Chugach Chiropractic Clinic LLC

11462 Business Boulevard, Eagle River, Alaska 99577
(907) 694-9224 ◆ Fax: (907) 694-1066
www.chugachchiropractic.com

Patient Information

AUTO ACCIDENT

PLEASE PROVIDE A VALID PICTURE ID TO THE FRONT DESK

SOCIAL SECURITY #: _____-_____-_____

FIRST NAME: _____ **MIDDLE:** _____

LAST NAME: _____ **SEX: MALE or FEMALE**

DATE OF BIRTH: _____/_____/_____ **MARITAL STATUS: M S D W**

CIRCLE ONE: EMPLOYED STUDENT RETIRED UNEMPLOYED

EMPLOYER/OCCUPATION: _____

EMAIL ADDRESS: _____@_____

DATE OF ACCIDENT: _____/_____/_____

ATTORNEY'S NAME:_____

ATTORNEY'S PHONE #: (_____)_____-_____

MAILING ADDRESS: _____

_____

CITY, STATE, ZIP: _____

PHYSICAL ADDRESS: _____

CELL PHONE: (_____)_____-_____

WORK PHONE: (_____)_____-_____

HOME PHONE: (_____)_____-_____

HOW DID YOU HEAR ABOUT US? (PLEASE CIRCLE ONE)

-WEBSITE **-LOCATION**
-FACEBOOK **-ANOTHER PROVIDER**
-STAFF: _____

-EXISTING PATIENT:_____

-OTHER (PLEASE SPECIFY): _____

Auto Insurance Information

INSURANCE COMPANY: _____

CLAIM NUMBER: _____

POLICY ID NUMBER: _____

INSURED'S NAME: _____

ADJUSTER'S NAME: _____

ADJUSTER'S #:(_____)_____-_____

Other Party's Insurance Information

INSURANCE COMPANY: _____

CLAIM NUMBER: _____

POLICY ID NUMBER: _____

INSURED'S NAME: _____

ADJUSTERS NAME: _____

ADJUSTER'S #:(_____)_____-_____

Emergency Contact

NAME: _____ **HOME PHONE #:** _____ **CELL/WORK #:** _____

Assignment & Release - *By signing below, I authorize Chugach Chiropractic Clinic LLC to release medical records required by my insurance company(s). I authorize my insurance company(s) to pay benefits directly to Chugach Chiropractic Clinic LLC. I agree that a reproduced copy of this authorization will be as valid as the original. I understand that I am responsible for any amount not covered by my insurance, or any amount for a patient for which I am the guarantor. I agree that I will be responsible for any reasonable collection agency or attorney fees incurred. I understand that by signing below, I am giving written consent for the use and disclosure of protected health information for treatment, payment, and health care operations.*

Consent to Treatment - *By signing below, I give my consent for examination and the performance any tests or procedures needed. If patient is a minor, by signing I give consent for examination, tests and procedures for the above minor patient.*

SIGNATURE: _____ **DATE:** _____

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I authorize Chugach Chiropractic Clinic to discuss my medical information, to include financials, with the following individuals (Please list their name and relationship to you):

1. _____
2. _____
3. _____
4. _____
5. _____

I understand that I may revoke this consent in writing at any time.

_____ _____ _____

Print Name **Signature** **Date**

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Financial Policy

It is the policy of Chugach Chiropractic Clinic LLC to assess a *$25 missed visit fee to patients who cancel appointments with less than 24 hours notice or patients who miss their appointments without notifying our office*. One missed visit will be considered "grace"; however, all missed visits thereafter will be assessed the missed visit fee. Please understand that we attempt to serve as many patients as possible, and when a visit is missed, it represents time that could have been used to provide care for others.

In order to help our patients determine their responsibility toward payment for services, please read the following, and initial your preference for payment of your account:

Private Pay: (please initial)

A_____ As I have no insurance, I agree to assume all responsibility and to keep my account current by paying for services when they are rendered.

B_____ I have insurance, but I wish to file my claims personally, and I agree to assume all responsibility and to keep my account current by paying for each visit at the time services are rendered.

Health Insurance: (please initial)

C_____ Your health insurance policy most likely has a deductible amount as well as a percentage of your fees for which you, as the patient, are responsible. For example: if you have a deductible of $100, and your insurance pays 80%, you are responsible for 20% of the charges incurred. It is our policy to have the initial visit fees paid by the patient at the time of his/her appointment.

Our business office will contact your insurance company and inform you of your coverage for chiropractic care. We will then determine your eligibility.

Statements are sent out to a patient's insurance company on a regular basis. Your insurance company will inform you of benefits received and paid. Our office will notify you if there are any amounts unpaid or if there is a credit balance. We request that you clear up any and all balances that are due at that time.

If there is an overpayment at the time you have finished your series of treatments, the credit balance will be refunded. If any outstanding balances exist on any adjoining family accounts, your credit balance will be applied to that account or, if you wish, applied toward further care.

Supplies must be paid for when they are received.

Health policies are an arrangement between an insurance company and you, the insured. We will be happy to cooperate with you in the preparation of your insurance forms. Any amount paid directly to our office will be promptly credited to your account. If the insurance company should send you the check, please bring the check to our office.

IT IS IMPORTANT FOR YOU TO UNDERSTAND, HOWEVER, THAT ALL HEALTH SERVICES RENDERED TO YOU ARE CHARGED TO YOU AND ARE YOUR PERSONAL RESPONSIBILITY.

IF YOU HAVE ANY QUESTIONS, PLEASE LET US KNOW. WE WANT YOU TO HAVE A CLEAR UNDERSTANDING OF OUR FINANCIAL POLICY SO THAT TOGETHER WE CAN CONCENTRATE ON RETURNING YOU TO GOOD HEALTH.

Patient/Responsible Party Signature_____ **Date**_____

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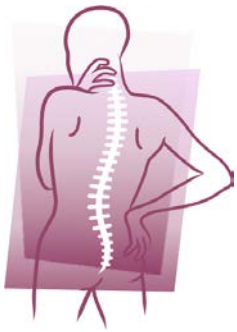
I have had an opportunity to review the Notice of Privacy Practices.

Patient's Printed Name	Date of Birth
Patient's Signature or that of Legal Representative	Today's Date
Print Name of Legal Representative (if applicable)	Relationship of Legal Representative to Individual



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DOCTORS LIEN /ASSIGNMENT OF PAYMENT

I _____ do herby request and authorize my attorney and/ or the insurance carrier to pay Chugach Chiropractic Clinic LLC any monies due on account, the same to be deducted from any settlement made on my behalf for injury date of_____.

Further, I agree to pay Chugach Chiropractic Clinic LLC the difference, if any between the total amount of charges on my account and the amount paid by the attorney and /or insurance carrier. It is further understood that I the undersigned agree to pay Chugach Chiropractic Clinic LLC the amount of charges on my account should my condition be such that it is not covered by the insurance carrier, or if for any reason the insurance carrier refuses to pay this claim.

Patient's Signature: _____Date:_____

Printed Name: _____

Witness: _____

Chugach Chiropractic Clinic LLC

Automobile Accident Questionnaire

Name:_____ Date:_____

1. Date of Accident:_____ Time:_____ a.m./p.m.
2. Driver of car:_____ Where you were seated:_____
3. Owner of car:_____ Year and Model of car:_____
4. Visibility at time of accident: poor/fair/good/other:_____
5. Road conditions at time of accident: icy/rainy/wet/clear/dark/other:_____
6. Where was your car struck? right/left/rear/front/side/other:_____
7. Type of accident: ❒ head-on collision ❒ broad-side collision ❒ rear-end collision
   ❒ front impact, rear-ended car in front ❒ non-collision:_____
8. What part of the car was damaged?_____
9. Describe what happened to you upon impact?_____

   _____
10. Did you see the accident was about to happen? ❒ Yes ❒ No
11. Did you brace for impact? ❒ Yes ❒ No
12. Were you wearing a seatbelt? ❒ Yes ❒ No
13. Were you wearing a shoulder harness? ❒ Yes ❒ No
14. Does the car have headrests? ❒ Yes ❒ No
15. If yes, what was the position of your headrest?
    ❒ top of headrest even with bottom of head ❒ top of headrest even with top of head
    ❒ top of headrest even with middle of head
16. Was your car braking? ❒ Yes ❒ No Was the other car braking? ❒ Yes ❒ No
17. Was your car moving at the time of the accident? ❒ Yes ❒ No If yes, how fast would you estimate you were going?_____
18. How fast would you estimate the other car was traveling?_____
19. What was the position of your head and body at the time of impact?
    ❒ head turned left/right ❒ body straight in sitting position
    ❒ head looking back ❒ body rotated left/right
    ❒ head straight forward ❒ other:_____
20. At the time of the accident, recall what parts of your head or body hit what parts of the vehicle:

    _____

    _____
21. As a result of the accident were you: ❒ rendered unconscious ❒ dazed ❒ other:_____
22. Could you move all parts of your body? ❒ yes ❒ no
    If no, why not?_____
23. Were you able to get out of the car and walk unaided? ❒ yes ❒ no
    If no, why not?_____
24. Did you have any cuts or bruises from this accident? ❒ yes ❒ no

If so, where?_____

25. Describe how you felt immediately after the accident?_____

_____

How did you feel later that ❒ day ❒ night?_____

How did you feel the next day(s)?_____

26. Check symptoms apparent <u>since</u> the accident:

❒ headache	❒ loss of smell	❒ numbness in fingers
❒ neck pain/stiffness	❒ loss of taste	❒ cold hands
❒ mid-back pain	❒ loss of memory	❒ cold feet
❒ low-back pain	❒ fatigue	❒ diarrhea
❒ eyes sensitive to light	❒ tension	❒ constipation
❒ pain behind eyes	❒ shortness of breath	❒ chest pain
❒ dizziness	❒ irritability	❒ nervousness
❒ fainting	❒ depression	❒ cold sweats
❒ ringing/buzzing in ears	❒ sleeping problems	❒ anxious
❒ loss of balance	❒ numbness in toes	❒ other:_____

27. What is your occupation?_____ Employer?_____

28. Have you missed time from work? ❒ yes ❒ no Work hours are: ❒ full-time ❒ part-time

If you have missed time from work, how much time have you missed?_____

29. Did you seek medical help immediately/soon after the accident? ❒ yes ❒ no

If yes, how did you get there?_____

30. Doctor/hospital/clinic seen:_____ Date:_____

31. What was done?_____

Were x-rays taken? ❒ yes ❒ no If yes, of what body part?_____

32. What treatments/prescriptions were given? ❒ bed rest ❒ brace ❒ adjustments ❒ medications

_____

33. What benefit(s) did you receive from treatment(s)?_____

34. Date of last treatment:_____

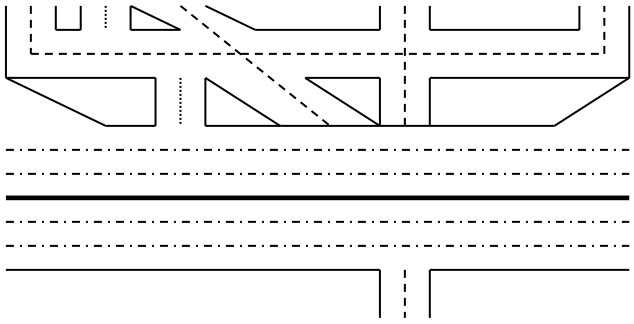
35. Are any of your activities of daily living any different now compared to before the accident? ❒ yes ❒ no

List anything you are unable to do:_____

List anything that is painful to do:_____

List anything that is difficult to do:_____

36. Indicate on the diagram below how the accident happened:



Comments:_____

_____

_____

_____

_____

_____

_____

37. Do you have an attorney handling this case? ❒ yes ❒ no
If yes, who? (name/address)_____

Insurance Information

Patient's personal insurance:
Insured's name (if other than patient)_____ Policy #:_____
Insurance Company Name:_____ Phone#:_____
Address:_____ City:_____ State/Zip:_____
Claim #:_____ Adjuster's name/phone:_____

Other party's insurance:
Insured's name (if other than patient)_____ Policy #:_____
Insurance Company Name:_____ Phone#:_____
Address:_____ City:_____ State/Zip:_____
Claim #:_____ Adjuster's name/phone:_____

Other insurance:
Insured's name (if other than patient)_____ Policy #:_____
Insurance Company Name:_____ Phone#:_____
Address:_____ City:_____ State/Zip:_____
Claim #:_____ Adjuster's name/phone:_____

Patient's Demographic Information

Patient's full name:_____ Social Security #:_____

Address:_____ Date of Birth:_____

Mailing address (if different):_____ Phone:_____

Employer name:_____ Occupation:_____

Employer's address:_____ Work phone:_____

Spouse's name:_____ Spouse's Social Security #:_____

Spouse's employer:_____ Occupation:_____

Assignment of Payment

My attorney and/or insurance carrier are hereby requested and authorized to pay direct to Chugach Chiropractic Clinic LLC any monies due on account, the same to be deducted from any settlement made on my behalf.

Further, I agree to pay Chugach Chiropractic Clinic LLC the difference, if any between the total amount of charges on my account and the amount paid by the attorney and/or insurance carrier. It is further understood that I, the undersigned agree to pay Chugach Chiropractic Clinic LLC the full amount of charges on my account should my condition be such that it is not covered by my policy or if for any reason the insurance carrier refuses to pay my claim.

Patient's signature:_____ Date:_____

Printed name:_____

Witness:_____

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Electronic Health Records Intake Form

In compliance with requirements for the government EHR incentive program

First Name:_____ **Last Name**:_____

Email address: _____@_____ **Date**:_____

How did you hear about our office? _____

Preferred reminder method (Circle one): Email / Phone / Mail / Text **DOB:** __/__/____

Gender (Circle one): Male / Female **Preferred Language:** _____

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

Smoking Start Date: _____

CMS requires providers to report both race and ethnicity

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) Native Hawaiian or Pacific Islander / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? (Please include regularly used over the counter medications)

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any *medication* allergies?

Medication Name	Reaction	Onset Date	Additional Comments

☐ **I choose to decline receipt of my clinical summary after every visit** *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

Patient Signature: _____ **Date:** _____

For office use only

Height: _____ Weight:_____ Blood Pressure:_____/_____ Pulse: _____

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Symptom Questionnaire

Patient Name: _____ Date: _____

Reason for today's visit: ❑ New Injury ❑ Old Injury ❑ Chronic Pain ❑ Wellness Visit

Are you in pain? ❑ Yes ❑ No

Rate your pain with the following scale. No Discomfort 1 2 3 4 5 6 7 8 9 10 Intense Pain

When did your condition begin or accident occur? _____ Where did your injury/accident occur? _____

Please explain what happened: _____

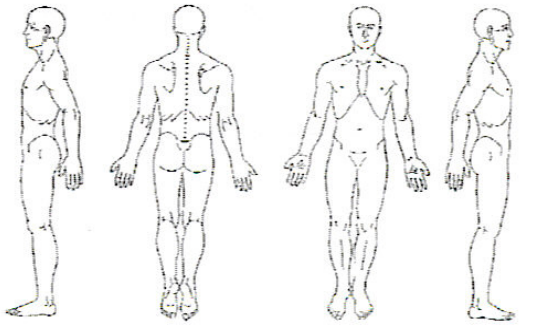
Is your condition getting worse? ❑ Yes ❑ No ❑ Constant ❑ Comes and Goes

Is your condition interfering with your: ❑ Work ❑ Sleep ❑ Daily Routine If so, how? _____

Has this or something similar happened in the past?

❑ Yes ❑ No ❑ Explain: _____

Please use the body chart below to mark affected areas.



Have you been treated by a physician for this pain?

❑ Yes ❑ No ❑ If so, where? _____

Have you ever been treated by a chiropractor?

❑ Yes ❑ No ❑ If so, who? _____

Are you taking any of the following medications? What types?

❑ Pain Killers _____
❑ Muscle Relaxants _____
❑ Insulin _____
❑ Supplements _____
❑ Other _____

Do you have or have you had any of the following medical conditions or procedures?

❑ Heart Attack / Stroke	❑ Ulcers / Colitis	❑ Fainting / Seizures / Epilepsy
❑ Heart Condition / Pacemaker	❑ Cancer / Chemotherapy	❑ Severe / Frequent Headaches
❑ Artificial Valves	❑ Anemia / Diabetes	❑ Sinus Problems
❑ Artificial Bones / Joint / Implants	❑ Kidney Problems	❑ Emphysema / Asthma
❑ Arthritis	❑ Frequent Neck Pain	❑ Tuberculosis
❑ High / Low Blood Pressure	❑ Lower Back Problems	❑ Difficulty Breathing

Please list any surgeries with dates and / or any other serious medical condition(s) not listed above:

List any past serious accidents with dates:

Please list anything you are allergic to:

Family History (list any major diseases such as cancer, diabetes, heart problems, bone / joint diseases):

Do you exercise? ❑ No ❑ Yes _____ amounts per week Are you dieting? ❑ No ❑ Yes Since: _____

Do you smoke? ❑ No ❑ Yes If yes, how much? _____ How long? _____

Are you wearing: ❑ Shoe lifts ❑ Inner soles ❑ Arch Supports

For Women: Are you pregnant? ❑ Yes ❑ No If so, how many weeks? _____

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Oswestry Back Pain Scale Questionnaire

This questionnaire has been designed to give your doctor information as to how your back has affected your ability to manage in everyday life. Please answer every question by circling the **one** number that best describes your condition today. We realize you may feel that two of the statements may describe your condition, but **please circle only the number which most closely describes your current condition**.

Question 1 - Pain Intensity
0. I can tolerate the pain I have without having to use pain medication.
1. The pain is bad but I can manage without having to take pain medication.
2. Pain medication provides me complete relief from pain.
3. Pain medication provides me with moderate relief from pain.
4. Pain medication provides me with little relief from pain.
5. Pain medication has no effect on my pain.

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

Question 3 – Lifting
0. I can lift heavy weights without increased pain.
1. I can lift heavy weights, but it increases pain.
2. Pain prevents me from lifting heavy weights off the floor, but I can manage if the weights are conveniently positioned.
3. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently located.
4. I can only lift very light weights.
5. I cannot lift or carry anything at all.

Question 4 – Walking
0. Pain does not prevent me from walking any distance.
1. Pain prevents me from walking more than 1 mile.
2. Pain prevents me from walking more than 1/2 mile.
3. Pain prevents me from walking more than 1/4 mile.
4. I can walk only with crutches or a cane.
5. I am in bed most of the time and have to crawl to the toilet.

Question 5 – 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 for more than 1 hour.
3. Pain prevents me from sitting for more than 1/2 hour.
4. Pain prevents me from sitting for more than 10 minutes.
5. Pain prevents me from sitting at all.

Question 6 – Standing
0. I can stand as long as I want without increased pain.
1. I can stand as long as I want, but it increases my pain.
2. Pain prevents me from standing for more than 1 hour.
3. Pain prevents me from standing for more than 1/2 hour.
4. Pain prevents me from standing for more than 10 minutes.
5. Pain prevents me from standing at all.

Question 7 – Sleeping
0. Pain does not prevent me from sleeping well.
1. I can sleep well only by using pain medication.
2. Even when I take medication, I sleep less than 6 hours.
3. Even when I take medication, I sleep less than 4 hours.
4. Even when I take medication, I sleep less than 2 hours.
5. Pain prevents me from sleeping at all.

Question 8 – Social Life
0. My social life is normal and does not increase my pain.
1. My social life is normal but increases my level of pain.
2. Pain prevents me from participating in more energetic activities.
3. Pain prevents me from going out very often.
4. Pain has restricted my social life to my home.
5. I have hardly any social life because of my pain.

Question 9 – Traveling
0. I can travel anywhere without increased pain.
1. I can travel anywhere, but it increases my pain.
2. My pain restricts my travel over 2 hours.
3. My pain restricts my travel over 1 hour.
4. My pain restricts my travel to short necessary journeys under 1/2 hour.
5. My pain prevents all travel except for visits to the physician/ therapist.

Question 10 – Working
0. My normal homemaking/job activities do not cause pain.
1. My normal homemaking/job activities increase my pain, but I can still perform all that is required of me.
2. I can perform most of my homemaking/job duties, but pain prevents me from performing more physically stressful activities.
3. Pain prevents me from doing anything but light duties.
4. Pain prevents me from doing even light duties.
5. Pain prevents me from doing any job or homemaking chores.

Name: _____ **Date:** _____

Lumbar (Lower Back)

The Neck Pain Disability Index Questionnaire

Instructions: Please circle ONE NUMBER in each section which most closely describes your problem.

Section 1: Pain Intensity
0. I have no pain at the moment.
1. The pain is very mild at the moment.
2. The pain is moderate at the moment.
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.

Section 2: Personal Care (Washing, Dressing, etc.)
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 and I am slow and careful.
3. I need some help but manage most of my personal care.
4. I need help every day in most aspects of self care.
5. I do not get dressed, I wash with difficulty and stay in bed.

Section 3: Lifting
0. I can lift heavy weights without extra pain.
1. I can lift heavy weights but it gives extra pain.
2. Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example on a table.
3. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
4. I can lift very light weights.
5. I cannot lift or carry anything at all.

Section 4: Reading
0. I can read as much as I want to with no pain in my neck.
1. I can read as much as I want to with slight pain in my neck.
2. I can read as much as I want with moderate pain in my neck.
3. I cannot read as much as I want because of moderate pain in my neck.
4. I can hardly read at all because of severe pain in my neck.
5. I cannot read at all.

Section 5: Headaches
0. I have no headaches at all.
1. I have slight headaches that 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.

Section 6: Concentration
0. I can concentrate fully when I want to with no difficulty.
1. I can concentrate fully when I want to with slight difficulty.
2. I have a fair degree of difficulty in concentrating when I want to.
3. I have a lot of difficulty in concentrating when I want to.
4. I have a great deal of difficulty in concentrating when I want to.
5. I cannot concentrate at all.

Section 7: Work
0. I can do as much work as I want to.
1. I can do my usual work, but no more.
2. I can do most of my usual 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.

Section 8: Driving
0. I can drive my car without any neck pain.
1. I can drive my car as long as I want with slight pain in my neck.
2. I can drive my car as long as I want with moderate pain in my neck.
3. I cannot drive my car as long as I want because of moderate pain in my neck.
4. I can hardly drive at all because of severe pain in my neck.
5. I cannot drive my car at all.

Section 9: Sleeping
0. I have no trouble sleeping.
1. My sleep is slightly disturbed (< 1 hr sleepless).
2. My sleep is mildly disturbed (1-2 hrs sleepless).
3. My sleep is moderately disturbed (2-3 hrs sleepless).
4. My sleep is greatly disturbed (3-5 hrs sleepless).
5. My sleep is completely disturbed (5-7 hrs sleepless).

Section 10: Recreation
0. I am able to engage in all my recreation activities with no neck pain at all.
1. I am able to engage in all my recreation activities, with some pain in my neck.
2. I am able to engage in most, but not all, of my usual recreation activities because of pain in my neck.
3. I am able to engage in a few of my usual recreation activities because of pain in my neck.
4. I can hardly do any recreation activities because of pain in my neck.
5. I cannot do any recreation activities at all

Name: _____ **Date:** _____

Cervical (Neck)