ____ M ____ F

Address _____ City/State/Zip _____

Phone _____ SS# _____ Case/Acct# _____

BILL: _____ **PIP** _____ **Health/Other Ins.** _____ **Dr.** _____ **Atty.** _____ **Patient**

Primary Insurance: _____ Phone _____

Adjuster _____ ID/Claim# _____

Address _____ Insured _____

City/State/Zip _____ Date of Injury ____/____/____

Attorney: _____ Phone _____

Address _____ City/State/Zip _____

ASSIGNMENT, LIEN AND AUTHORIZATION/INSURANCE BENEFITS

For and in consideration of receiving services by "Assignee" and for other good and valuable consideration. I hereby agree to the following: I authorize assignee to release any information pertinent to my case to any insurance company. adjuster. or attorney to facililate collection under this Assignment. Lien. Reservation of Benefits and Authorization.

ASSIGNMENT OF BENEFITS, RESERVATION AND REQUEST TO ESCROW ANY DISPUTED BENEFITS:

I HEREBY ASSIGN MY insurance benefits and any and all causes of action available under my policy of automobile insurance to. DIAGNOSTIC IMAGING CONSULTANTS OF ST. PETERSBURG, PA d/b/a DIAGNOSTIC IMAGING CONSULTANTS hereinafter, collectively referred to as the Assignee. Additionally, both the assignee and the undersigned patient acknowledge they are foregoing or assuming certain rights under this agreement that they would not otherwise have under normal circumstances, and as such. agree the same serves as additional consideration for this assignment of benefits to the provider/assignees. In the event my insurance company, obligated to make payments to me upon charges made by assignee for services, refuses to make or reduces such payments and in order to maximize the benefits available under my policy coverage. I hereby request the insurance company (assuming there is coverage remaining at the time the company receives the Assignees' bill and if the company fails to pay Assignee to full amount of the bill(s) submitted). To avoid exhaustion of coverage while Assignee pursues its rights under this Agreement, both parties to this agreement (the Assignee and I) further authorize, direct, notice and request the Insurance Company to set aside and place in escrow an amount equal to the full amount of any such denial or reduction, and to hold that amount in escrow until the dispute is resolved in the appropriate forum.

IN THE EVENT MY insurance company obligated to make payments to me upon the charges made by Assignee for their services refused to make such payments, upon demand by me or Assignee. I hereby assign and transfer to Assignee any and all causes of action that I might have or that might exist in my favor against such company and authorize Assignee to prosecute said cause of action either in my name or in Assignee name and further I authorize Assignee to compromise, settle or otherwise resolve said claim or cause of action as they see fit.

I AUTHORIZE ASSIGNEE to release any information pertinent to my case to any insurance company, adjuster or attorney to facilitate collection under this Assignment, Lien and Authorization. I agree that the above mentioned Assignee be given Special Power of Attorney to endorse/sign my name on any and all checks and claim forms for payment of my bill.

I UNDERSTAND THAT I remain personally responsible for the total amounts due the Assignee for their services as insurance coverage may only pay a certain percentage of the bill: as, I may have an insurance deductible or my insurance benefits may exhaust or otherwise be limited. I further understand and agree that this Assignment, Lien and Authorization does not require Assignee to await payments and they may demand payments from me immediately upon rendering services at their option, although the Assignee agrees to first demand immediate payment from the insurance company as their first means of pursuing payment for services rendered. Also, I understand that if this account is assigned to an attorney for collection and/or suit, the assignee shall be entitled to reasonable attorney fees and costs of collection. I also understand that, if any bad check is written. I agree to pay for those added costs.

Dated this_____ day of_____, 20 _____ .

Patient Signature _____ Printed Name _____ Witness _____

5136 Central Ave., St. Petersburg, FL 33707
Phone: 727-579-2500 Toll Free: 877-579-8800 Fax: 727-579-1060