Auto Accident History

Date: _____

Patient Title: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Dr. ☐ Prof. ☐ Rev.

Name: _____ **Nickname:** _____ **Date of Birth:** _____

Address: _____ **City:** _____ **St:** _____ **Zip:** _____

Primary Phone: _____ **Mobile Phone:** _____ **Work Phone:** _____

Email Address: _____ ☐ **Personal** ☐ **Work**

Emergency Contact: _____ **Relationship:** _____ **Phone#** _____

Marital Status: ☐ Single ☐ Married ☐ Other **Employment:** ☐ Employed ☐ Unemployed ☐ Student ☐ Retired

Employer: _____ **Occupation:** _____

Date of Accident: _____ **Time of Accident:** _____ ***am/pm*** ☐ Daylight ☐ Dawn ☐ Dusk ☐ Dark

Road conditions at the time of accident: ☐ Wet ☐ Dry ☐ Snow ☐ Ice ☐ Other: _____

Was this accident on the job? ☐ Yes ☐ No *If yes, were you in a company vehicle*: ☐ Yes ☐ No

Where were you seated? ☐ Driver ☐ Passenger ☐ Rear seat-right ☐ Rear seat-left ☐ other _____

Were you aware of the approaching collision prior to impact? ***Or* did it catch you by surprise**? ☐ Aware ☐ Surprise

Did you lose consciousness upon impact? ☐ Yes ☐ No **Did you experience a flash of light upon impact?** ☐ Yes ☐ No

Did the police come to the accident scene? ☐ Yes ☐ No **was a police report created?** ☐ Yes ☐ No

Did you go to the hospital? ☐ Yes ☐ No **When?** ☐ Immediately ☐ ____ hours later ☐ ____ days later

How did you get to the hospital? ☐ Drove yourself ☐ Ambulance ☐ Friend/Family drove ☐ other _____

Which hospital? _____ **Were you admitted to the hospital?** ☐ Yes ☐ No

What did the hospital do for your injuries? (*Collars, splints, medication, x-rays, etc.*)

_____

What area(s) were x-rayed? _____ **What was their diagnosis?** _____

What were their recommendations for follow up care? _____

Were there any other doctors consulted after your accident/as a result of your accident? ☐ Yes ☐ No

***If yes, please provide the information listed below*:**

Doctor/Facility: _____ **Specialty:** _____ **Date first seen:** _____

Type of treatment: _____ **Treatment frequency:** _____ **How long did you treat?** _____

Doctor/Facility: _____ **Specialty:** _____ **Date first seen:** _____

Type of treatment: _____ **Treatment frequency:** _____ **How long did you treat?** _____

Were you wearing a seatbelt? ☐ Yes ☐ No ***if yes, did you endure any bruises or injuries from the seatbelt*?** ☐ Yes ☐ No

Did your head hit against the headrest upon impact? ☐ Yes ☐ No ***if adjustable, was the headrest position altered*?** ☐ Yes ☐ No

Was the seat broken as a result of the accident? ☐ Yes ☐ No **Was the seat altered as a result of the accident?** ☐ Yes ☐ No

Did the airbag deploy? ☐ Yes ☐ No ***if yes, did it strike you*?** ☐ Yes ☐ No If ***yes, where*?** _____

Which way was your head pointing at the time of impact? ☐ Straight ☐ Right ☐ Left **Your body?** ☐ Straight ☐ Right ☐ Left

Where were your hands upon impact? ☐ One on the wheel ☐ Both on the wheel ☐ Not applicable

Were you wearing glasses or a hat at the time of impact? ☐ Yes ☐ No ***If yes, were they still on after the accident?*** ☐ Yes ☐ No

YOUR VEHICLE:

Year: _____ **Make:** _____ **Model:** _____

Was your car stopped at the time of impact? ☐ Yes ☐ No ***If not,* estimate speed of your vehicle?** _____ *(mph)*

If your vehicle was moving at the time of impact, was it ☐ slowing down ☐ gaining speed ☐ Steady speed?

OTHER VEHICLE:

Year: _____ **Make:** _____ **Model:** _____

Was the other car moving at the time of impact? ☐ Yes ☐ No ***if yes*, what was the approximate speed of the other vehicle?** _____ (mph)

At the time of impact, was the other car: ☐ slowing down ☐ Gaining speed ☐ Steady speed

AUTOMOBILE INSURANCE INFORMATION:

Driver of the vehicle you were in: _____ **Name of their/your automobile insurance:** _____

Policy Number: _____ **Claim number:** _____

Adjusters Name: _____ **Adjusters phone number:** _____

Driver of the other vehicle: _____ **Name of their automobile insurance:** _____

Policy Number: _____ **Claim Number:** _____

Adjusters Name: _____ **Adjusters phone number:** _____

Please describe, to the best of your knowledge, in your own words

What happened during this accident?

_____

_____

_____

_____

You may draw the accident here:

Check all the symptoms that you have noticed since the accident:

☐ Headaches/Migraines	☐ Neck pain	☐ Upper back pain	☐ Shoulder pain	☐ Mid back pain	☐ Arm/leg pain
☐ Low back pain	☐ Depression	☐ Buzzing in ears	☐ Arm/leg pain	☐ Jaw pain/Clicking	☐ Chest pain
☐ Dizziness	☐ Fatigue	☐ Loss of memory	☐ Cold hands/feet	☐ Numbness/tingling	☐ Fever
☐ Loss of smell	☐ Irritability	☐ Digestive problems	☐ Menstrual problems	☐ Joint pain/stiffness	☐ Paralysis
☐ Loss of sleep	☐ Pinched nerve	☐ Loss of balance	☐ Light bothers eyes	☐ Nervousness	☐ Vision
☐ Urinary problems	☐ Upset stomach	☐ Tension	☐ Fainting	☐ Pins/needles feeling	☐ Sore muscles
☐ Sleeping problems	☐ Sciatica	☐ Sinus pain	☐ Head feels heavy	☐ Difficulty swallowing	
☐ Other: _____					

LIST SYMPTOMS SEPARATELY IN ORDER OF SEVERITY

1st Body Area: _____

How often do you experience these symptoms?

☐ Constant 100% ☐ Frequent 75%

☐ Intermittent50% ☐ Occasional 25% ☐ Rare 10%

What makes symptoms increase? _____

_____

What makes symptoms decrease? _____

_____

Type of pain: ☐ Sharp ☐ Dull ☐ Aching ☐ Burning

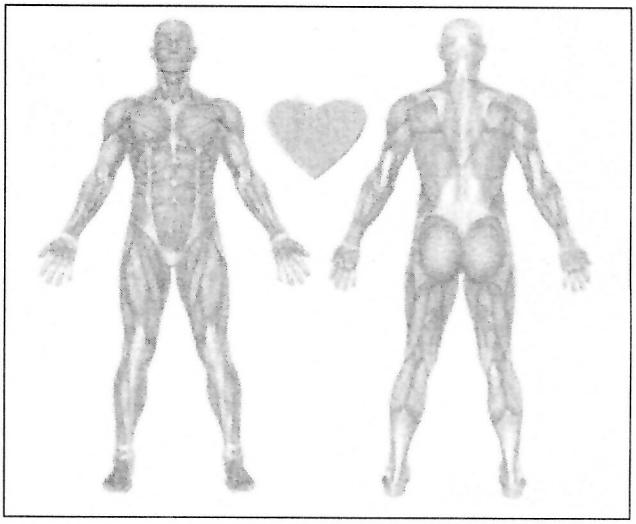
☐ Numb ☐ Throb ☐ Other: _____

Please rate the intensity of your symptoms:

(0 being no symptoms/10 being extreme)

0 ** 1 ** 2 ** 3 ** 4 ** 5 ** 6 ** 7 ** 8 ** 9 ** 10

Please mark area(s) of pain on the figure below



2nd Body Area: _____

How often do you experience these symptoms?

☐ Constant 100% ☐ Frequent 75%

☐ Intermittent 50% ☐ Occasional 25% ☐ Rare 10%

What makes symptoms increase? _____

_____

What makes symptoms decrease? _____

_____

Type of pain: ☐ Sharp ☐ Dull ☐ Aching ☐ Burning

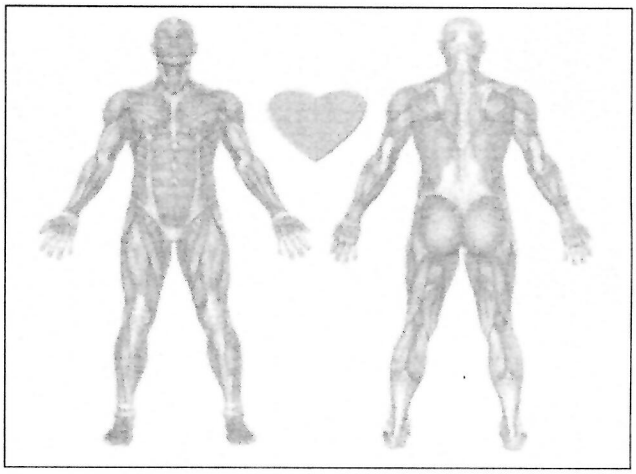
☐ Numb ☐ Throb ☐ Other: _____

Please rate the intensity of your symptoms:

(0 being no symptoms/10 being extreme)

0 ** 1 ** 2 ** 3 ** 4 ** 5 ** 6 ** 7 ** 8 ** 9 ** 10

Please mark area(s) of pain on the figure below



3rd Body Area: _____

How often do you experience these symptoms?

☐ Constant 100% ☐ Frequent 75%

☐ Intermittent 50% ☐ Occasional 25% ☐ Rare 10%

What makes symptoms increase? _____

_____

What makes symptoms decrease? _____

_____

Type of pain: ☐ Sharp ☐ Dull ☐ Aching ☐ Burning

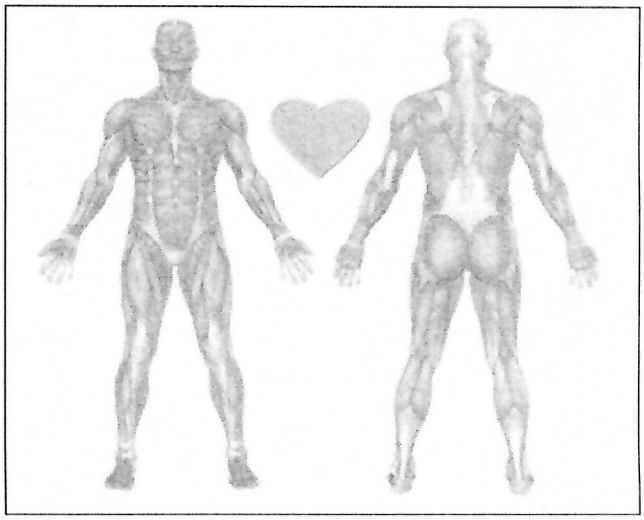
☐ Numb ☐ Throb ☐ Other: _____

Please rate the intensity of your symptoms:

(0 being no symptoms/10 being extreme)

0 ** 1 ** 2 ** 3 ** 4 ** 5 ** 6 ** 7 ** 8 ** 9 ** 10

Please mark area(s) of pain on the figure below



At the time of the accident, did you become or experience any of the following:

☐ Confusion ☐ Disoriented ☐ Light headed ☐ Dizzy ☐Nauseated ☐Blurred Vision
☐ Ringing/buzzing in ears ☐ Loss of balance ☐ Other: _____
Do you still have any of those symptoms? ☐ Yes ☐ No If yes, which ones? _____

Occupational Information:

Job Involves:
☐ Sitting ☐ Standing *How long*? _____ ☐ Lifting *How much*? _____ ☐ Bending ☐ Twisting ☐ Turning ☐ Stooping
Physical activity at work: ☐ Sedentary ☐ Manual labor ☐ Light manual labor ☐ Heavy manual labor
Have you missed any time from work as a result of this accident? ☐ Yes ☐ No ***If yes*, how many days?** _____
What are the dates you missed work? _____ **Are your work activities restricted as a result of this accident?**
☐ Yes ☐ No ***If yes*, please explain**: _____
Do any of your work activities aggravate your current condition/main complaints? ***If yes*, please explain**: _____
_____

Personal Health History:

Do you smoke? ☐ Yes ☐ No ***if yes, how many packs per week*?** _____
Have you smoked in the past? ☐ Yes ☐ No ***when did you quit*?** _____
Do you consume alcohol? ☐ Yes ☐ No ***If yes*, how many drinks per week?** _____
Do you consume caffeine? ☐ Yes ☐ No ***If yes*, how many drinks per day?** _____
Do you exercise? ☐ Yes ☐ No ***If yes*, how often?** _____
What type of exercise are you active; _____
Do you have a high stress level? ☐ Yes ☐ No ***If yes*, please explain:** _____

Please list any medications and/or vitamins that you are currently taking *(including the dosage)*

_____ **Frequency:** _____ **Dosage:** _____ **What is this for?** _____
_____ **Frequency:** _____ **Dosage:** _____ **What is this for?** _____
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_____ **Frequency:** _____ **Dosage:** _____ **What is this for?** _____

I understand the information contained within this form and guarantee this form was completed correctly and to the best of my knowledge:

_____ _____ _____
Patient printed name ***Patient signature*** **Date**

X-RAY CONFIRMATION - FOR FEMALES
At this time, to the best of my knowledge, I am not pregnant, and I consent to radiographic pictures as necessary:

_____ _____
Patient signature **Date**

AUTHORIZATION FOR CARE OF A MINOR:

_____ _____ _____
Name of minor patient (printed) ***Name of parent/guardian (printed)*** ***Signature of parent/guardian***

The Health Doctors, PC

Consent for Treatment & Assignment:

I, _____, authorize The Health Doctors, PC, and whomever they may designate as their assistant to provide treatment as deemed necessary understand, as with any medical treatment that no specific result is guaranteed. I hereby assign payment directly to The Health Doctors, PC for all services provided and I am responsible for any/all deductibles, copayments, and/or unpaid balances that may occur;

_____ _____ _____

Patient Signature ***Staff Initials*** ***Date signed***

Authorization To Release Medical Information:

I, _____ authorize the release of any/all medical information necessary to expedite the processing of my insurance claim(s), to process my personal injury claim(s), and/or to share my medical information with another physician in which the patient has been referred.

_____ _____ _____

Patient Signature ***Staff Initials*** ***Date signed***

HEALTH CARE AUTHORIZATION:

I, _____ give permission to The Health Doctors, PC to contact me with appointment reminders, missed appointment(s) notification, birthday/holiday cards, and/or newsletters. I also give permission to disclose protected health information in the presence of anyone accompanying me into a treatment room and/or consultation room by my request.

By signing this form, you are giving The Health Doctors, PC permission to use and disclose your protected health information in accordance with the directives listed above. You have the right to refuse to sign this authorization. If you refuse to sign this, The Health Doctors, PC will not refuse to provide you treatment.

_____ _____ _____

Patient Signature ***Staff Initials*** ***Date signed***

HIPAA NOTICE:

I have read and understand the Notice of Privacy Practices for Protected Health Information;

_____ _____ _____

Printed Name ***Signature*** ***Date***

EXPIRATION: ***This authorization will not expire as long as you are an active patient of this office.***

THE HEALTH DOCTORS, P.C.
Chiropractic Health Care, P. C.

Nat Agrippina, B.S., D.C.
Doctor of Chiropractic

Patient's Name: _____ ***DOB:*** _____

HIPAA – PRIVACY POLICY

It is the policy of our practice that all physicians staff, and any outsourced 3rd party financial, insurance or legal representatives preserve the integrity and the confidentiality of protected health information (PHI) pertaining to our patients. The purpose of this policy is to ensure that our practice and its physicians and staff have the necessary medical and PHI to provide our patients the highest quality medical care possible. Patients should not be afraid to provide information to our practice and its physicians and staff for purposes of treatment, payment, and healthcare operations. Our HIPAA policy in its entirety can be obtained through our office. Please let us know if you would like to receive a copy before signing this consent.

OFFICE POLICY ON MANAGED CARE INSURERS

We are pleased to meet the needs of our patients and referring physicians by enrolling with numerous managed care insurance programs. While we are able to provide you with this service, it is extremely difficult to keep track of all the individual requirements of each plan. Even with the same insurance company the plans may differ. Providing quality holistic care for our patients is our primary concern, and we are more than willing to provide that care within your insurance contract guidelines if you let us know at each visit what those guidelines are.

Unfortunately, if you do not inform us of any special requirements in your contract and we subsequently provide services, such as intersegmental traction, Ice/heat therapy, Electric Muscle Stim, Hydro Therapy, Cold laser therapy, consults, exams etc. that are not covered, we will have no choice but to bill you directly for those charges. All fees submitted and denied by your carrier will become your responsibility.

Our office will file insurance claims for you, however, office visit co pays and deductibles are payable on the day you are seen. Please remember that you are responsible for all fees, regardless of insurance coverage. Some insurance plans require prior authorization. **This is your responsibility**. If we do not receive the authorization in advance, payment is due at the time of service. With your cooperation, you should be able to receive all benefits offered by your insurance plan, and we will be able to concentrate on caring for your medical needs.

AUTHORIZATION – PLEASE INITIAL & SIGN BELOW

_____ I understand HIPAA and its policies

_____ I have read and understand the office policy stated above and agree to accept responsibility as described

_____ I authorize the release of medical information necessary to process a claim, to health care professionals requesting consultation, and third party payers responsible for payment of medical and surgical benefits to The Health Doctors, P C., Nat Agrippina, B.S.D.C.

_____ _____

Patient or Responsible representative Signature ***Date***

FINANCIAL POLICY

Chiropractic care is covered under many insurance plans. Most of our patients that have health or accident insurance will fall under one of the plans discussed in this policy as it applies to your particular situation.

Please initial each item and sign and date at the bottom.

_____**PATIENTS WITHOUT INSURANCE** we request that 100% of each visit be paid at the time of service.

_____**RE-EXAM POLICY** If you have not been seen in our office in the past 3 months, there will be re-exam fee plus and adjustment fee, and possibly an Ex-Ray fee, if it has been over a year or if a fall or accident has occurred.

_____**GROUP OR INDIVIDUAL INSURANCE** When possible, we will call to verify benefits on your insurance. However, the benefits quoted to us by your insurance company are not a guarantee of payment. *Payment will be due by you at the time of service for any non-covered services, deductibles or co-pays and any PR balances.*

_____**PERSONAL INJURY OR AUTOMOBILE ACCIDENTS** please notify your auto insurance carrier of your visit to our office immediately. Notify our office manager immediately if an attorney is representing you. Although you are ultimately responsible for your bill, we will wait for settlement of your claim for up to **SIX MONTHS** (longer at our digressions) after your care is completed. Once the claim is settled or if you suspend or terminate care, any fees for services are due immediately.

_____**"ON THE JOB" INJURY (WORKERS COMPENSATION)** if you are injured on the job, your care should be paid for under your employer's Worker's Compensation insurance. You will need to inform your employer of the accident and obtain the name and address of the carrier of their insurance. If your employer does not provide us with this information, and/or a settlement has not been made in within **3 MONTHS,** or if you suspend or terminate care, any fees and services are due immediately.

_____**MEDICARE** we do accept assignment from Medicare. The payment is usually directly deposited, electronically to our office for the services that Medicare will cover, which for Chiropractors is ONLY manual manipulation of the spine. Medicare pays 80% of the allowable fee **once the deductible has been met**. You are required to pay the deductible and the remaining 20% as well as any non- covered services (exams & X-rays). Our office completes and submits your claims to Medicare. If you have a 2ndary policy MC will forward the bill to them. We DO NOT bill 2ndary Insurance.

_____**SECONDARY INSURANCE** Please inform us any secondary insurance you may have. We will assist you if you need help in filing. We do not submit to secondary insurance carriers.

I have read and understand and initialed the payment policy of the The Health Doctors, P.C.
I understand that my insurance is an arrangement between myself and my insurance company. I also understand that if my insurance does not respond in 60 days, or if I suspend or terminate my schedule of care as prescribed by the doctor at The Health Doctors, P.C. that fees will be due and payable immediately.

Patient's signature or guardian /responsible party **Date**

Print Patient Name: _____

The Health Doctors PC - 1700 Abbey Court, Alpharetta, Georgia 30004 - Phone: 770-664-0099 - Fax: 770-664-9894

Medical Providers' Contract

This is an agreement between the undersigned: _____, hereafter called ***"patient"*** and *The Health Doctors P.C./Dr. Ignazio Agrippina, D.C, DABC,* hereafter called ***"provider"*** for full and complete payment of the providers' medical treatment and all associated services and expenses, by the patient, from the proceeds of any insurance settlement, judgement at trial, or recovery from any other means or sources. This contract covers all dates of service starting with the initial visit.

In consideration, provider hereby agrees to provide, following the reasonable requests and appropriate authorization, the release of documents of patients care. This will be done following the Georgia statute:

O.C.G.A. 31-33-3 (2010) 31-33-3. Costs of copying and mailing; patient's rights as to records. (a) The party requesting the patient's records shall be responsible to the provider for the costs of copying and mailing the patient's record. A charge of up to $20.00 may be collected for search, retrieval, and other direct administrative costs related to compliance with the request under this chapter. A fee for certifying the medical records may also be charged not to exceed $7.50 for each record certified. The actual cost of postage incurred in mailing the requested records may also be charged. In addition, copying costs for a record which is in paper form shall not exceed $.75 per page for the first 20 pages of the patient's records which are copied; $.65 per page for pages 21 through 100; and $.50 for each page copied in excess of 100 pages. All of the fees allowed by this Code section may be adjusted annually in accordance with the medical component of the consumer price index. The Office of Planning and Budget shall be responsible for calculating this annual adjustment, which will become effective on July 1 of each year. To the extent the request for medical records includes portions of records which are not in paper form, including but not limited to radiology films, models, or fetal monitoring strips, the provider shall be entitled to recover the full reasonable cost of such reproduction. Payment of such costs may be required by the provider prior to the records being furnished. This subsection shall not apply to records requested in order to make or complete an application for a disability benefits program.

In further consideration, the provider agrees, upon reasonable request and appropriate authorization, to meet with the patient's attorney to discuss the treatment of the patient. Such meeting shall be of reasonable duration, based on the patient's condition and shall be without charge to the patient or the attorney.

Patient agrees to pay provider, regardless of the outcome of any case, claim or litigation in which provider's reports, medical records, diagnoses, treatment plan or billing are used.

Following the outcome of the claim, case, litigation, if collection becomes necessary, patient will then become liable for interest, from the last date of service at the highest legal rate and provider's attorney fees and any expenses for collections of fees and services.

A copy of this contract is to be sent to the patient's attorney with a request the attorney follow these directions in making payment from any recovery to the undersigned provider.

This agreement shall follow the patient and binds all attorneys and firms handling the patient's case.

Patient directs their attorney to withhold payment or the provider's total bill for services/expenses for any settlement to recovery from whatever source and to make payment immediately to the provider.

Patient further directs their attorney to provide to provider a copy of the check from the responsible party paying the claim, as well as the settlement and reimbursement sheet of the case. The attorney is further

directed to consider provider's unpaid billing amount "in dispute", should there be an attempt to alter the nature of this contract.

This is an obligation coupled with an interest. It is NOT an agreement based on any outcome of any claims or litigation.

If any clause or provision of this agreement becomes invalid, illegal, or unenforceable for any reason, it is the intent of the parties that the remaining part of this agreement not thereby be affected.

This agreement does not waive any right of the provider or preclude the provider from any reasonable actions to collect.

A copy of this contract may serve in place of its original.

This agreement has been read, understood, agreed, and signed by both patient and provider on this date:

_____/_____/_____.

×_____ ×_____

Patient Signature ***Provider on behalf of The Health Doctors PC***

THE HEALTH DOCTORS
Chiropractic Health Care, P.C.

Nat Agrippina, B.S., D.C.
Doctor of Chiropractic

Doctor's Lien

To: Attorney/Insurance Carrier

_____

_____

_____

_____

Re: Medical Records and Doctor's Lien

I do hereby authorize The Health Doctors, P.C. to furnish you, my attorney/insurance carrier with a full report of his case history, examination, diagnosis, treatment, and prognosis of myself in regard to my accident which occurred on _____.

I hereby give a lien to said doctor on any settlement, claim, judgment or verdict as a result of said accident and authorize and direct you, my attorney/insurance carrier to pay directly to The Health Doctors, P.C. such sums as may be due and owing him for services rendered me, and to withhold such sums from such settlement, claim, judgment or verdict as may be necessary to protect The Health Doctors, P.C. adequately.

I fully understand that I am directly and fully responsible to The Health Doctors, P.C. for all Chiropractic bills submitted by him for services rendered me and that this agreement is made solely for additional protection and in consideration of his awaiting payment. I further understand that such payment is not contingent on any settlement, claim, judgment, or verdict by which I may eventually recover said fee.

Dated: _____ **Patient's Signature:** _____

The undersigned, being the Attorney of Record or Authorized Representative of the insurance carrier for the above patient does hereby acknowledge receipt of the above lien and does agree to honor the same to protect adequately The Health Doctors P.C.

Dated: _____ **Authorized Signature:** _____

Notice: ***Please date, sign and return to The Health Doctors, P.C***