PATIENT INFORMATION

Name _____ Today's Date _____

Date of Birth _____ Height _____ Weight _____ Dominant Hand? R L

Address _____ City _____ Zip _____

Phone (cell) _____ Phone (other) _____

email _____ DL# _____

Health Insurance Company _____ Policy# _____

Address _____ City _____ Zip _____

Adjuster _____ Phone _____

Car Insurance Company _____

Address _____ City _____ Zip _____

Adjuster _____ Phone _____

Agent _____ Phone _____

Policy # _____ Claim # _____

What Medical Payments Coverage? _____ What Uninsured Motorist Coverage? _____

What Law Firm Represents You? _____

Address _____ City _____ Zip _____

Your Lawyer's Name? _____ Phone _____

Name of Insured on your Car Policy _____

For office use only
Patient #

Date of Loss/Accident? _____ Date you first saw *any* Doctor after accident _____

Cost of all medical treatment since the accident? $ _____

How much income have you lost since the accident $ _____

What is the property damage (repair amount) of your car? $ _____

Name of your Personal M.D. _____ Phone _____

Address _____ City _____ Zip _____

Write any Ambulance, Hospital, M.D., Chiropractor, Dentist, Acupuncturist, PT, etc., since accident

Name	Type	Phone#	Amount of Bill	For office use only Records Rec'd

Please use other side of page to write additional doctors & hospitals

Accident History Questionnaire

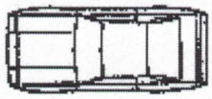
PERSONAL INJURY PATIENT HISTORY

Name _____ Date _____

Address _____ Phone Number _____

Cell Phone _____ Email _____

1. Date of Accident: _____ 2. Time: _____ AM/PM
3. Driver of Car: _____ 4. Where were you seated? _____
5. Who owns the car? _____
6. Year & Model of your car. _____
   Year & Model of other car. _____
7. What was the approximate damage done to your car? $ _____
8. Visibility at time of accident: ☐ poor ☐ fair ☐ good ☐ other: _____
9. Road conditions at time of accident: ☐ icy ☐ rainy ☐ wet ☐ clear ☐ dark ☐ other (describe): _____
10. Where was your car struck?

FRONT  REAR

In your own words, please describe accident: _____

_____

_____

11. Type of Collision: ☐ Head-on ☐ Broad-side ☐ Front Impact ☐ Rear-end car in front ☐ Rear impact ☐ Non-collision
12. At the time of the accident, recall what parts of your head or body hit what parts on the inside of your car:

_____

13. Did you see the accident coming? ☐ yes ☐ no → 14. Did you brace for impact? ☐ yes ☐ no
15. Were seatbelts worn? ☐ yes ☐ no → 16. Were shoulder harnesses worn? ☐ yes ☐ no
17. Does you car have headrests? ☐ yes ☐ no
18. If yes, what was the position of those headrests compared to your head before the accident?
    ☐ Top of headrest even with **bottom** of head ☐ Top of headrest even with **top** of head
    ☐ Top of headrest even with **middle** of neck
19. Was your car braking? ☐ yes ☐ no → 20. Was your car moving at the time of the accident? ☐ yes ☐ no
21. If yes, how fast would you estimate you were going? _____ mph → 22. the other car? _____ mph
23. Head/Body position at the time of impact:
    ☐ Head turned left/right ☐ Head looking back ☐ Head straight forward
    ☐ Body straight in sitting position ☐ Body rotated right/left ☐ Other:
24. As a result of the accident you were:
    ☐ Rendered unconscious ☐ In shock ☐ Dazed, circumstances vague ☐ Other:
25. How was the shoulder harness adjusted? ☐ Loose ☐ Snug
26. Were you wearing a hat or glasses? ☐ yes ☐ no
27. Could you move all parts of your body? ☐ yes ☐ no
28. If no, what parts couldn't you move and why? _____
29. Were you able to get out of the car and walk unaided? ☐ Yes ☐ No
30. If no, why not? _____
31. Did you get any bleeding cuts? ☐ yes ☐ no If yes, where? _____
32. Did you get any bruises? ☐ yes ☐ no If yes, where? _____
33. Describe how you felt immediately after the accident: _____
    Later that day: _____
    The next day: _____

34. Check symptoms apparent since the accident:

☐ Headache	☐ Chest pain	☐ Neck pain/Stiffness	☐ Mid back pain	☐ Light sensitivity
☐ Anxious/Nervousness	☐ Pain behind eyes	☐ Dizziness	☐ Low back pain	☐ Sleeping problems
☐ Numbness in fingers	☐ Loss of smell	☐ Numbness in toes	☐ Fainting	☐ Cold feet
☐ Facial Pain	☐ Loss of memory	☐ Fatigue	☐ Breath shortness	☐ Loss of taste
☐ Irritability	☐ Depression	☐ Ringing/Buzzing	☐ Cold Sweats	☐ Loss of balance
☐ Tension	☐ Constipation	☐ Cold hands	☐ Clicking / Popping Jaw	
☐ Diarrhea	☐ Other_____			

35. Occupation:_____ 36. Employer:_____
37. Have you missed time from work: ☐ yes ☐ no
38. If yes, full time off work: _____to_____
39. If yes, part time off work: _____to_____
40. Did you seek medical help immediately after the accident? ☐ yes ☐ no
41. If yes, how did you get there? ☐ Ambulance ☐ Police ☐ Someone drove me ☐ Drove myself ☐ Other:_____
42. Doctor #1: Name: _____ 43. First Visit Date: _____
44. Were you examined? ☐ yes ☐ no → 45. Were X-rays taken? ☐ yes ☐ no
46. Did you receive treatment? ☐ yes ☐ no ☐ Medications ☐ Braces ☐ Collars
47. If yes, what kind of treatment did you receive?_____
48. What benefits did you receive from the treatment?_____
49. Date of last treatment? _____
50. Doctor #2: Name:_____ 51. First Visit Date:_____
52. Were you examined? ☐ yes ☐ no → 53. Were X-rays taken? ☐ yes ☐ no
54. Did you receive treatment? ☐ yes ☐ no ☐ Medications ☐ Braces ☐ Collars
55. If yes, what kind of treatment did you receive?_____
56. What benefits did you receive from the treatment?_____
57. Date of last treatment: _____
58. Do you have an attorney on this claim? ☐ yes ☐ no
59. If yes, who? _____

Address_____

City_____ State _____ Zip _____ Phone _____

Illustrate how the accident happened.

PAST MEDICAL HISTORY: Place an (X) if it applies and describe.

☐ None related to current complaints ☐ Hospital or operation ☐ Auto Accident ☐ Work Accident ☐ Illness ☐ Other

Describe _____

_____

Symptoms

Patient _____ Date _____ Date of Injury _____

Please fill in all symptoms you currently have <u>that you did not have</u> before the accident.

Orthopedic & Musculoskeletal Symptoms

- ☐ "Clunk" sound with neck movements
- ☐ Neck pain
- ☐ Upper back pain
- ☐ Low back pain
- ☐ Shoulder pain ☐ Left ☐ Right
- ☐ Upper arm pain ☐ Left ☐ Right
- ☐ Elbow pain ☐ Left ☐ Right
- ☐ Forearm pain ☐ Left ☐ Right
- ☐ Wrist pain ☐ Left ☐ Right
- ☐ Hand pain ☐ Left ☐ Right
- ☐ Hip pain ☐ Left ☐ Right
- ☐ Upper leg pain ☐ Left ☐ Right
- ☐ Knee pain ☐ Left ☐ Right
- ☐ Lower leg pain ☐ Left ☐ Right
- ☐ Ankle pain ☐ Left ☐ Right
- ☐ Foot pain ☐ Left ☐ Right
- ☐ Jaw pain
- ☐ Clicking in Jaw
- ☐ Pain when chewing
- ☐ Face pain
- ☐ Chest pain
- ☐ Stomach pain
- ☐ Bruise to _____
- ☐ Scrape/Cut to _____
- ☐ Other Symptom _____
- ☐ Other Symptom _____

Neurological Symptoms

- ☐ Numb/Tingling Arm / Hand L R
- ☐ Numb/Tingling Leg / Foot L R
- ☐ Weakness Arm / Hand L R
- ☐ Weakness Leg / Foot L R

Symptoms Associated with Injuries

- ☐ Stiffness or limited movement in joint(s)
- ☐ Headaches
- ☐ Muscle spasms/sore muscles
- ☐ Dizziness, lightheaded, woozy feeling
- ☐ Visual disturbances or vision change
- ☐ Sleep changes/disruption of patterns
- ☐ Pain radiates from one place to another
- ☐ Anxiety or nervous when driving
- ☐ Irregular Heartbeat or uneven pulse
- ☐ Feeling depressed about things
- ☐ I am taking the following medications ____

_____

Brain/Neuropsych/MTBI/PTSD Symptoms

- ☐ I prefer being alone now (not socializing)
- ☐ I am sleepy, tired during day or doze off easily
- ☐ Upset stomach, nausea, heartburn or vomiting
- ☐ Difficulty concentrating, mind wanders easily
- ☐ I get overwhelmed easily
- ☐ Mood swings, happy one moment then sad
- ☐ Agitation (can't sit still, need to move around)
- ☐ Sadness, tearful episodes, crying easily
- ☐ Blurry vision, had to get or change glasses
- ☐ Asking people to repeat things or hearing problem
- ☐ I make wrong turns driving or can't remember time
- ☐ I get confused easily or cannot multi-task anymore
- ☐ I have difficulty finding some words when talking
- ☐ Bright lights bother me
- ☐ I cannot pay attention as long as before
- ☐ I am eating more or less than normal
- ☐ Room spins, lightheaded or woozy feeling
- ☐ Balance problems
- ☐ I feel like my head is "Foggy"
- ☐ I have forgotten computer passwords or ATM PIN
- ☐ I have to re-read things to understand what I read
- ☐ My thinking is slowed down
- ☐ Difficulty with adding/subtracting numbers
- ☐ Fear I will never be the same again
- ☐ Difficulty learning new things
- ☐ Difficulty understanding what people say to me
- ☐ Difficulty remembering or memory problems
- ☐ Cannot take on any more responsibility
- ☐ I can't make decisions as quickly as before
- ☐ Loss of libido or lack of sexual desire
- ☐ I do not feel as confident of my abilities
- ☐ I get panic attacks, fast heartbeat, nervous
- ☐ I am more irritable than usual
- ☐ Some food or drink tastes "Funny" to me now
- ☐ I get frustrated very easily
- ☐ Difficulty planning my life or organizing my work
- ☐ Flashbacks or frightening thoughts about accident
- ☐ I have had bad dreams about the accident
- ☐ I avoid places & objects that remind me about it
- ☐ I feel emotionally numb-no interest in my hobbies
- ☐ I'm feeling strong guilt, worry or depression
- ☐ I am having trouble remembering the accident
- ☐ I am easily startled since the accident - "jumpy"
- ☐ I feel tense or "on edge" most of the time
- ☐ I am having difficulty sleeping
- ☐ I get angry easily or even yell at people now

Patient Signature _____ Dr. Signature _____

Duties Performed Under Duress at Work and Home

Patient _____ Date _____ Date of Injury _____

☐ Initial ☐ Update

Please check all that apply to your WORK *because of the accident.*

- ☐ I go to work but work in pain
- ☐ I limit my work activities
- ☐ Bending at work hurts
- ☐ Stooping at work hurts
- ☐ Sitting at work hurts
- ☐ Using the Computer at work hurts
- ☐ Pushing at work hurts
- ☐ Pulling at work hurts
- ☐ Kneeling at work hurts
- ☐ I have lost status in my company
- ☐ I have lost job security
- ☐ I didn't get a promotion
- ☐ I don't enjoy work as much as before
- ☐ I doze off at work
- ☐ I take unpaid time off work to go to Dr.
- ☐ I daydream at work more than before
- ☐ I feel tired at work
- ☐ I work in pain because I have bills to pay
- ☐ I can't take time off because I would lose my job
- ☐ I keep working so I don't lose status at company
- ☐ My business would fail if I took time off
- ☐ I believe in working even when I'm in pain
- ☐ I feel obligated to work even though I'm in pain
- ☐ My business would lose money if I took time off
- ☐ My work is not as good as it was before accident
- ☐ My boss reprimanded me for poor performance
- ☐ I got a different job within the same company
- ☐ I got a different job in another company
- ☐ I make less money than before the accident
- ☐ I cannot do the same work/job as before accident
- ☐ I can't concentrate as well at work
- ☐ I take paid time off to go to Dr.
- ☐ I make mistakes at work I didn't used to
- ☐ I hide my poor work performance from my boss
- ☐ I need medication to be able to work. I take _____ mg of _____ at ____ am when my pain level gets to ____/10 and/or again at _____ pm when my pain gets to ____/10

Please check all that apply to your HOME/DOMESTIC duties *because of the accident.*

- ☐ My house is not as clean now
- ☐ My yard is not as neat now
- ☐ My garden is not as productive now
- ☐ I do yard work, but do it in pain
- ☐ I cannot do my normal yard work
- ☐ I do house work, but do it in pain
- ☐ I cannot do my normal house work
- ☐ Doing laundry hurts me
- ☐ I cannot do laundry now
- ☐ Washing dishes hurts me
- ☐ I cannot wash dishes now
- ☐ Vacuuming hurts me
- ☐ I cannot vacuum now
- ☐ Cooking hurts me
- ☐ I cannot cook now
- ☐ Washing the car hurts me
- ☐ I cannot wash my car
- ☐ _____
- ☐ _____
- ☐ I cannot take time off because I care for children
- ☐ I have _____ children ages _____
- ☐ I had to hire a paid housekeeper
- ☐ I asked someone for unpaid housekeeping help
- ☐ I had to hire a paid gardener
- ☐ I asked someone for unpaid yard work help
- ☐ Mowing the lawn hurts me
- ☐ I cannot mow the lawn
- ☐ Taking out the trash hurts me
- ☐ I cannot take out the trash
- ☐ I do not enjoy my gardening/yardwork like I used to
- ☐ I do not enjoy my housework like I used to
- ☐ Gardening hurts me
- ☐ I cannot do my gardening at all since the accident
- ☐ Others living with me do my share of the work now
- ☐ Others living with me do my share of the yard work
- ☐ Others living with me do my share of the gardening
- ☐ _____
- ☐ _____

_____ _____

Signature Date

Loss of Enjoyment of Sports, Hobbies, Travel, Daily Activities, & School (p. 1 of 2)

Patient _____ Date _____ Date of Injury _____

☐ Initial ☐ Update

Please check all that apply to your EXERCISE & SPORTS Activity *because of the accident.*

- ☐ My exercise was affected by this crash
- ☐ I go to the gym & work out in pain
- ☐ I no longer go to the gym to work out
- ☐ I run but in pain
- ☐ I no longer run
- ☐ I take walks & have pain while walkiing
- ☐ I no longer take walks
- ☐ I used to make income at sports
- ☐ I have lost sports income since crash
- ☐ I am an amateur athlete
- ☐ I am a professional athlete
- ☐ _____
- ☐ _____
- ☐ I have gained _____ pounds since the accident
- ☐ I had to quit my _____ team after the accident
- ☐ I had to quit my _____ team after the accident
- ☐ I had to quit my _____ team after the accident
- ☐ I had to quit my _____ team after the accident
- ☐ I don't enjoy the sport of _____ anymore
- ☐ I didn't enjoy the sport of _____ for ____ weeks
- ☐ I don't enjoy the sport of _____ anymore
- ☐ I didn't enjoy the sport of _____ for ____ weeks
- ☐ I don't enjoy the sport of _____ anymore
- ☐ I didn't enjoy the sport of _____ for ____ weeks
- ☐ I don't enjoy the sport of _____ anymore
- ☐ I didn't enjoy the sport of _____ for ____ weeks

Please check all that apply to your HOBBY Activities *because of the accident.*

- ☐ My hobbies were affected by accident
- ☐ Hobby #1 _____
- ☐ I can't do hobby #1 anymore
- ☐ I do hobby #1 but in pain
- ☐ I have lost money from not doing #1
- ☐ I didn't do hobby #1 for _____ weeks
- ☐ Hobby #2 _____
- ☐ I can't do hobby #2 anymore
- ☐ I do hobby #2 but in pain
- ☐ I have lost money from not doing #2
- ☐ I didn't do hobby #2 for _____ weeks
- ☐ Hobby #3 _____
- ☐ I can't do hobby #3 anymore
- ☐ I do hobby #3 but in pain
- ☐ I have lost money from not doing #3
- ☐ I didn't do hobby #3 for _____ weeks
- ☐ Hobby #4 _____
- ☐ I can't do hobby #4 anymore
- ☐ I do hobby #4 but in pain
- ☐ I have lost money from not doing #4
- ☐ I didn't do hobby #4 for _____ weeks
- ☐ _____

Please check all that apply to your TRAVEL Activities *because of the accident.*

- ☐ Business travel was affected by crash
- ☐ Pleasure travel was affected by crash
- ☐ I hurt driving in my own car
- ☐ I am in too much pain to drive
- ☐ I hurt when a passenger in a car
- ☐ I am in too much pain to sit in a car
- ☐ I have anxiety when I'm in a car
- ☐ I hurt when I'm on an airplane
- ☐ I am in too much pain to travel by plane
- ☐ Travel Plan #1 _____
- ☐ I did not go on travel plan #1
- ☐ I went, but did not enjoy #1 as much
- ☐ I went and the accident had no effect on #1
- ☐ Travel Plan #2 _____
- ☐ I did not go on travel plan #2
- ☐ I went, but did not enjoy #2 as much
- ☐ I went and the accident had no effect on #2
- ☐ I missed time with my family/friends b/c can't travel

Loss of Enjoyment of Sports, Hobbies, Travel, Daily Living, & School (p. 2 of 2)

Patient _____ Date _____ Date of Injury _____

☐ Initial ☐ Update

Please check all the DAILY LIVING Activities that cause you pain *because of the accident.*

- ☐ Dressing
- ☐ Putting on pants
- ☐ Putting on shoes
- ☐ Tying my shoes
- ☐ Putting on shirt
- ☐ Drying my hair
- ☐ Combing my hair
- ☐ Washing my hair
- ☐ Taking a shower
- ☐ Taking a bath
- ☐ Leaning forward
- ☐ Laying in bed
- ☐ Sitting in my favorite chair
- ☐ Sleeping
- ☐ Going out with my friends
- ☐ Sitting in a restaurant
- ☐ Shopping
- ☐ Driving to/from work
- ☐ Sitting in Church
- ☐ Playing with my children
- ☐ Caring for my children
- ☐ Bending at the waist
- ☐ Sitting in a movie theater
- ☐ Exercise
- ☐ Eating
- ☐ Stooping
- ☐ Squatting down
- ☐ Kneeling
- ☐ Brushing my teeth
- ☐ Riding in a car
- ☐ Opening a jar
- ☐ Lifting a pan when cooking
- ☐ Closing the trunk on my car
- ☐ Opening the garage door
- ☐ Using my home computer
- ☐ Climbing stairs
- ☐ Going down stairs
- ☐ Sexual activity
- ☐ Turning my head to left or right
- ☐ Holding my head up all day
- ☐ Watching TV
- ☐ I have pain sitting & doing nothing
- ☐ Talking on the phone
- ☐ Reading
- ☐ Writing
- ☐ Opening doors
- ☐ Drying with a towel after a bath or shower
- ☐ Life has become a chore just to do normal things
- ☐ It is depressing to live like this
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

Please check all that apply to your SCHOOL & EDUCATION Activities *because of the accident.*

- ☐ School was affected by the accident
- ☐ I am a student at _____
- ☐ I am in the _____ year/grade
- ☐ I was ☐ full time ☐ part time
- ☐ I am now ☐ full time ☐ part time
- ☐ I had to take fewer classes b/c of crash
- ☐ I missed _____ days of school
- ☐ I had to drop out of school b/c of crash
- ☐ My grades are lower since the crash
- ☐ I have pain carrying my school books
- ☐ I hurt sitting in class more than _____ minutes
- ☐ My neck hurts when I look down to read
- ☐ I don't learn as quickly as before the crash
- ☐ I don't learn things as well as before the crash
- ☐ I have difficulty concentrating in class
- ☐ It takes much longer to study/do my homework
- ☐ _____
- ☐ _____

_____ _____

Signature of Patient Date

Stark Family Chiropractic Inc.

Financial Policy

All patients are considered cash/self pay until our staff can verify insurance benefits.

____**Patients with Insurance:** We will bill your insurance for services rendered in the office. We will do our best to check on your benefits prior to receiving care, however insurance companies will not allow that a quote of coverage is a guarantee of benefits. **We will collect 100% of services not covered by your insurance carrier. If you have a copay, coinsurance, or unmet deductible, you will be responsible to payment at time of service.** Insurance is a contract between the patient and their carrier, so it is important you take responsibility for understanding your benefits. If your policy prohibits collection of deductible and/or coinsurance prior to claim processing, we will require a credit card to be kept on file. **If your insurance sends payment checks to you, rather than to this office, you will be required to keep a credit card on file**. Payment for services not covered due to unmet deductible, coinsurance amount, or policy exclusions, or **payments sent directly to patient will be automatically processed after receipt of Explanation of Benefits (EOB) from your insurance carrier.**
Patient Initials_____ Staff Initials_____

____**Medicare Patients: Medicare Part B only covers manipulation of the spine. All other services are not covered and will be your responsibility.** You will be required to meet your annual Part B deductible and pay 20% of the allowed fee on the spinal manipulation, in addition to 100% of all non-covered services. Medicare Part B patients with a Supplemental policy will generally have their deductible and the 20% copay covered by the supplement. However supplemental policies generally do NOT pay for services that Medicare does not allow. Medicare patients will be required to sign an Advanced Beneficiary Notice (ABN) prior to starting care, any time there is a significant change in diagnosis, and/or at the beginning of each year. **Patient Initials_____ Staff Initials_____**

____**Personal Injury:** Most Personal Injury claims are covered 100%. However, it is your responsibility to provide our office with the documentation necessary to prove a valid claim, including the name(s) and contact information of any claims adjuster/attorney handling the case, the claim numbers, and mailing address to send bills. Failure to provide the documentation needed will result in immediate conversion of your case to cash, and all payment will be due immediately. **Patient Initials_____ Staff Initials_____**

____**Patients without insurance coverage:** You will be required to pay for your services at the time they are rendered. If payment at time of service is going to produce a financial hardship, we do offer cash payment plans for a significant savings. You will be required to keep a credit card on file to qualify for the payment plans. Please discuss this option with one of the doctors if you feel it is necessary to complete the care you need. **Patient Initials_____ Staff Initials____**

____I have read and understand the financial policy of Stark Family Chiropractic Inc. I also understand that if I have insurance, or a valid auto claim, my carrier may pay for some to most of the charges billed, but no benefits are guaranteed. I understand that I am ultimately financially responsible for all services not paid by insurance of other third party. Should there be a balance due at the end of my treatment plan, I will receive an invoice for that amount and I will pay it upon receipt, or I will contact Stark Family Chiropractic Inc to make payment arrangements.

Print Name_____Date_____

Signature_____Staff Initials_____

Informed Consent for Chiropractic Care

When a patient seeks chiropractic health care, and we accept a patient for such care, it is essential for both of us to be working towards the same objective. It is important that each patient understand both the objective(s) and the method(s) that will be used to attain this objective. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition and the recommended care to be provided so that you can make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks, and alternatives.

Chiropractic is a science, philosophy, and art which concerns itself with the relationship between the spinal structure and the health of the nervous system. As chiropractors, we understand that health is a state of optimal physical, mental, and social well-being, and not merely the absence of disease of infirmity.

One disturbance to the nervous system is called a vertebral subluxation. This occurs when one of more of the 24 vertebrae in the spinal column become misaligned and/or do not move properly. This causes an unhealthy change to nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by a chiropractic adjustment. An adjustment is the specific application of force to correct and/or reduce the vertebral subluxation. Our chiropractic method of correction is by specific adjustments to the spine. Adjustments are done by hand or instrument where the doctor will put pressure on the specific segment(s) of the spine to adjust the vertebrae into a better position.

If at any time we encounter a non-chiropractic or unusual finding, we will advise you of those findings and recommend some further testing, or refer you to another health care provider.

Chiropractic care has been proven to be very safe and effective. It is not unusual however, to be sore after your first few corrective adjustments. Although extremely rare, it is possible to suffer from other side effects: i.e. muscle spasms, stiffness, rib fracture, headache, dizziness, or stroke. There are treatment options available for your condition other than chiropractic procedures. These treatment options include, but are not limited to, self-administered over the counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; physical therapy; steroid injections; bracing; and surgery.

All questions regarding the doctor's objective to my care in this office have been answered to my satisfaction. The benefits, risks, and alternatives of chiropractic care have been explained to me to my satisfaction. I have read, and fully understand, the above statements and therefore accept chiropractic care on this basis.

Print Name _____ Signature _____ Date _____

Consent to evaluate and adjust a minor child

I, _____ being the parent or legal guardian of _____ have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care.

Pregnancy Release

This is to certify that to the best of my knowledge, I am not pregnant and the doctor has my permission to perform an x-ray evaluation. I have been advised that x-rays can be hazardous to an unborn child.

Date of last menstrual cycle:_____

Signature _____ Date _____

STARK FAMILY CHIROPRACTIC INC.
PROVIDER/PATIENT/ATTORNEY
CLAIM AGREEMENT AND LIEN
17922 Magnolia St., Fountain Valley, CA 92708
(714) 887-7009 Fax (714) 968-4384

This agreement is entered into between Stark Family Chiropractic Inc. ("Provider"),

_____ ("Patient") and _____
("Attorney"), in consideration of the mutual obligation set forth herein an established their responsibilities to each other during the duration of the patient's claim arising from the patient's accident _____ ("Claim" or "Claim Date").

1. The Attorney hereby agrees that he/she is party to this contract and further recognizes that the attorney is receiving a benefit from this agreement which constitutes valid consideration and the Attorney is bound by this contract.
2. The Patient hereby authorizes the Provider to produce to the Attorney, at reasonable intervals and at the Attorney's request, with complete reports of the Patient's medical condition, care and cost of treatment. The Provider agrees to furnish these reports within a reasonable time, and at a reasonable cost.
3. The Patient hereby gives a lien to the Provider against all proceeds derived from this claim after the Attorney's fees and costs (whether by settlement, judgement, or otherwise) to secure payment of all fees owed to Provider by the Patient for treatment arising out of injuries sustained (or by the Attorney, if such fees arise from this claim), as of the time such proceeds are received. The Patient hereby directs the Attorney to honor said lien and to pay such sums as are secured hereby directly to the Provider, as soon as possible after any proceeds are received.
4. The Patient hereby expressly recognizes that even though this lien has been given, the Patient remains personally responsible for the Provider's fees and that payment must be made by the Patient regardless of whether any money is received through this claim.
5. The Patient and the Provider hereby agree to submit any dispute concerning the Provider's fees to a non-binding advisory arbitration conducted by the OCMA/OCBA Liaison Committee, until said disputes are resolved. The Attorney agrees to hold in trust a significant amount of the Patient's proceeds to satisfy the Provider's claim fees.
6. The Provider hereby agrees to await the Patient's personal payment of his fees until this claim is concluded (except to the extent that payment is available from insurance which provides health care benefits for the Patient), and to be available to the Attorney, upon reasonable notice and for reasonable compensation (which is payable in advance by the Attorney) for consultations, depositions, and court appearances.
7. The Attorney and the Patient hereby agree to notify the Provider immediately, should the Patient retain new legal counsel. The Patient agrees to direct new legal counsel to execute another copy of this "Claim Agreement and Lien."
8. Before the Attorney distributes any monies received through this claim, the Attorney agrees to request from the Provider a current Patient account balance.
9. Should any party seek judicial enforcement of this agreement, the prevailing party shall be entitled to reasonable attorney's fees.
10. This "Claim Agreement and Lien" can not be modified, changed, or revoked by any party without the expressed written consent of all parties.

Patient Name_____ Patient Signature _____ Date_____

Provider Name_____ Provider Signature _____ Date_____

Attorney Name _____ Attorney Signature _____ Date _____

Instruction to Attorney- **Please date, sign and return one copy to the Provider's office as soon as possible. Fax or mail. Keep one copy for your records.**

Stark Family Chiropractic Inc.

Notice of Privacy Practices

This notice describes how your information is stored, may be used, and/or disclosed.

How we store your information: Patient information is stored here in the office on a secure server with no outside access. Patient charts and x-ray films are also stored here in the office. Patient charts/x-ray films do not leave the premises unless one of the doctors needs to review notes about your case after hours. In this instance, the patient chart is solely in the doctor's possession until the following morning when said chart is returned to the office.

What we do not do with your information: Information that you have provided to us about your financial situation, medical conditions, and care you have received is held in the strictest of confidence. This applies whether information was communicated during a discussion, in writing, via email, over the phone (including information left on voice mails), or text.

We do not give out, exchange, barter, rent, sell, or disseminate any information about our patients to anyone who receives our services. Know that any and all patient information is confidential and is held in a HIPAA compliant manner.

How we do use your information: Information is only used as is reasonably necessary to process your care, send billing to an insurance company, or to provide you with health care services which may require communication between Stark Family Chiropractic Inc. and other health care providers.

No patient's information or identifying photos will ever be used without patient's advanced written permission.

Printed Name:_____

Signature:_____

Date:_____

Stark Family Chiropractic Inc., 17922 Magnolia Street, Fountain Valley, CA 92708
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