ESTNER
INJURY CENTERS
Chiropractic | Physiotherapy

e: contact@DrEstner.com w: DrEstner.com

# PATIENT/INSURANCE CARRIER AGREEMENT/LIEN

Name: _____

Insurance Carrier: _____

DOB: _____

Date of Injury: _____

I hereby authorize Estner Injury Centers (EIC)/Dr. Stephen M. Estner and/or associates to furnish you, the insurance carrier, with a full report of the case history, examination, diagnosis, treatment, prognosis, and all other pertinent materials of myself in regard to the accident/injury in which I was involved.

I hereby authorize and direct you, the responsible insurance carrier, to pay Estner Injury Centers/Dr. Stephen M. Estner and/or associates such sums as may be due and owing him for professional services rendered to me both by reason of the aforesaid accident/injury and by reason of any other bills that are due and owing to his office and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect the interest of EIC/Dr. Estner and/or associates.

I fully understand that I am directly and fully responsible to EIC/Dr. Estner and/or associates for all professional bills submitted by him for services rendered me that this agreement is made solely for EIC/Dr. Estner and/or associates' additional protection and in consideration of pending payment. In the event payment is made by the insurance company directly to you the patient, the payment will be signed over to EIC and/or Dr. Estner and assoc. If the payment is made out to EIC and or Dr. Estner and/or associates, I agree to forward the payment to: 875 Pontiac Avenue Cranston, RI 02910. If in the event the bill is not satisfied it will be forwarded to a collection agency after 30 days of notice of payment issued by insurance carrier. If in the event the outstanding bill is not satisfied by the insurance company and the outstanding bill in its entirety is due immediately. The 30-day grace period will be allowed and following nonpayment, balance will be forwarded to collections agency.

Patient's Signature _____ Date: _____

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# PATIENT INFORMATION

Date: _____

Patient Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Cell Phone: _____ Email: _____

Sex: M____ F____ X____

Age: ____ Height: _____ Weight: _____ DOB: _____

Occupation: _____ Employer: _____

Primary Dr.:_____

## PRIVACY POLICY

*All patient information is confidential. Every attempt will be made to respect confidentiality when communicating. Privacy policy is posted in each office. Patient information will be released with signed consent. Family members/friends are not permitted to obtain any personal information without signed consent. Employees of Estner Injury Centers have reviewed this privacy policy.*

## PERMISSION OF CORRESPONDENCE:

- I grant permission to receive appointment text reminders
- I grant permission to leave a voicemail on my phone
- I grant permission to be contacted regarding test results, confirmation of appointments and insurance
- I grant permission to communicate with the office via text and phone

_____

**Signature of Patient** **Date:**

_____

(Minors) Parent/Legally Authorized Representative Relationship to Patient Date:

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# VEHICLE ACCIDENT INFORMATION

## Patient Information

Patient Name _____ Date _____

Date of Accident _____ Time of Accident _____ AM or PM

Please describe the accident in your own words: _____

_____

_____

_____

Were you the: □ Driver □ Front Passenger □ Rear Passenger □ Pedestrian □ Motorcycle Operator

How many total occupants were in your vehicle? _____

## Accident Site & Impact

Road/Street Name _____ City/State _____

Estimated speed you were traveling _____

Did your car impact another vehicle? □ Yes □ No Did your car impact anything else? □ Yes □ No

Did any part of your body strike anything in the vehicle? □ Yes □ No If yes, explain _____

Was the impact from : □ Front □ Rear □ Left □ Right □ Other _____

## Patient Condition and Treatment

Were you unconscious immediately after the accident? □ Yes □ No If yes, for how long?_____

Please decribe how you felt immediately after the accident: _____

_____

Did you go to the Hospital or Urgent Care? □ Yes □ No / When did you go? □ Immediatley after accident □ Next Day □ Other

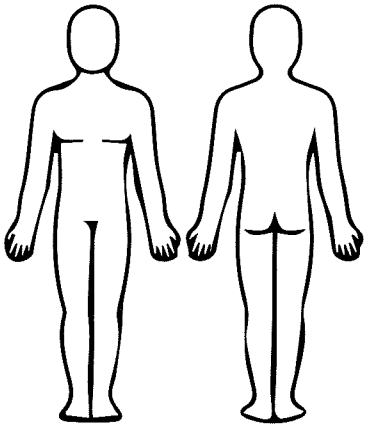
Name of Facility: _____ Treatment Received_____

## Symptoms & Injuries

Have you been able to work since this injury? □ Yes □ No How many days of work have you missed? _____

If you have had any following symptoms since your injury, please check the box:

| | | | |
|---|---|---|---|
| □ Arm/Shoulder Pain | □ Feet/Toe Numbness | □ Neck Pain | □ Ear Buzzing |
| □ Back Pain | □ Hand/Finger Numbess | □ Neck Stiff | □ Ear Ringing |
| □ Back Stiffness | □ Headaches | □ Shortness of breath | □ Fatigue |
| □ Chest Pain | □ Irritability | □ Sleep Difficulty | □ Leg Pain |
| □ Dizziness | □ Jaw Problems | □ Stomach Upset | □ Memory Loss |
| □ Vision Blurred | □ Tension | □ Nausea | |




Please mark the picture where you continue to have pain, numbness, tingling →

Does it interfere with your : □ Work □ Sleep □ Daily Routine □ Recreation

Movements that are painful to perform: □ Sitting □ Standing □ Walking

□ Bending □ Lying Down

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

_____ _____

Signature of Patient, Parent, Guardian, or Personal Representitive Date

_____ _____

Please Print name of Patient, Parent, Guardian, or Personal Representitive Relationship to Patient

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# AUTHORIZATION FOR THE RELEASE OF INFORMATION

TO_____

_____

**Patient Name** **Record Number** **Date of Birth**

_____

__ I authorize_____ to: _X_ I authorize the facsimile transmission of the above records.

__ Obtain information from my medical record from: Fax # _____

__ Release information from my medical record to: Date Transmitted _____

_____

Name Phone Number

_____

Address City State Zip

_____

Please release the following information from my medical record: Date(s) of service_____

_X_ All pertinent information

_X_ Medical Records + Radiology Reports

___ Other: _____

**The purpose of this request is for:** (please check ALL that apply)

__ Further Medical Care __ Legal __ Insurance __ Disability/ Workman's Comp. __ Radiology __ Other

_____

I understand that this authorization shall expire, without my express revocation, six (6) months from the date written below. I understand that a photocopy of this authorization is considered acceptable in lieu of the original.

_____

Signature of Patient Date

_____

Parent/Legally Authorized Representative Relationship to Patient Date

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# DOCTOR'S LIEN

To: Attorney(s): _____

Patient's Name: _____

I hereby authorize Estner Injury Centers (EIC)/Dr. Stephen M. Estner and/or associates to furnish you, my attorney(s), with a full report of the case history, examination, diagnosis, treatment, prognosis and all other pertinent materials of myself in regard to the accident in which I was involved.

I hereby authorize and direct you, my attorney(s), to pay Estner Injury Centers/Dr. Stephen M. Estner and/or associates such sums as may be due and owing him for professional services rendered to me both by reason of the aforesaid accident and by reason of any other bills that are due and owing to his office and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect the interest of EIC/Dr. Estner and/or associates. I hereby further give a lien on my case to EIC/Dr. Estner and/or associates against any and all proceeds of any settlement, judgment or verdict which may be paid to you, my attorney(s), or myself as the result of injuries which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to EIC/Dr. Estner and/or associates for all professional bills submitted by him for services rendered me that this agreement is made solely for EIC/Dr. Estner's and/or associates' additional protection and in consideration of pending 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.

Patient's Signature _____ Date: _____

**ATTORNEY(S): Please sign, date, and return this document to the office of Estner Injury Centers/Dr. Stephen M. Estner, D.C., P.C. as soon as possible.**

The undersigned being attorney(s) of record for the above patient does herby agree to observe all the terms and conditions of the above lien and agree(s) to withhold such sums from any settlement, judgment, or verdict as may be necessary to adequately protect the interest of Estner injury Centers/D Stephen M. Estner and/or associates.

Attorney(s) Signature _____ Date: _____

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# HEALTH INSURANCE CONFIRMATION

Date: _____

Patient: _____

**I acknowledge that Estner Injury Centers has asked me to provide a copy of my health insurance for the purpose of referral to another facility. If in the event my health insurance status changes, I will inform the office.**

_____ I **have** provided a copy of a current active insurance card

_____ I **do not have** health insurance of any type at this time

Signature: _____

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# Informed Consent

**Patient Name:** _____ **Date:** _____

*Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.*

**The nature of the chiropractic adjustment:** The Primary treatment used by Doctor of Chiropractic is spinal manipulative therapy. Dr. Estner and/or associates may use his/her hands or a mechanical instrument in such a way as to realign the joints. This may cause an audible "pop" similar to the noise when you crack your knuckles.

**The material risks inherent in a chiropractic adjustment:** As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation therapy. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to serious complications including stroke. Other types of complications include but are not limited to the following: fractures, disk injuries, dislocations, muscle strain, cervical myelopathy (nerve injury) and burns. Some patients will feel some stiffness and soreness following the first few days of treatment, this is normal.

**The doctor will make every reasonable effort during examination to screen for contraindications to receiving 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.**

I have read the above explanation of the chiropractic adjustment and related risks. I have discussed this document with Dr. Estner and/or associates and have had my questions answered to my satisfaction. By signing below, I have weighed the risks involving and undergoing treatment and have decided that it is my best interest to undergo the recommended treatment.

**Signature:** _____