Accident Questionaire

Name:_____ Age:_____ Today's Date:_____
Address:_____ City:_____State:_____ Zip Code:_____
Cell Phone: ( )_____ Home Phone: ( )_____ Male:____ Female:_____
Social Security #_____ Birth date:_____ Email: _____
Occupation:_____ Employer:_____
Work Phone: ( )_____
Single:__ Married:__ Divorced:__ Widowed:__ Student:__ Who referred you?_____
****Females: To your knowledge could you be or are you pregnant?** _____
Emergency Contact Name & Number: _____

Tell Us Why You're Here

What is the primary reason for your visit ?_____

Is this due to a/an: □ Automobile accident □ Work-related injury □ Personal injury case □ Slip/Fall □ None

Date of Accident:_____ Time of Accident:_____ A.M. / P.M.

When did your pain/symptoms begin (include date if possible)?_____

The overall severity of your complaints/concerns is:

□ Mild □ Mild to moderate □ Moderate □ Moderately Severe □ Severe

The overall frequency is: □ Occasional □ Intermittent □ Frequent □ Constant

On a scale of 0 to 10, how would you rate your pain/symptoms today? (Please circle a number below.)

None= 0 1 2 3 4 5 6 7 8 9 10= Worst

If your symptoms change, when are they worse: □ Morning □ Afternoon □ Evening □ Night □ N/A

Are your symptoms/pain getting: □ Better □ Worse □ Staying the same

Please explain in detail (How, When, & Where):_____

_____

_____

Have you had the same or similar problems in the past? □ No □ Yes---When? _____

Do you have any additional complaints/concerns/health problems? □ No □ Yes---please describe:

_____

Use the following key to mark your complaints on the Diagram at the right:

Pain= P **Numbness= N** **Weakness= W**

Soreness= O **Stiffness= X** **Swelling= S**

Burning = B **Tingling= T**

If your complaints include pain, how would you describe it?
(please check all that apply):

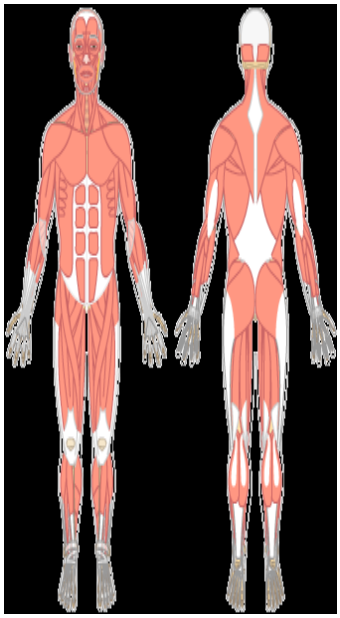
☐ Aching ☐ Burning ☐ Dull ☐ Sharp ☐ Shooting ☐ Stabbing

☐ Throbbing ☐ Other:_____

Since your symptoms began, have you noticed any function changes: ☐ Breathing ☐ Bowel ☐ Bladder ☐ Sexual ☐ No Changes

Do Work activities aggravate your present complaints?

☐ Yes ☐ No



IF YOUR INJURY IS NOT PERTAINING TO AN AUTOMOBILE ACCIDENT PLEASE STOP HERE!!!!!

State in which accident occurred?_____ Speed of the vehicle you were in:_____MPH

Where were you in the vehicle? ☐ Front ☐ Passenger ☐ Back Driver Side ☐ Back Passenger Side

Vehicle type:

☐ Compact ☐ Mid-size ☐ Full-size ☐ Pickup truck ☐ Sport-utility vehicle ☐ Mini-van ☐ Other _____

Was the vehicle accelerating? ☐ No ☐ Yes

What was your vehicle doing immediately prior to impact?

☐ Changing lanes ☐ Slowing for traffic congestion ☐ Turning right at an intersection

☐ Stopped for a traffic light ☐ Turning left at an Intersection ☐ Stopped for a stop sign

Other:_____

What was your vehicle's point of impact? ☐ Front bumper ☐ Left front fender ☐ Left rear fender ☐ Left side

☐ Rear bumper ☐ Right front fender ☐ Left rear fender ☐ Right side

Amount of damage to your vehicle: ☐ Minimal ☐ Moderate ☐ Extensive ☐ Totaled ☐ Unsure

Road Conditions: ☐ Dry ☐ Damp ☐ Wet ☐ Muddy ☐ Black Ice ☐ Raining ☐ Snowing ☐ Ice

☐ Covered with gravel Other_____

Visibility: ☐ Excellent ☐ Night ☐ Dusk ☐ Raining ☐ Snowing ☐ Fog

Was another vehicle involved? ☐ No ☐ Yes---How Many: _____

Which vehicle hit the other:_____

Was a police report filed? ☐ No ☐ Yes---Can you provide our office with a copy? ☐ No ☐ Yes

At Impact

Air bags deployed: ☐ No ☐ Yes

Position of headrest: ☐ Adjusted high ☐ Adjusted low ☐ All the way up ☐ All the way down

☐ Properly adjusted ☐ Improperly adjusted

Type of seat restraints you were wearing: ☐ A shoulder harness only ☐ A lap belt only ☐ No seatbelt

☐ Seatbelt with shoulder harness

Were you prepared for impact? ☐ No ☐ Yes

Was the driver's foot on the brake at the time of impact? ☐ No ☐ Yes---Was it knocked off?

What was the position of your head and neck prior to impact? ☐ Down ☐ Up ☐ Straight ahead

☐ Level and to the left ☐ Level and to the right ☐ Up and to the right

☐ Up and to the left ☐ Down and to the right ☐ Down and to the left

Did you lose consciousness? ☐ No ☐ Yes

Did you receive emergency care at the scene? ☐ No ☐ Yes

Where did you go immediately after accident? ☐ Home ☐ To-work ☐ Hospital ☐ Emergency clinic

☐ Other_____

Other Vehicle

Other vehicle type: ☐ Compact ☐ Mid-size ☐ Full-size ☐ Pickup truck ☐ Sport-Utility vehicle ☐ Mini-van

☐ Other:_____

Speed of the other vehicle: _____MPH

Was the vehicle accelerating? ☐ No ☐ Yes

What was the other vehicle's point of impact? ☐ Front bumper ☐ Left front fender ☐ Left rear fender

☐ Left side ☐ Right side ☐ Right rear fender ☐ Rear bumper ☐ Right front fender

What was the other vehicle doing immediately prior to impact?

☐ Changing lanes ☐ Slowing for traffic congestion ☐ Turning right at intersection

☐ Stopped for a traffic light ☐ Turning left at an intersection ☐ Stopped for a stop sign

Additional information: _____

_____

I certify that the information provided above is accurate and complete to the best of my knowledge.

Patient Signature: _____ Date Signed: _____

PROFICIENT CHIROPRACTIC

2050 Woodson Road, Suite: 101, Overland, MO, 63114, (314) 447-0725

Authorization, Assignment & Release Form

Our office will be happy to file claims with your insurance company. Please read and sign the form below.

In consideration of your undertaking to care for me, I agree to the following:

1. You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney, or adjustor in order to process any claim for reimbursement of charges incurred.

2. I authorize the direct payment to you of any sum I now or hereafter owe you, by my attorney out of the proceeds of any settlement of my case, and/or by any insurance company obligated to make payment to me or you based in whole or in part upon the charges made for your services.

3. In the event any insurance company obligated by contractual agreement to make payment to me or to you for the charges made for your services refuses to make such payment upon demand by you, I hereby assign and transfer to you the cause of action that exists in my favor against any such company (the name(s) of which is believed to be correctly set forth under pertinent data) and authorize you to prosecute said action as my name as you see fit and further authorize you to compromise, settle or otherwise resolve said claim as you see fit. However, it is understood that until a reasonable effort has been made to collect the sums due from the insurance company or companies contractually obligated, you will refrain from collecting the amounts owed, directly from me. I understand that whatever amounts you do not collect from insurance companies proceeds, whether it be all or part of what is due, I personally owe and agree to pay to you.

4. In addition to the above, I hereby waive the statute of limitations on collection and/or recovery in this state of Missouri.

5. I further agree that this Authorization and Assignment is irrevocable and ongoing until all monies owed are paid in full.

6. This Authorization for Assignment will be in continual effect until revoked by both parties.

_____ _____

Date Patient/Insured Signature

HIPAA Notice of Privacy Practices

[Name]_____

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. **Uses and Disclosures of Protected Health Information**

   Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in-sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, the contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law, Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500. Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights: Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information: Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information: This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in

your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filling a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**

PROFICIENT CHIROPRACTIC
2050 Woodson Rd. STE. 101, Overland, Mo 63114
Phone: (314) 447-0725 Fax: (314) 447-0726

Dr. Edgar Everett, III
Chiropractic Physician

Dr. Xaivier T. Tipler
Chiropractic Physician

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name:_____Signature_____ Date_____

PROFICIENT CHIROPRACTIC
2050 WOODSON ROAD
OVERLAND, MO 63114
(314) 447-0725

This is to acknowledge my approval to allow Dr. Everett III & Dr. Tipler to take my picture for the sole use of patient file identification only. This photo will never be used for any purpose other than patient identification, nor will this photo or any information be shared with any outside source.

Patient Signature: _____

Date: _____

"ADJUSTING SPINES & CHANGING LIVES"