PRECISION
CHIROPRACTIC

Personal Injury/Accident Medical History Intake Form

Please allow our staff to photocopy your driver's license and accident information exchange card

NOTICE: In the event that the accident insurance will not cover, you are responsible for your bill. Thank you.
Care for a Patient Injury Claim cannot be billed to your regular health insurance.

Signature:_____ Date: _____

PLEASE PRINT CLEARLY

Full Name:_____

Email:_____ Gender: M F Age:_____ Birth Date:_____

Address:_____ City:_____

State:_____ Zip:_____

Social Security #:_____ Home Phone:(____)_____ Cell Phone:(____)_____

Name of Spouse, Parent or Guardian:_____ Age:_____

Birth Date:_____ SS#:_____

Females: Are you or is there a possibility that you may be pregnant?__ Y/N

Employer:_____ Occupation: _____Wk Phone:_____

How did you hear about us?_____

In case of emergency

Contact:_____ Relationship:_____

Phone Number:(____)_____ Cell:(____)_____ Wk Phone:(____) _____

Auto Insurance/Attorney Information

Do you have Med Pay?: Y N

Insurance Company of the Person **at fault:**_____

Name of **Agent:**_____

Insurance Company Address:_____ City:_____ State: _____Zip:_____

Accident Information

Date of Accident___/___/____ Time of Accident _____ am/pm

Location of accident_____

Please write a brief description of how your injury occurred:

_____

_____

_____

If your injury in NOT due to an automobile collision, please skip to the section titled "*Quality"*

Were you stopped? (Yes / No) If no, approximate speed: _____ mph

Was there another vehicle stopped? (Yes/ No) If no turned to (Left/Right)

At impact, were you looking straight ahead? (Yes/No) If no was your head turned (right /left/ Up/Down)

At impact, was your body straight in your seat? (Yes/ No) If no, was it turned to the (Left/Right)

Were you aware that you were about to be hit? (Yes/ No)

Were you wearing a seatbelt at the time of the accident? (Yes/ No)

Did your (Chest/Head) hit the steering wheel? (Yes/ No), Did an airbag deploy? (Yes/ No)

Did your head hit the (Windshield/Side Window)? (Yes/ No) Did your shoulder hit the door? (Yes/ No)

Did your knees hit the dashboard? (Yes/ No), Did your seat break? (Yes/ No)

Do you have any (cuts/bruises) for the accident? (Yes/ No) If Yes, where?_____

Was your car equipped with headrests? (Yes/ No)

If Yes, at what height was the top of the headrest?_____ (Base of Head/Mid head/Top of Head)

Did you lose consciousness? (Yes/No) If so, how long_____

Describe Accident

What was your position in the vehicle? ____Driver ____Passenger

Who hit who? ____you were struck ____struck another vehicle

What was your vehicle's point of impact?_____

What was the other vehicle's point of impact?_____

What happened to your body at the moment of impact? _____thrown back and forth _____ thrown side to side
Were you wearing seat restraints? ____Y/N
What position were your vehicles head rest in? ____ lowest position ____middle position ____highest position

Were you prepared for the impact?

____ was completely surprised ____saw the collision coming ____ saw the collision coming and braced accordingly.
What position was your body in just prior to impact?
____straight ahead ____rotated left ____rotated right____ can't remember
What was your mental/emotional state immediately following the accident?
____was not rendered unconscious ____was not rendered unconscious but was shaken up and disoriented
____was rendered unconscious
Did you receive medical attention at the scene of the accident?____ Y/N
Where did you go immediately after the accident?_hospital ____home ____resumed daily activities
Symptomatolgy (Pain Characteristics for Major Area of Complaint)

The Pain Started

_____

The pain is made better by

_____

And Worse by

_____

The pain has the following qualities

_____

____There is ____There is not radiation into_____

____There is ____There is not referred pain into_____
____There is ____There is not parasthesia (tingling/numbness) into

_____

The pain is located?

_____

The Pain is (as far as timing is concerned: i.e. comes & goes, Constant, etc.)

_____

Indicate the symptoms that are a result of this accident:

DIZZINESS	DIFFICULTY SLEEPING	JAW PROBLEMS	NAUSEA
MEMORY LOSS	ARM/SHOULDER PAIN	IRRITABILITY	BACK PAIN
HEADACHE(S)	NUMB HANDS/FINGERS	FATIGUE	LOW BACK PAIN
BLURRED VISION	TENSION	CHEST PAIN	BACK STIFFNESS
BUZZING IN EAR	NECK PAIN	SHORT BREATH	LEG PAIN
EARS RINGING	STIFF NECK	STOMACH UPSET	NUMB FEET/TOES

OTHER_____

Daily Activities Pain Rating

How many days out of an average week do you have pain?_____ On a scale of 1-10, rate your pain_____

How much time out of an average day are you in pain?____ On a scale of 1-10 _____

What are the worst times of the day for the pain?_____

Describe the overall severity of the pain_____

What are the best times of the day for the pain?_____

_____mild to moderate but can live with it _____ Moderate, having trouble coping with

How do the following activities affect your pain?

Sitting _____ Looking Up_____
Walking_____ Looking Down_____
Standing_____ Lifting_____
Laying Down_____

Progression: How is your pain compared to when the pain episode first started?

_____

What do you do to relieve the pain?

_____

What are some recreational activities that you participated in before this current problem and which ones cannot be performed now to the same extent?

Please mark each that apply to your daily activities due to your problem:

___Has difficulty climbing stairs
___Changes position frequently to try and get comfortable
___Has to hold onto something to sit/stand from a chair
___Has a loss of appetite
___Walks More slowly than normal
___Stays in bed most of the day
___Has difficulty sleeping
___Does not do jobs around the house
___Has to use handrails to get up stairs, Etc.
___Can only walk short distances
___Has to lie down and rest frequently
___Has to sit most of the day
___Have to get other people to do things for you
___Has difficulty getting dressed due to problem
___Has difficulty bending
___Has become more irritable
___Has difficulty turning over in bed
___Has to get dressed with someone's help

How often do you have to stop activities and sit or lie down to control your symptoms?
___Several times a day ___Occasionally ___Approximately once per day ___Never ___All day

Social History: ___Single ___Married ___Divorced ___# of Children ___Smoker ___ Non-Smoker
___Does not drink Alcohol ___Does not take drugs

1. Quality

On the diagram below, please show **where** you are experiencing **all** of your present complaints using the following letters.

A: ache

B: burning pain

K: cramping

D: dull pain

R: throbbing pain

N: numbness

T: tingling

S: sharp or stabbing pain

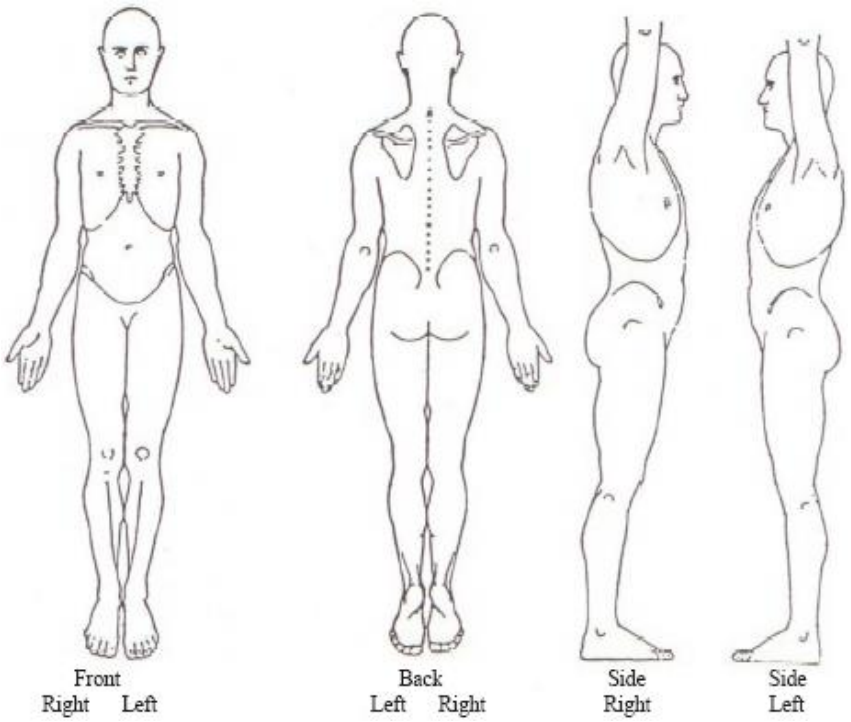
U: nonspecific pain

RP: radiating pain

H: hot

B: burning pain

C: cold



2. Radiation

Does the pain you are experiencing travel to any other part of your body? (If yes, please describe)

_____

3. Severity

On the scale below, please **circle the severity** of your **main complaint** (At Its Worst)

No pain 0 . . . . . l . . . . . l . . . . . l . . . . . l . . . . . l . . . . . l . . . . . l . . . . . l . . . . . l . . . . . 10 Intolerable
1 2 3 4 5 6 7 8 9

TREATMENT INFORMATION

Did you go to the Emergency Room (yes / No) If yes, when? _____

Name of the hospital Emergency Room:_____

List any medications that you were given:_____

List any instructions that you were given:_____

From the following list, circle the treatment(s) that you received at the Emergency Room:

Exam/X-Ray/MRI/CT Scan/Back Brace/ Neck Brace/ Home Instructions/Other:_____

List all the doctors that you have seen as a result of your injuries (other than at the ER):

Date	Doctor	Treatment
1._____		
2._____		
3._____		

Do you have any future appointments with any other doctor regarding your injuries? (Yes/ No)

If yes, when and with whom?_____

Parent / Guardian Signature_____ Date_____

Occupational History

Your Employer_____

What is your current job satisfaction? ____very satisfied ____satisfied ____dissatisfied ____very dissatisfied
Are your Job Duties Physically demanding for you? Y/N **Have you had any disability time?** Y/N
If you are currently working which are you performing? ____regular duties ____limited duties ____light duties
Medical History:
List the Physicians and other practitioners you have seen for this problem: List the Medications you are currently taking:_____
_____

List the treatments you have had for your problem, as well as, list the types of Diagnostic Testing for this problem

___Hot packs ___Ultrasoud ___Chiropractic ___X-rays ___

Please rate your ability to perform the following functions of daily living:
Check one of the 4 categories for EACH Item

Activity	Requires No Assist	Requires Some Assist	Full Assist Needed	Cannot Do
Bathing/Grooming				
Dressing				
Concentrating				
Lay to sit/ Sit to Stand				
Toileting				
Recreation Activities				
Walking				
Climbing Stairs				
Eating				
Shopping				
Working				
Managing Medications				
Using the Phone				
House Work Laundry/Cooking				
Lifting				
Driving				
Social Life				
Other				
Other				

Neck Index

Form N1-100

Rev 3/12/19

Patient Name: _____ Date: _____

This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by circling the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity
0 I have no pain at the moment
1 The pain is very mild at the moment
2 The pain comes and goes, and is moderate
3 The pain is fairly severe at the moment
4 The pain is very severe at the moment
5 The pain is the worst imaginable at the moment

Personal Care
0 I can look after myself normally without causing extra pain
1 I can look after myself normally, but it causes extra pain
2 It is painful to look after myself. I am slow & careful
3 I need some help, but I manage most of my personal care
4 I need help every day in most aspects of care
5 I do not get dressed, I wash with difficulty and stay in bed

Sleeping
0 I have no trouble sleeping
1 My sleep is slightly disturbed (less than 1 hour sleepless)
2 My sleep is mildly disturbed (1-2 hours sleepless)
3 My sleep is moderately disturbed (2-3 hours sleepless)
4 My sleep is greatly disturbed (3-5 hours sleepless)
5 My sleep is completely disturbed (5-7 hours sleepless)

Lifting
0 I can lift heavy weights without extra pain
1 I can lift heavy weights, but it causes extra pain
2 Pain prevents me from lifting heavy weights off the floor, but I Manage if they are conveniently positioned (ex. on a table)
3 Pain prevents me from lifting heavy weights off the floor, But I manage light-medium weights if conveniently positioned.
4 I can only lift very light weights
5 I cannot lift or carry anything at all

Reading
0 I can read as much as I want with no neck pain
1 I can read as much as I want with slight neck pain
2 I can read as much as I want with moderate neck pain
3 I cannot read as much as I want I HAVE moderate neck pain
4 I can hardly read at all because of severe neck pain
5 I cannot read at all because of neck pain

Driving
0 I can drive my car without any neck pain
1 I can drive my car as long as I want with slight neck pain
2 I can drive my car as long as I want with moderate neck pain
3 I cannot drive my car as long as I want due to moderate neck pain
4 I can hardly drive at all because of severe neck pain
5 I cannot drive at all because of neck pain

Concentration
0 I can concentrate fully when I want with no difficulty
1 I can concentrate fully when I want with slight difficulty
2 I have a fair degree of difficulty concentrating when I want
3 I have a lot of difficulty concentrating when I want
4 I have a great deal of difficulty concentrating when I want
5 I cannot concentrate at all

Recreation
0 I am able to engage in all recreation activities without neck pain
1 I am able to engage in recreational activity with some neck pain
2 I can engage in most, but not all, recreation because of neck pain
3 I can only engage in a few recreations, because of neck pain
4 I can hardly do any recreation because of neck pain
5 I cannot do any recreation at all

Work
0 I can do as much work as I want
1 I can only do my usual work – no more
2 I can only do most of my work – but no more
3 I cannot do my usual work
4 I can hardly do any work at all
5 I cannot do any work at all

Headaches
0 I have no headaches at all
1 I have slight headaches, which come infrequently
2 I have moderate headaches – which come infrequently
3 I have moderate headaches – which come frequently
4 I have severe headaches – which come frequently
5 I have headaches almost all the time

**For office use only:
** Index Score = Sum of all statement selected (# of sections with a statement selected x5) x100 (Neck index score)

Back Index

Rev 3/12/19

Form BI-100

Patient Name: _____ Date: _____

This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by circling the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity
0 The pain comes & goes, and is very mild
1 The pain is mild, and does not vary much
2 The pain comes and goes and is moderate
3 The pain is moderate, and does not vary much
4 The pain is severe and comes and goes
5 The pain is severe and does not vary much

Sleeping
0 I get no pain in bed
1 I get pain but it doesn't prevent me from sleeping well
2 Because of my pain, normal sleep is reduced by <25%
3 Because of my pain, normal sleep is reduced by <50%
4 Because of my pain, normal sleep is reduced by <75%
5 Pain prevents me from sleeping at all

Sitting
0 I can sit in any chair as long as I like
1 I can only sit in my favorite chair as long as I like
2 Pain prevents me from sitting more that 1 hour
3 Pain prevents me from sitting more than ½ hour
4 Pain prevents me from sitting more than 10 minutes
5 I avoid sitting because it increases pain immediately

Standing
0 I can stand as long as I want without pain
1 Some pain while standing, but doesn't increase with time
2 Pain prevents me from standing more than 1 hour
3 Pain prevents me from standing longer than ½ hour
4 Pain prevents me from standing longer than 10 minutes
5 I avoid standing because it increases pain immediately

Walking
0 I have no pain while walking
1 I have some pain with walking, doesn't increase w/distance
2 I cannot walk more than 1 mile without increasing pain
3 I cannot walk more than ½ mile without increasing pain
4 I cannot walk more than ¼ mile without increasing pain
5 I cannot walk at all without increasing pain

Personal Care
0 I do not have to change washing/dressing to avoid pain
1 I do not normally change dressing/changing-though it causes some pain
2 Washing/Dressing increases pain, but I manage not to change my ways
3 Washing/Dressing increases pain, and it's necessary to change my ways
4 I am unable to wash/dress without some help
5 I am unable to wash/dress without help

Lifting
0 I can lift heavy weights without extra pain
1 I can lift heavy weights, but it causes extra pain
2 Pain prevents me from lifting heavy weight off the floor
3 Pain prevents me from lifting heavy weight off the floor, but I can Manage if they are conveniently positioned (ex. On a table)
4 Pain prevents me from lifting heavy weight off the floor, but I can Manage light to medium weight if conveniently positioned.
5 I can only lift very light weight

Traveling
0 I get no pain while traveling
1 Some pain while traveling, but usual travel doesn't make it worse
2 Extra pain while travelling, but I do not seek alternatives
3 Extra pain while travelling, I seek alternatives
4 Pain restricts all forms of travel, except when lying down
5 Pain restricts all forms of travel

Social Life
0 Social life is normal, no extra pain
1 Social life is normal, but increases degree of pain
2 Pain has no significant affect on my social life apart from limiting My more energetic interests
3 Pain has restricted my social life and I do not go out often
4 Pain has restricted my social life to my home
5 I have hardly any social life because of the pain

Changing Degree of Pain
0 My pain is rapidly getting better
1 My pain fluctuates, but is overall getting better
2 My pain is getting better, but improvement is slow
3 My pain is neither better, nor worse
4 My pain is gradually worsening
5 My pain is rapidly worsening

**For office use only:
** Index Score = Sum of all statement selected (# of sections with a statement selected x5) x100 (Neck index score)

PRECISION
CHIROPRACTIC

We want you to know how your Patient Health Information (PHI) will be used in this office and your rights concerning those records. In addition to how your PHI will be used, office policies regarding payment and collections, and consent to treat are listed below. By signing at the end of these policies, you agree to all stipulations.

1. The patient understands and agrees to allow Precision Chiropractic to use their PHI for the purpose of treatment payment, health care operations, and coordination of care.

2. The patient has the right to examine and obtain a copy of his/her own health records at any time and request corrections.

The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.

3. A Patient's written consent need only be obtained one time for all subsequent care given the patient in this office.

4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.

5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by Precision Chiropractic to assure that your records are not readily available to those who do not need them.

6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.

7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care

8. Precision Chiropractic reserves the right to charge 18% interest on all outstanding balances over 90 days and from this day forward.

Patient Signature _____ Date _____

AUTHORIZATIONS, ASSIGNMENTS OF BENEFITS AND CONSENT TO TREAT

To: Precision Chiropractic Doctors, hereafter referred to as OFFICE

1. I authorize, assign and direct my insurance carrier, to pay directly to said OFFICE such sums as may be due and owing the OFFICE of services rendered me, now or hereafter, which are payable under my insurance contract, or contractual agreement

2. Patient agrees, that in the event patient receives any checks, drafts or other payment subject to this agreement, patient agrees to act as fiduciary agent to the OFFICE. The OFFICE agrees to apply any proceeds to the patient's debt for services rendered

3. I fully understand and agree insurance policies are an arrangement between the insurance carrier and myself. I will be responsible for expenses not paid by insurance. I understand and agree that either health insurance or automobile insurance may not pay all of the charges of the OFFICE for my treatment. I understand and agree to pay the customary charges of the OFFICE and agree that if my health insurance or automobile insurance does not pay for my treatment in full, I will be responsible for the remaining balance. I understand and agree that Precision Chiropractic reserves the right to charge $30 for missed appointments and that it may be necessary for OFFICE to record a lien on my case to ensure payment. I agree to pay the charges associated with filing of the lien.

4. I understand that if necessary of OFFICE to employ collection counsel and/or an attorney on my bill, I the patient will be responsible for any said collection and/or attorney fees.

5. I agree the OFFICE has the right to call my home or place of employment regarding appointment or insurance issues.

6. I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including nutritional assessment, and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic and/or licensed doctors of chiropractic who now or in the future treat me while employed by, or are associated with or serving as back-up for the doctor of chiropractic, including those working at the clinic or office or any other office or clinic.

7. I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to, fractures, disk injuries, strokes, dislocations and sprains. I do expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedures which the doctor feels at the time, based upon the facts then known, is in my best interests.

8. I have read, or have had read to me the above consent. I have also had an opportunity to ask questions about its consent, and by signing below I agree to the above-named procedures I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions(s) I seek treatment.

9. A photocopy of this form shall be as valid as original

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

_____

Patient's signature Date

_____ _____

Legal guardian if patient is a minor Relationship to min

Precision Chiropractic
Notice of Privacy Practices

This notice describes how health information about you may be used and disclosed and how you can get access to this information. It is effective July 21, 2003, and applies to all protected health information contained in your health records maintained by us. We have the following duties regarding the maintenance, use and disclosure of your health records:

(1) We are required by law to maintain the privacy of the protected health information in your records and to provide you with this Notice of our legal duties and privacy practices with respect to that information.
(2) We are required to abide by the terms of this Notice currently in effect.
(3) We reserve the right to change the terms of this Notice at any time, making the new provisions effective for all health information and records that we have and continue to maintain. All changes in this Notice will be prominently displayed and available at our office.

There are a number of **situations in which we may use or disclose** to other persons or entities your confidential health information. Certain uses and disclosures will require you to sign an acknowledgement that you received this Notice of Privacy Practices. These include providing care, payment, and health care operations. Any use or disclosure of your protected health information required for anything other than providing care, payment or health care operations requires you to sign an Authorization. Certain disclosures that are required by law, or under emergency circumstances, may be made without your Acknowledgement or Authorization. Under any circumstance, we will use or disclose only the minimum amount of information necessary from your health records to accomplish the intended purpose of the disclosure.

We will attempt in good faith to obtain your signed Acknowledgement that you received this Notice to use and disclose your confidential medical information for the following purposes. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office once you have provided Consent.

Treatment: We will use your health information to make decisions about the provision, coordination or management of your healthcare, including analyzing or diagnosing your condition and determining the appropriate treatment for that condition. It may also be necessary to share your health information with another health care provider whom we need to consult with respect to your care. These are only examples of uses and disclosures of health information for treatment purposes that may or may not be necessary in your case.

Payment: We may need to use or disclose information in your health record to obtain reimbursement from you, from your health insurance carrier, or from another insurer for our services rendered to you. This may include determinations of eligibility or coverage under the appropriate health plan, pre-certification and pre-authorization of services or review of services for the purpose of reimbursement. This information may also be used for billing, claims management and collection purposes, and related healthcare data processing through our system.

Operations: Your health records may be used in our business planning and development operations, including improvements in our methods of operation, and general administrative functions. We may also use the information in our overall compliance planning, healthcare review activities, and arranging for legal and auditing functions.

There are certain circumstances under which we may use or disclose your health information **without first obtaining your Acknowledgement or Authorization.** Those circumstances generally involve public health and oversight activities, law-enforcement activities, judicial and administrative proceedings, and in the event of death. Specifically, we may be required to report to certain agencies information concerning certain communicable diseases, sexually transmitted diseases or HIV/AIDS status. We may also be required to report instances of suspected or documented abuse, neglect or domestic violence. We are required to report to appropriate agencies and law-enforcement officials information that you or another person is in immediate threat of danger to health or safety as a result of violent activity. We must also provide health information when ordered by a court of law to do so. We may contact you from time to time to provide appointment reminders or information about care alternatives or other health-related benefits and services that may be of interest to you.

Others Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your healthcare

Communication Barriers and Emergencies: We may use and disclose you protected health information if we attempt to obtain consent from you but are unable to do so because of substantial communication barriers and we determine, using professional

judgment, that you intend to consent to use or disclosure under the circumstances. We may use or disclose your protected health information in an emergency care situation. If this happens, we will try to obtain your consent as soon as reasonably practicable after the delivery of care. If we are required by law or as a matter of necessity to treat you, and we have attempted to obtain your consent but have been unable to obtain your consent, we may still use or disclose your protected health information to treat you.
The most common use of your personal or health information will be to contact you regarding appointment reminders, scheduling or follow-up, office news, marketing, or special events, and health/wellness information. If you prefer that our office is not identified on the exterior of correspondence, that we not identify our office name while leaving a message, or you would like to be excluded from general office mailings, please submit this information to us in writing.

Except as indicated above, your health information will not be used or disclosed to any other person or entity without your specific authorization, which may be revoked at any time. In particular, except to the extent disclosure has been make to governmental entities required by law to maintain the confidentiality of the information, information will not be further disclosed to any other person or entity with respect to information concerning mental-health treatment, drug and alcohol abuse, HIV/AIDS or sexually transmitted diseases that may be contained in your health records. We likewise will not disclose your health-record information to an employer for purposes of making employment decisions, to a liability insurer or attorney as a result of injuries sustained in an automobile accident, or to educational authorities, without your written authorization.

You have certain **rights regarding your health record information,** as follows:

(1) You may request that we restrict the uses and disclosures of your health record information for care, Payment and operations, or restrictions involving your care or payment related to that care. We are not required to agree to the restriction; however, if we agree, we will comply with it, except with regard to emergencies, disclosure of the information to you, or if we are otherwise required by law to make a full disclosure without restriction.

(2) You have a right to request receipt of confidential communications of your medical information by an alternative means or at an alternative location. If you require such an accommodation, you may be charged a fee for the accommodation and will be required to specify the alternative address or method of contact and how payment will be handled.

(3) You have the right to inspect, copy and request amendments to your health records. Access to your health records will not include psychotherapy notes contained in them or information compiled in anticipation of or for use in a civil, criminal or administrative action or proceeding to which your access is restricted by law. We will charge a reasonable fee for providing a copy of your health records, or a summary of those records, at your request, which includes the cost of copying, postage, and preparation of an explanation or summary of the information.

(4) All requests for inspection, copying and/or amending information in your health records, and all requests related to your rights under this Notice, must be made in writing and addressed to the Privacy Officer at our address. We will respond to your request in a timely fashion.

(5) You have a limited right to receive an accounting of all disclosures we make to other persons or entities of your health information except for disclosures required for providing care, payment and healthcare operations, disclosures that require an Authorization, disclosure incidental to another permissible use or disclosure, and otherwise as allowed by law. We will not charge you for the first accounting in any twelve-month period; however, we will charge you a reasonable fee for each subsequent request for an accounting within the same twelve-month period.

(6) If this notice was initially provided to you electronically, you have the right to obtain a paper copy of this notice and to take on e home with you if you wish.

You may file a written complaint to us or to the Secretary of Health and Human Services if you believe that your privacy rights with respect to confidential information in your health records have been violated. All complaints must be in writing and must be addressed to the Privacy Officer (in the case of complaints to us) or to the person designated by the U.S. Department of Health and Human Services if we cannot resolve your concerns. You will not be retaliated against for filing such a complaint. More information is available about complaints at the government's web site, http://www.hhs.gov/ocr/hipaa.

All questions concerning this Notice or requests made pursuant to it should be addressed to:

PRIVACY OFFICER
DANIEL LYONS, DC
2920 SOUTH WEBSTER AVE.
GREEN BAY, WI 54301
(920)347-4884

Last Name:_____ **Family Members:**_____

Insurance Coverage:

(Please present your insurance card when returning this form)

☐ Primary Medical Insurance:

Ins. Carrier:_____ Phone:_____

Policy Holder Name:_____

Policy Holder's DOB:_____ Relationship:_____

Policy #_____ Group:_____

(Please present your insurance card when returning this form)

☐ Secondary Medical Insurance:

Ins. Carrier:_____ Phone:_____

Policy Holder Name:_____

Policy Holder's DOB:_____ Relationship:_____

Policy #_____ Group:_____

(Please present your insurance card when returning this form)

☐ Teritiary (Other) Medical Insurance:

Ins. Carrier:_____ Phone:_____

Policy Holder Name:_____

Policy Holder's DOB:_____ Relationship:_____

Policy #_____ Group:_____

(If you are seeking treatment as a result of an accident or injury sustained while on the job- please complete this section)

☐ Workers Compensation Insurance:

Employer:_____ Phone:_____

Address:_____

Did you file an accident/injury: YES or NO Date of report:_____

Date of Accident/Injury: _____Time:_____ Workers

Compensation Carrier:_____

(If you are seeking treatment as a result of an accident or injury sustained while on the job- please complete this section)

☐ Auto Accident/Insurance (or Personal Injury):

Your Auto Ins.
Carrier:_____Phone:_____

Name Of Adjuster:_____ Claim#_____

Their Auto Ins. Carrier:_____

Assignment of Benefits: I hereby assign and grant the benefits that I am eligible to receive for professional services rendered in the office of Precision Chiropractic. I authorize the release of any medical information necessary to process and insurance claims for payment. I understand that I am financially responsible for those charges not paid by my insurance.

Patient Signature:_____ Date:_____

Assignment of Benefits

Patient: _____

Insurance Company: _____

Date of Loss: _____ Policy #: _____ Claim #: _____

The undersigned patient and/or responsible part, in addition to the continuing personal responsibility and consideration of treatment rendered or to be rendered assigns to Lyons Health, LLC all benefits payable under the terms of my/our policy benefits.

Release of Information: You are authorized to release information concerning my condition and/or treatment to my insurance company, attorney or insurance adjuster for the purposes of processing my claim for benefits and payment of services rendered to me.

Irrevocable Assignment of Rights: You are assigned the exclusive, irrevocable right to any cause of action that exists in my favor against any insurance company for he terms of the policy, including the exclusive, irrevocable rights to receive payment for such services, make demand in my name for payment, and prosecute and receive penalties, interest, court costs, and other legally compensable amounts owned by and insurance or stat statue. I, as the patient and/or responsible party, further agree to cooperate, provide information as needed, and appear as needed, wherever to assist in the prosecution of such claims for benefits upon request.

Demand for Payment: To any insurance company providing benefits of any kind to me/us for treatment rendered by Lyons Health, LLC, you are hereby tendered demand to pay in full the bill for services rendered by the physician/facility named above within 60 days following your receipt of such bill services to extent such bills are payable under the terms of my/our policy for benefits, ales any amount which I/we personally owe which are not payable under the terms of the policy. This demand specifically conforms to Article 21.55 of the Texas Insurance Code, providing for attorney fees, collecting percentage penalties, court costs, and interest from judgment, upon violation.

Statute of Limitations: I waive my rights to claim any statute of limitations regarding claims for services rendered or to be rendered by Lyons Health, LLC. In addition to reasonable costs of collection, including attorney fees and court costs if incurred.

Limited Power of Attorney: I hereby grant Lyons Health, LLC the power to endorse my name upon any checks, drafts or other negotiable instrument representing payment from any insurance company representing payment for services rendered by Lyons Health, LLC. I agree that any insurance payment representing an amount in excess of the charges for treatment rendered will be credited to my account.

Termination of Care Waiver: I hereby acknowledge and understand that if I do not keep appointments as recommended to me by my doctor, he/she has the full and complete right to terminate responsibility for my care and relinquish any disability granted me within a reasonable period of time. If during the course of my care, my insurance company requires me to take an examination from any other doctor, or if I/we choose to see another doctor, I will notify Lyons Health, LLC.

A photocopy of this instrument shall serve as an original.

_____ _____

Patient Signature (or Parent/Guardian) Date

PRECISION
CHIROPRACTIC

DOCTOR'S LIEN

I do hereby authorize, Precision Chiropractic,/ Dr .Daniel D. Lyons D.C. to furnish you, my attorney, with a full report of his examination, diagnosis, treatment, prognosis, etc., of myself with regard to the accident which I was involved in on _____.

I hereby authorize and direct you, my attorney, to pay directly to the said doctor(s) such sums as may be due and owing him for medical service rendered me by reason of the above accident and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect said doctor.

I hereby further give a lien on my case to said doctor(s) against any and all proceeds of my settlement, judgment or verdict which may be paid to you, my attorney, or myself, as a result of the injuries for which I have been treated or in connection herewith.

I agree to never 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 will honor this lien as inherent to the settlement and enforceable upon the case as if it were executed by him or her.

I fully understand that I am directly and fully responsible to the said doctor(s) for all medical bills submitted by him for service rendered me and that this agreement is made solely for the said doctor's additional protection and in consideration of his awaiting payment. I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

Please acknowledge this letter by signing below and returning it the doctor's office. I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not wait for payment but declare the entire balance due and payable.

Patient Name _____ Date_____

Patient Signature _____ Date_____

ACKNOWLEDGEMENT OF ATTORNEY

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 the settlement, judgment or verdict as may be necessary to adequately protest said doctor(s) above named. Any settlement of this claim without honoring this assignment/lien will cause you to be responsible to this office for payment. The prevailing party in any litigation resulting from enforcement of this enforcement of this lien shall be entitled to actual attorney's fees and court costs.

Attorney Name _____ Date_____

Attorney Signature_____ Date_____