



Date: _____

Patient #: _____

Chiropractic Case History/Patient Information

Name: _____ Social Security # _____ Home Phone: _____

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

E-mail address: _____ Fax # _____ Cell Phone: _____

Can we send reminders via e-mail? Yes No Can we leave a message on your voice mail? Yes No

Age: _____ Birth Date: _____ Race: _____ Marital: M S W D Male Female

Occupation: _____ Employer: _____

Employer's Address: _____ Office Phone: _____

Spouse/Guardian (Circle one): _____ Phone: _____

Employer: _____ Date of Birth: _____ SS#: _____

Person to reach in case of emergency: _____ Phone: _____

Address: _____ Alternate Phone: _____

Who (other than yourself) can we speak with regarding your account? _____

Who (other than yourself) can we speak with regarding your care? _____

How were you referred to our office? _____

When doctors work together it benefits you. May we have your permission to update your medical doctor regarding your care at this office? _____

Family Medical Doctor: _____ Facility Name: _____

PAYMENT FOR SERVICES RENDERED

As a courtesy to our patients, Partners in Health & Wellness will attempt to obtain payment from insurance carriers, and/or workers compensations plans, motor vehicle insurance companies or any other responsible parties. It is our policy to complete the insurance forms and submit to your carrier directly. We will make our best effort to secure payment from your carrier for you. However, if we do not have a resolution within 90 days, we reserve the right to secure payment from you. Be sure to check with your insurance company prior to the 90 day time frame to resolve any issue that may arise. We do expect payment at the time of service for any payment that is due by you (co-pay, deductibles, co-insurance, cash payments, etc.) whether you have insurance coverage or not.

I understand that in the event that no health insurance coverage exists, payment arrangements can be made with Partners in Health & Wellness. I, _____, authorize Partners in Health & Wellness to debit the credit card listed below, in my absence, for payment (deductibles, co-insurance, co-payments) due.

Credit Card #: _____ Expire Date: _____

Authorized Signature: _____ Witness: _____

Name: _____

Date: _____

PERSONAL INJURY PATIENT HISTORY

ACCIDENT HISTORY

Date of Accident: _____ Time: _____

Were you the? driver front seat passenger rear left passenger rear middle passenger
 rear right passenger

Who owns the car? _____ Year & Model of Car? _____

Describe the damage to the vehicle you were in: mild moderate severe total

Visibility at the time of the accident: poor fair good

Road conditions: dry wet clear dark icy

Type of Accident: struck in the back struck in the front struck in the driver side
 struck in the passenger side

Was your car moving at the time of the accident? Yes No How fast? _____ MPH

How fast was the other vehicle moving? _____ MPH don't know

Was your car braking or attempting to slow down at the time of the accident? Yes No

Was there a secondary impact? Yes No

If yes, describe: _____

Please describe what happened to your body when the accident occurred: _____

Were you aware that the accident was about to occur? Yes No

Did you brace for the impact? Yes No

Did you have on a seatbelt shoulder harness both?

Does the car have an airbag? Yes No If yes, did it deploy? Yes No

What was the position of your head/body at impact? Head turned right Head turned left

Head looking back Head straight forward Body straight in sitting position

Body rotated right Body rotated left

As a result of the accident were you: Rendered unconscious Dazed, circumstances vague
 Shaken up, but could function

Please describe how you felt immediately after the accident. PLEASE BE SPECIFIC AND DETAILED.

Later that: Day Night

The next day (s):

PARTNERS IN HEALTH & WELLNESS

Check symptoms apparent since the accident that were not present before the accident.

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Loss of memory | <input type="checkbox"/> Sleeping problems |
| <input type="checkbox"/> Neck pain | <input type="checkbox"/> Fainting | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Numb toes |
| <input type="checkbox"/> Mid back pain | <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Tension | <input type="checkbox"/> Numb fingers |
| <input type="checkbox"/> Low back pain | <input type="checkbox"/> Loss of balance | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Cold hands |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Loss of smell | <input type="checkbox"/> Anxious | <input type="checkbox"/> Cold feet |
| <input type="checkbox"/> Pain behind eyes | <input type="checkbox"/> Loss of taste | <input type="checkbox"/> Depression | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Cold sweats |
| <input type="checkbox"/> Eyes sensitive to light | | | |

Other: _____

Have you missed time from work due to this injury? Yes No
If yes, full-time work part-time work. Date of work absence? _____

Did you seek medical care immediately/soon after the accident? Yes No
If yes, how did you get there? drove myself someone else drove me ambulance police
How long after the accident was it before you were seen by a doctor? _____

Dr./Hospital Name(s): _____

Were x-rays taken? Yes No Was treatment given? Yes No

What if any medications were prescribed? _____

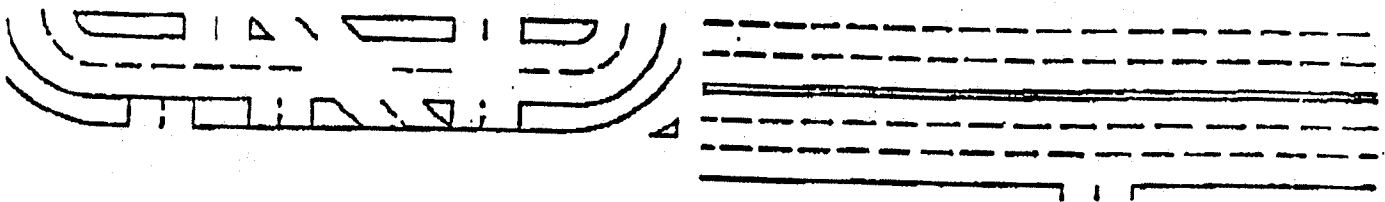
What benefits did you receive from the treatment? _____

_____ What was the last date of treatment? _____

Do you notice any of your home activities that are different now than from before the accident? No
If yes, list the activities that you are totally unable to perform: _____

_____ List home activities that are painful or difficult now (be specific): _____

**Indicate on this diagram how the accident happened
(Note the care you were in as car "A")**



I attest that the above statements are factual to the best of my knowledge. I give permission to Dr. Hecht and Partners in Health & Wellness permission to discuss my injuries with other providers that I have seen for this event. I further give permission for the aforementioned doctor/clinic to obtain pertinent medial records from this accident including but not limited to radiographs, exam reports, intake forms, and lab results.

Signature of Patient

Date

PARTNERS IN HEALTH & WELLNESS

Our Office Policies

Patient's Responsibility:

- If you have major medical health insurance, we must file it according to our contract with the insurance company. All co-payments are due at the time of the visit. All deductibles, co-insurance amounts, and non-covered services will be due at the time of settlement. If payment is not received within 90 days of your last treatment, you will be required to follow-up with the liability, med-pay, or attorney in regard to payment. At that time, you may be required to settle your bill for services rendered with this office. Financial arrangements are available when necessary. Any financial arrangement that is not honored with Partners in Health (and) Wellness may be considered for collection action. Any account submitted for collection action will incur a \$25.00 processing fee.
 - If your insurance company requires a primary care referral, it is your responsibility to obtain such prior to services being rendered or the insurance company may not cover the visit.
 - Some insurance companies require specific paperwork for authorization of treatment. These forms must be completed prior to services being rendered or the insurance company may deny your claim. We will submit the forms to the insurance company for you for approval and let you know of your coverage.
 - If you decide to use an attorney, a Lien must be signed and prompt payment from your attorney will be paid to the office once the case has been settled.
 - If you choose to "self file" with the responsible party's insurance company, payment will be due at the time of service and a receipt will be given with your balance for filing purposes.
 - No statements or reports will be released to the patient until the balance on the case is paid. Also, we will only release your records to an insurance company or attorney if we have a written authorization that is signed and dated from you. This authorization may not be provided by phone or e-mail.
 - There is a \$35.00 fee for non sufficient check returns.
 - It is customary that patient's schedule appointments prior to coming in for treatment. Walk-in and call-in patients will be seen on a work in basis. Pre-scheduled appointments will be seen first.
 - No show/no call missed appointments will be charged a fee of \$25.00 if not cancelled within 24 hours. We realize that emergencies arise that may prevent you from making your appointment. Please call as soon as possible so that we can work to reschedule you at the earliest possible time.
-

I have read and understand the above statements and agree to adhere to these office policies.

Signature of Patient/Guardian

Date

Patient Name: _____

CONSENT FOR USE OF DISCLOSURE OF HEALTH INFORMATION

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information. There are several circumstances in which we may have to use or disclose your information:

- To another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
- To another party if they are potentially responsible for the payment of your services.
- Within our practice for quality control or other operational purposes.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before you sign this consent form (164.520). We reserve the right to change of privacy practices, we will notify you in writing when you come in for treatment or by mail.

YOUR RIGHT TO LIMIT USES OR DISCLOSURES.

You have the right to request that we do not disclose your information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding.

YOUR RIGHT TO REVOKE YOUR AUTHORIZATION.

You may revoke your consent to us at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

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

I have read and understand the above consent form and agree to the above terms.

Signature of Patient/Guardian

Date

AUTHORIZATION AND RELEASE

I authorize payment of insurance benefits directly to Dr. Charles Hecht/Partners in Health & Wellness. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by Dr. Hecht, any fees for services will be immediately due and payable.

I understand and agree to allow Partners in Health to use my Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. Further details of our (HIPAA Notice) privacy policy are available.

Patient/Guardian Signature

Date

Signature of Witness