Patient Intake Form

ACTIVE CHIROPRACTIC THERAPY

ACTIVE CHIROPRACTIC THERAPY
3611 Branch Avenue, Suite 303
Temple Hills, MD 20748
Phone: (301) 702-7246 Fax: (866) 748-9520
Email: staff@activechirotherapy.com

PATIENT INFORMATION

Patient Name: _____ Email: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____ Work: _____ Preferred # ☐ Home ☐ Cell ☐ Work

Emergency Contact Name: _____ Emergency Contact Phone: _____

Attorney Name: _____ Attorney Phone: _____

Date of Birth: _____ Age: _____ SS# _____ Sex: ☐ Male ☐ Female ☐ _____

☐ Married ☐ Widowed ☐ Single ☐ Minor ☐ Separated ☐ Divorced ☐ Partnered

Occupation: _____ Employer/School: _____ Phone: _____

Whom may we thank for referring you? _____

ACCIDENT INFORMATION

Date of Accident: _____ Time of Accident: _____ How many people were in the vehicle? _____

Road/Street Name: _____ City/State: _____ Nearest Intersection: _____

Which direction were you heading? _____ Driving Conditions ☐ Dry ☐ Wet ☐ Icy ☐ Other What speed were you traveling? _____

Please describe the accident in your own words: _____

IMPACT INFORMATION

Did your vehicle impact another vehicle? ☐ Yes ☐ No Is there visible damage to the car? ☐ Yes ☐ No If yes, briefly explain: _____

Did your vehicle impact a structure? ☐ Yes ☐ No If yes, briefly explain: _____

Did any part of your body strike anything in the vehicle? ☐ Yes ☐ No If yes, what/where: _____

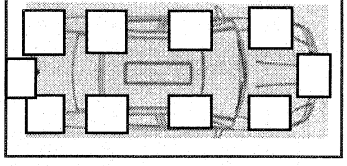
Was impact from: ☐ Front ☐ Rear ☐ Right ☐ Other _____

At the time of impact were you: ☐ Looking straight ahead ☐ Looking right ☐ Looking left ☐ Looking up ☐ Looking down

Were both hands on the steering wheel? ☐ Yes ☐ No If no, was one hand on the steering wheel? ☐ Yes ☐ No

Was your foot on the brake? ☐ Yes ☐ No If yes, which foot? _____ Were you: ☐ Surprised ☐ Braced for impact

Place an X where the impact(s) occurred



VEHICLE 1 INFORMATION (The vehicle you were in)

Make and Model of vehicle you were in: _____

Were you wearing a seatbelt? ☐ Yes ☐ No

If yes, what type? ☐ Lap ☐ Shoulder

Did the vehicle have airbags? ☐ Yes ☐ No

If yes, did they inflate properly? ☐ Yes ☐ No

Did your seat have a headrest? ☐ Yes ☐ No

Were you at work at the time? ☐ Yes ☐ No

Were you the:

☐ Driver ☐ Front Passenger

☐ Rear Passenger ☐ Pedestrian

Was the vehicle you were in at fault? ☐ Yes ☐ No

Other people in the car (Full proper name and relationship to you):

_____

_____

_____

OTHER VEHICLE INFORMATION/3rd party

Driver's Name: _____

Is the insured the same as the driver? ☐ Yes ☐ No

If no, name of insured: _____

Make & Model of other vehicle: _____

Which direction was the other vehicle heading? _____

How fast was the other vehicle going? _____

VEHICLE 1 INSURANCE INFORMATION (MANDATORY)

It doesn't matter who is at fault, we need the insurance information for the vehicle you were in. This is required in order for Active Chiropractic Therapy to bill under a motor vehicle accident claim.

Insurance Company Name: _____

Claim Number: _____

Adjuster's Name: _____

Adjuster's Phone: _____ Ext. _____

Have you opened a medical claim? ☐ Yes ☐ No

Did your insurance send you a PIP Application? ☐ Yes ☐ No

If so, have you returned it to them? ☐ Yes ☐ No

OTHER AUTO INSURANCE INFORMATION

Third Party Insurance Co. Name: _____

Claim # for other vehicle: _____

Adjuster's Name: _____

Adjuster's Phone: _____ Ext. _____

POLICE INFORMATION

Did police come to accident? ☐ Yes ☐ No

Were there any witnesses? ☐ Yes ☐ No

Was a police report filed? ☐ Yes ☐ No

Was a traffic violation issued? ☐ Yes ☐ No If yes, to whom: _____

MEDICAL HISTORY

HIV/AIDS	Yes o	No o	Goiter	Yes o	No o	Pinched Nerve	Yes o	No o
Alcoholism	Yes o	No o	Gonorrea	Yes o	No o	Pneumonia	Yes o	No o
Allergy Shots	Yes o	No o	Gout	Yes o	No o	Polio	Yes o	No o
Anemia	Yes o	No o	Heart Disease	Yes o	No o	Prostate Problem	Yes o	No o
Anorexia	Yes o	No o	Hepatitis	Yes o	No o	Prosthesis	Yes o	No o
Apendicitis	Yes o	No o	Hernia	Yes o	No o	Psychiatric Care	Yes o	No o
Arthritis	Yes o	No o	Herniated Disc	Yes o	No o	Rheumatoid Arthritis	Yes o	No o
Asthma	Yes o	No o	Herpes	Yes o	No o	Rheumatic Fever	Yes o	No o
Bleeding Disorders	Yes o	No o	High Blood Pressure	Yes o	No o	Scarlet Fever	Yes o	No o
Breast Lump	Yes o	No o	High Cholesterol	Yes o	No o	Sexually Transmitted Disease	Yes o	No o
Bronchitis	Yes o	No o	Kidney Disease	Yes o	No o	Stroke	Yes o	No o
Bulimia	Yes o	No o	Liver Disease	Yes o	No o	Suicide Attempt	Yes o	No o
Cancer	Yes o	No o	Measles	Yes o	No o	Tonsilitis	Yes o	No o
Cataracts	Yes o	No o	Migraine Headaches	Yes o	No o	Thyroid Problems	Yes o	No o
Chemical Dependency	Yes o	No o	Miscarriage	Yes o	No o	Tuberculosis	Yes o	No o
Chicken Pox	Yes o	No o	Mononucleosis	Yes o	No o	Tumors, Growths	Yes o	No o
Diabetes	Yes o	No o	Multiple Sclerosis	Yes o	No o	Typhoid Fever	Yes o	No o
Emphysema	Yes o	No o	Mumps	Yes o	No o	Ulcers	Yes o	No o
Epilepsy	Yes o	No o	Osteoporosis	Yes o	No o	Vaginal Infections	Yes o	No o
Fractures	Yes o	No o	Pacemaker	Yes o	No o	Whooping Cough	Yes o	No o
Glaucoma	Yes o	No o	Parkinson's Disease	Yes o	No o	Other: _____		

EXERCISE

- ☐ None
- ☐ Moderate
- ☐ Daily
- ☐ Heavy

WORK ACTIVITY

- ☐ None
- ☐ Moderate
- ☐ Daily
- ☐ Heavy

HABITS

- ☐ Smoking _____Packs/Day
- ☐ Alcohol _____Drinks/Weeks
- ☐ Coffee/Caffiene _____Cups/Day
- ☐ High Stress _____ Reason

Are you pregnant? Yes ☐ No ☐ **Date of delivery:** _____

Injuries you've had:	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

Medication

Pharmacy: _____

Pharmacy Phone: _____

Allergies

Vitamins/Supplements

PATIENT CONDITION

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

Please describe how you felt immediately after the accident: _____

_____

_____

_____

HOSPITAL

Did you go to the hospital? ☐ Yes ☐ No How did you get there? ☐ Ambulance ☐ Private Vehicle

When did you go? ☐ Immediately after the accident ☐ Next day ☐ 2 or more days later

Name of Hospital: _____ Name of Doctor: _____

Diagnosis:

_____

_____

X-Rays taken: _____

OTHER TREATMENT

Have you treated anywhere elsewhere for this injury? ☐ Yes ☐ No

If yes, type of treatment(s): _____

Start date of treatment: _____ Last treatment date: _____

Name of doctor: _____ Name of Facility: _____

SYMPTOMS/INJURIES

Have you been able to work since the injury? ☐ Yes ☐ No How many days missed? _____

Prior to the injury were you able to work on an equal basis to others of your age? ☐ Yes ☐ No

If you have any of the following symptoms/injuries since the accident, please check:

☐ Arm/Shoulder Pain	☐ Feet/Toe numbness	☐ Neck pain
☐ Back Pain	☐ Hand/Finger numbness	☐ Neck stiff
☐ Chest Pain	☐ Headaches	☐ Shortness of breath
☐ Dizziness	☐ Irritability	☐ Sleep difficulty
☐ Ear Buzzing	☐ Jaw problems	☐ Stomach upset
☐ Ear Ringing	☐ Leg pain	☐ Tension
☐ Fatigue	☐ Memory loss	☐ Vision blurred

Is this condition(s) getting: ☐ Better ☐ Worse ☐ The same ☐ Unknown

Type of Pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness
☐ Aching ☐ Shooting ☐ Burning ☐ Tingling
☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other: _____

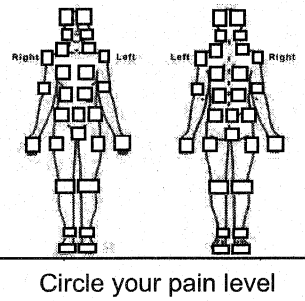
How often do you have this pain? _____

Is it constant or does it come and go? _____

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

Movements that are painful to perform: ☐ Sitting ☐ Standing ☐ Walking
☐ Bending ☐ Lying Down

Mark an X anywhere you have pain, numbness or tingling



Circle your pain level

Slight 1 2 3 4 5 6 7 8 9 10 Severe

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 representative Date

ACTIVE CHIROPRACTIC THERAPY

INFORMED CONSENT FOR EXAMINATION AND TREATMENT

I/We hereby consent to the performance of examination and treatment by the licensed Doctor of Chiropractic, chiropractic assistants and/or massage therapist who may be employed by or engage in practice at Active Chiropractic Therapy.

As a part of the analysis, examination, and treatment, you are consenting to the following procedures: Spinal Manipulative, Range of Motion Testing, Muscle Strength Testing, Radiographic Studies, Palpation, Orthopedic Testing, Postural Analysis Testing, Ultrasound, Hot/Cold Therapy, Electrical Muscle Stimulation, Vital Signs and Neurological Testing.

I have had an opportunity to discuss with the doctor or other clinic personnel the nature and purpose of the different physical therapy procedures and chiropractic adjustments. I understand that neither chiropractic nor medical treatment is an exact science that my care may involve judgments based upon fact and information known to the doctor. The doctor uses this judgment to attempt to anticipate or explain risks and complications and an undesirable result does not necessarily indicate an error in judgment. No guarantee for results can be made or expected but rather I wish to rely on the doctor to choose and recommend a best course of treatment based upon facts known that is in my best interests.

I further understand that there are certain degrees of risk associated with medical care, chiropractic care, and physical therapy, which include rarely, but not limited to, fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains, separations, burns, strokes, and sprains/strains and I am willing to accept and consent to the risk associated with the care that I am about to receive.

I have read and/or the above information has been explained regarding consent. I have had an opportunity to ask questions about my examination and treatment. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Patient's Name (PRINT):_____

Patient's Signature: _____ **Date:**_____

_____

Relationship or Authority (if not signed by patient)

HIPAA Patient Consent Form

We are required by the health insurance portability and accountability act of 1996 (HIPAA) to maintain the privacy of your protected health information (PHI) and to provide you with a notice of privacy practices. Our notice of privacy practices provides information about how we may use and disclose your PHI, and contains a section describing your rights as a patient under the law. You have the right to review our notice before signing this consent and you are advised to do so.

By signing this form, you consent to our use and disclosure to third parties of your PHI for treatment, payment, healthcare operations and for certain marketing purposes, as described in our Notice of Privacy Practices. If you sign this Consent but later change your mind, you have the right to revoke this Consent by delivering to us a written, dated document signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent.

The patient understands that:

- The clinic has a Notice of Privacy Practices. The patient has received, and had the opportunity to review, this Notice before signing the consent. The Clinic encourages all patients to review the Notice of Privacy Practices.
- The Clinic reserves the right to modify the Notice of Privacy Practices to keep up with changes in the law or office practices. We will make all modifications available for review by patients.
- Protected health information may be disclosed or used for treatment, payment, or healthcare operations
- The Clinic or its business affiliates may use your PHI to contact you with educational and promotional items in the future via email, U.S. Mail, telephone, fax and/or prerecorded messages. We **WILL NOT** ever sell or "SPAM" your personal contact information.
- The patient has the right to restrict the uses of his or her information, but the Clinic does not have to agree to all such restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures that require the patient's prior written consent will then cease.
- The Clinic may condition receipt of treatment upon the execution of this consent.

The Consent was signed by:_____

Printed Name - Patient or Representative

_____

Signature Date

ACTIVE CHIROPRACTIC THERAPY, LLC
3611 Branch Avenue, Suite 303
Temple Hills, MD 20748
Phone: (301) 702-7246 Fax: (866) 748-9520
Email: records@activechirotherapy.com

AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

PATIENT'S NAME:_____ DATE OF BIRTH:_____
PATIENT'S ADDRESS:_____ OR
_____ SOCIAL SECURITY #:_____
_____

I hereby authorize disclosure of any and all health records in your possession, including X-ray films as follows: _____ (Facility or Doctor) is authorized to disclose medication information about me.

The specific information to be disclosed is related to care given for injuries sustained on _____.

This information may be disclosed to:

ACTIVE CHIROPRACTIC THERAPY, LLC
3611 Branch Avenue, Suite 303
Temple Hills, MD 20748
Tel (301) 702-7246
Fax (866) 748-9520

I understand this authorization may be revoked by me at anytime in writing except if action has already been taken in reliance upon the authorization before it is received by the health care provider. I also understand that this authorization will expire in one year unless otherwise indicated.

I acknowledge that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and is no longer protected by Federal Law.

_____ _____ _____
Print Patient's Name Patient's Signature Date

If signed by a personal representative, a description of the representative's authority to act is as follows

_____ _____
Print Signature for Minor Child

_____
Relationship to Minor Child

ACTIVE CHIROPRACTIC THERAPY
3611 Branch Ave Suite 303
Temple Hills, MD 20748
Phone:(301) 702-7246 Fax: (866) 748-9520
Email: billing@activechirotherapy.com

NOTICE OF DOCTOR'S LIEN

Patient Name: _____
Account #: _____
Claim # _____
Date of Incident: _____
Attorney/Insurance_____

I do hereby authorize Active Chiropractic Therapy to furnish you, my Attorney/Insurance, with a full report of the examination diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I was recently involved.

I hereby authorize and direct you, my attorney/Insurance, to pay directly to said doctor such sums as may be due and owing Active Chiropractic Therapy for medical service rendered me both by reason of this accident and by reason of any other bills that are due to Active Chiropractic Therapy office and to withhold such sums from any settlement, judgement or verdict as may be necessary to adequately protect said doctor. All bills shall be paid promptly in the usual manner. This specifically includes but is not limited to any and all PIP, Med-Pay, or Med Expense payments.

And I hereby further give a lien of my case to Active Chiropractic Therapy against any and all proceeds of my settlement, judgement or verdict which may be paid to you, my doctor, or myself, as a result of the injuries for which I have been treated or injuries in connection therewith. I agree never to rescind this document and that a rescission will not be honored by my attorney. I hereby instruct that in the event another attorney is substituted in this matter, the new attorney honor this lien as inherent to the settlement and enforceable upon the case as if it were executed by him/her. I fully understand that I am directly and fully responsible to Active Chiropractic Therapy for all medical bills submitted by Active Chiropractic Therapy for service rendered me and that this agreement is made solely for Active Chiropractic Therapy additional protection and in consideration of Active Chiropractic Therapy awaiting payment. And I further understand that such payment is not contingent on any settlement, judgement or verdict by which I may eventually recover said fee.

Please acknowledge this letter by signing below.

Patient Name (print)_____

Patient/GuardianSignature_____Date_____

The undersigned being attorney of record for the above patient does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgement or verdict as may be necessary to adequately protect said doctor above named.

Attorney's Name (print)_____

Attorney's Signature_____Date_____

Please date, sign and return one copy to the doctor's office. Also keep one copy for your records.