CONFIDENTIAL VEHICLE ACCIDENT REPORT

Name: _____ DOB: _____ Age: _____ Gender: _____

Address:_____City:_____ State: _____ Zip: _____

Home phone: _____ Cell Phone: _____ Work Phone: _____

Driver's license #: _____ Marital Status: _____

Occupation: _____ Email: _____

Nearest Relative – Name & Telephone: _____

Height: _____ Weight: _____ Race: _____ Date of accident: _____

Time of accident: _____

Were you: a) driver: _____ b) passenger – front: _____ c) passenger – rear: _____ d) number of passengers: _____

e) pedestrian: _____

Were you wearing a shoulder harness: Y / N Were you wearing a seatbelt: Y / N

Your vehicle: a) auto b) truck c) van d) motorcycle e) motorhome f) bicycle g) other

Year and model of your vehicle: _____

Owner of vehicle: _____ Approx. damage to the vehicle: $_____ Was it drivable: Y / N

Other vehicle: a) car b) truck c) van d) motorcycle e) motorhome f) bicycle g) other

Year and model of other vehicle: _____

Owner of vehicle: _____

Visibility at time of accident: ____ Poor ____ Fair ____Good

Road conditions at time of accident: ___ Dry ___Wet ___ Rainy ___Snow ___ Ice ___Fog ___ Clear ___Dark

How accident occurred: a) struck by another vehicle b) struck another vehicle c) struck stationary object d) other

Where was your vehicle hit: a) front b) rear c) front right side d) front left side e) rear right side

f) rear left side g) other

Other vehicle contact: a) front b) rear c) front right side d) front left side e) rear right side

f) rear left side g) other

In your own words, please describe the accident:

_____

_____

_____

_____

_____

_____

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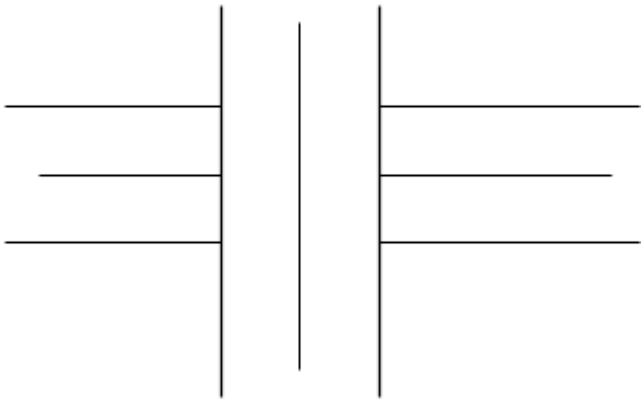
_____

_____

_____

INDICATE ON APPROPRIATE DIAAGRAM HOW THE ACCIDENT HAPPENED:



Did you see the accident coming: Y / N Were you pre-warned that the accident was about to happen: Y / N

Did you brace for impact: Y / N Does your car have headrests: Y / N

If yes, what was the position of those headrests compared to your head before the accident: a) top of headrest even with bott of head b) top of headrest even with top of head c) top of headrest even with middle of neck

Was the car you were in breaking: Y / N Your approx. speed: _____ Other vehicles approx. speed: _____

What was occurring at the moment of impact: (circle as many as apply)

a) tensed body for impact b) neck whipped forward and back c) spine torqued and twisted

d) thrown over seat e) thrown from vehicle f) pinned vehicle

g) thrown from side-to-side h) cut and bruised i) other: _____

What was your head position at the time of impact:

Head turned: ___ right ___ left ___ looking back ___pinned in vehicle

Body rotated: ___ right ___ left

Did you strike your: (circle as many as apply)

a) Head against: Dashboard Windshield Steering Wheel Right Door Left Door Headrest Unknown object

b) Shoulder against: Dashboard Windshield Steering Wheel Right Door Left Door Headrest Unknown object

c) Arm against: Dashboard Windshield Steering Wheel Right Door Left Door Headrest Unknown object

d) Elbow against: Dashboard Windshield Steering Wheel Right Door Left Door Headrest Unknown object

e) Wrist against: Dashboard Windshield Steering Wheel Right Door Left Door Headrest Unknown object

f) Hip against: Dashboard Windshield Steering Wheel Right Door Left Door Headrest Unknown object

g) Knee against: Dashboard Windshield Steering Wheel Right Door Left Door Headrest Unknown object

h) Ankle against: Dashboard Windshield Steering Wheel Right Door Left Door Headrest Unknown object

Were you rendered unconscious: Y / N

Were you able to move all of your body parts: Y / N If no, explain: _____

Were you able to get out of the car? Y / N If no, explain: _____

Did you bleed or get cuts and bruises: Y / N If yes, bleeding: _____ Cuts/bruises: _____

Were there any flying objects in the car: Y / N Where you hit: _____ Where: _____

Please describe how you felt:

During the accident: _____

Immediately after the accident: _____

Later that day: _____

The next day: _____

Circle symptoms you have noticed since the accident:

Headache	Dizziness	Light bothers eyes	Cold sweats
Neck pain	Head heavy	Loss of memory	Feet cold
Neck stiffness	Pins/Needles in arm	Ears ring	Hands cold
Sleeping problems	Pins/Needles in leg	Face Flush	Stomach upset
Numbness in fingers	Buzzing in ears	Constipation	Loss of taste
Mid-back pain	Nervousness	Loss of balance	Diarrhea
Low-back pain	Numbness in toes	Tension	Shortness of breath
Fainting	Fever	Loss of smell	Vomit
Irritability	Fatigue	Chest pain	Depression

Symptoms other than above: _____

Pain level: on a scale of 0-10, with 0 being pain free and fully functional, and 10 being constant agony and totally inability to function, where would you rate yourself: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

Indicate ability to perform the following activities:

U – Unable P – Painful D – Difficult L – Limited N – Normal

__ Coughing or sneezing	__ Lying on side	__ Gripping	__ Climbing stairs
__ Getting in/out of car	__ Bending forward	__ Pushing	__ Bending to brush teeth
__ Pulling	__ Turning over in bed	__ Kneeling	__ Reaching
__ Walking short distance	__ Balancing	__ Sexual activity	__ Standing more than 1 hour
__ Dressing self	__ Stooping	__ Lying on back	__ Sleeping
__ Lying on stomach	__ Sitting at table	__ Other: _____	

Have you lost any time from work as a result of this accident: Y / N If yes, please complete below:

a) Last day worked: _____

b) Type of employment: _____

c) Are you being compensated for time from lost work: Y / N

Was a police report filed: Y / N

Did you receive medical attention at the time of the accident: Y / N

If yes, what was done: _____

Were you taken by ambulance to the hospital: Y / N If yes, where: _____

What was done: _____

What was the diagnosis give: _____

Where did you go immediately after the accident: a) resume activities b) home c) this office

d) Medical attention: Y / N If yes, where: _____ Were you examined: Y / N

e) Were you x-rayed: Y / N If yes, where: _____ What treatment was given: _____

f) Date of treatment: _____

Second doctor/clinic seen: _____ Date of visit: _____

a) Were you examined: Y / N b) Were you x-rayed: Y / N

c) Were you given treatment: Y / N If yes, explain: _____

d) What benefits did you receive from treatment: _____

e) Date of last treatment: _____

Did you have any physical complaint before the accident: Y / N If yes, please describe: _____

_____

_____

Have you ever been involved in an accident before: Y / N If yes, please describe and indicate date: _____

_____

_____

List surgical operation(s) and year(s): _____

_____

_____

_____

Medications you take now (circle all that apply):

None Nerve pills Pain killers Muscle Relaxers

Stimulant(s) Tranquilizers Insulin Birth Control

Other: _____

Do you smoke: Y / N Packs per day: _____ For how long: _____

Drink alcohol: Y / N Drinks per day: _____

Caffeine: Y / N Cups per day: _____

Exercise regularly: Y / N What exercises: _____

During the day (at work or home) do you: a) sit b) computer c) desk d) stand in one position

Lift more/less than 25 lbs. Explain: _____

Have you ever suffered from (circle all that apply):

Dizziness Backaches Heart trouble Diabetes Arthritis

Headaches Asthma Digestive Disorders Nervousness Sinus trouble Neck pain

FAMILY MEDICAL HISTORY: Has any family member (parents, brothers, sisters, grandparents) had any of the following disorders. Please list family member next to disorder:

High blood pressure: _____ Heart disease: _____

Cancer: _____ Diabetes: _____

Thyroid: _____ Kidney: _____

Arthritis: _____ Tuberculosis: _____

Stoke: _____ Lund disease: _____

Patient Name: _____ Date: _____

Height: _____ Weight: _____ Date of birth: _____

Please list any medication(s) you are presently taking (including vitamins)

Medication	Dose	Reason

When treatment is concluded, Patient agrees to have Capitol Chiropractic paid directly from the insurance company or Attorney. IF patient is paid directly or no payment is received, patient is responsible for any billing incurred. _____

Your Auto Insurance Information

Company: _____

Address: _____

City: _____ State: ____ Zip:_____

Contact Name: _____

Phone number: _____

Policy Holder: _____

Policy number: _____

Claim number: _____

Other Vehicle Insurance Information

Company: _____

Address: _____

City: _____ State: ____ Zip:_____

Contact Name: _____

Phone number: _____

Policy holder: _____

Policy number: _____

Claim number: _____

Your Health Insurance Information

Policy Holder: _____

Company Name: _____

Policy number: _____

Relationship to Patient: self / spouse / child / other

Policy holder DOB: _____

Emergency contact: _____

FINACIAL AGREEMENT
Capitol Chiropractic • Don Lathrop, DC

I agree that, in return for the services provide4d by the doctors and therapists at *Capitol Chiropractic and Family Wellness Center*, I will pay my account at the time of services are rendered or I will make financial arrangements satisfactory to *Capitol Chiropractic and Family Wellness Center* for payment. If my insurance company or health plan designates co-payments, co-insurance and/or deductibles, I agree to pay them to *Capitol Chiropractic and Family Wellness Center*.

No Insurance Coverage: payment is expected on the day services are rendered. We accept cash, check, or credit card.

Insurance Coverage: insurance is a contract between you and your insurance company. You will need to pay your co-payments at the time of service. Failure to provide complete insurance information may result in patient responsibility for the entire bill. Although we may estimate what your insurance company may pay, it is the insurance company that makes the **final determination** of your eligibility and benefits. If your insurance company is not contracted with us, you agree to pay any portion of the charges not covered by them. It is the responsibility of the patient to verify with your insurance company if the provider(s) you are seeing are contracted with the insurance. **If your insurance company requires a referral and/or pre-authorization, it is your responsibility to obtain and provide that to our office.** Failure to obtain the referral and/or pre-authorization may result in a denial from the insurance company and the balance will be your responsibility.

Medicare: We are a participating provider with Medicare Part B. we agree to bill and accept contractual adjustments from Medicare. There may be services and supplies rendered in our office that are not covered by Medicare and therefore required an Advanced Beneficiary Notice (ABN) be signed by the patient/guarantor. By signing the ABN, it is understood that you are financially responsible for payment of any services and/or supplies that are not deemed medically necessary by Medicare.

Monthly Statement: If there is a personal patient balance on the account, we will send you a monthly statement. Patients are responsible for all charges resulting from treatment provided at *Capitol Chiropractic and Family Wellness Center.* Payment is due within 30 days of receipt of this statement unless other financial arrangements have been made with the office manager.

Past Due Accounts: I understand and agree that if my account is delinquent past 90 days without financial arrangement with the office manager, I may be turned over to the collection agency used by *Capitol Chiropractic and Family Wellness Center.*

Returned Checks: there is a fee of $25.00 on any checks returned by the bank due to non-sufficient funds or otherwise.

Know Your Benefits: I understand that while my insurance may confirm my benefits, confirmation of benefits is not a guarantee of payment and that I am responsible for any unpaid balance. I understand and agree that it is my responsibility to know if my insurance has any deductible, co-payment, co-insurance, out-of-network, usual and customary limit, prior authorization requirements, or any other type of benefit limitation for the services I receive and I agree to make payment in full. I understand and agree that it is my responsibility to know if my insurance requires a referral from my primary care physician and that it is up to me to obtain the referral. I understand that without this referral, my insurance will not pay for any services and that I will be financially responsible for all services rendered. I agree to inform the office of any changes in my insurance coverage. If my insurance has changed or is terminated at the time of service, I agree that I am financially responsible for the balance in full.

Once you sign this agreement, you agree to all the terms and conditions contained herein and the agreement will be in full force and effect.

_____	_____	_____
Print Name of patient	Signature of Patient or Guardian	Date

HIPAA NOTICE OF PRIVACY PRACTICES

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 CAREFUL

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

Use and Disclosures of Protected Health Information: Your protected health information may be used and disclosed by your physician, our 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, pay your health care bills, to support the operations 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 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 health care 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 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 and employee review activities.

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, to 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 included as required by law, public health issues, communicable diseases health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, and law enforcement. Required uses and disclosures under the law, we must make disclosures to you 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 physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

_____	_____	_____
Print Name of patient	Signature of Patient or Guardian	Date

INFORMED CONSENT

Every type of health care is associated with some risk of potential problem. This includes chiropractic health care. We want you to be informed about potential problems associated with chiropractic health care before consenting to treatment. This is called informed consent.

Chiropractic adjustments are the moving of bones with the doctor's hands or with the use of machines. Frequently, adjustments create a pop or click sound /sensation in the area being treated.

Stroke: Stroke is the most serious problem associated with chiropractic adjustments. Stroke means that a portion of the brain did not receive enough oxygen from the blood stream. The result can be temporary or permanent dysfunction of the brain, with the very rare complication of death. Chiropractic adjustments have been associated with strokes that arise from the vertebral artery only; this is because the vertebral artery is found inside the neck vertebrae. The adjustment that is related to a vertebral artery stroke is called the "extension-rotation-thrust adjustment." We do not do this adjustment on patients. Other types of neck adjustments may also be potentially related to vertebral artery strokes; but no one is certain. The most recent studies (Journal of the CCA-Vol. 37#2-June 1993) estimated that the incidence of this type of stroke is 1 per every 3,000,000 upper neck adjustments. This means that the average chiropractor would have to be in practice for hundreds of years before he would statistically be associated with a single stroke.

Disc Herniation: Disc herniations that create a pressure on the spinal nerve, or the spinal cord are frequently successfully treated by chiropractors and chiropractic adjustments, traction, etc. This includes both in the neck and back. Yet, occasionally chiropractic treatment adjustments, traction, etc. will aggravate the problem. Rarely surgery is required if the disc is in a weakened condition. This problem occurs so rarely that there are no available statistics to quantify their probability.

Soft Tissue Injury: Soft tissues primarily refer to muscles and ligaments. Muscles move bones and ligaments limit joint movement. Rarely a chiropractic adjustment, traction, massage therapy, etc., may tear some muscle or ligament fibers. The result is a temporary increase in pain available statistics to quantify their probability.

Rib Fractures: The ribs are found only in the thoracic spine and middle back. They extend from the back to the front chest area. Rarely a chiropractic adjustment will crack a rib bone, and this is referred to as a fracture. This occurs only on patients who have very weakened bones from such things as osteoporosis. Osteoporosis can be noted on X-rays. We adjust all patients carefully and especially those who show osteoporosis on X-rays. These problems occur so rarely that there are no available statistics to quantify their probability.

Soreness: It is common for chiropractic adjustments, traction, massage therapy, exercise, etc., to result in a temporary increase in soreness in the region being treated. This is nearly always a temporary symptom that occurs while your body is undergoing therapeutic change. It is not dangerous, but please do tell your doctor about it.

Other Problems: There may be other problems or complications that might arise from chiropractic treatment other than those noted above. These problems or complications occur so rarely that it is not possible to anticipate and/or explain them all in advance of treatment.

Chiropractic is a system of health care delivery and, therefore, as with any health care delivery system we cannot promise a cure for any symptom, disease, or condition as a result of treatment in this clinic. We will always give our best care; and if results are not acceptable, we will refer you to another provider who we feel will assist in your situation. If you have any questions, please ask your doctor. When you have a full understanding of the risks, please sign and date below.

Print Patient's Name	Signature of patient or Guardian	Date