

# PATIENT INFORMATION

Patient Name: \_\_\_\_\_ Nickname \_\_\_\_\_ Today's Date \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip Code \_\_\_\_\_ SS # \_\_\_\_\_

DOB \_\_\_\_\_ Age \_\_\_\_\_ Gender M / F Marital Status S M W D

Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ E-mail \_\_\_\_\_

Employer \_\_\_\_\_ Job Title/Description \_\_\_\_\_

**Emergency Contact** \_\_\_\_\_ Cell Phone \_\_\_\_\_ Relation \_\_\_\_\_

Family physician \_\_\_\_\_ Address \_\_\_\_\_ Phone # \_\_\_\_\_

Were you transported to a medical facility immediately following the accident? YES / NO

Have you received other medical treatment since the accident? YES / NO Date you first sought care after accident \_\_\_\_\_

Hospital \_\_\_\_\_

Medical Doctor \_\_\_\_\_

Chiropractor \_\_\_\_\_

Self Help (ice, aspirin, etc.) \_\_\_\_\_

Other \_\_\_\_\_

Lawyer/ Law Firm \_\_\_\_\_ Phone # \_\_\_\_\_

## DESCRIBE THE ACCIDENT

1. **Actions of YOUR vehicle:** crossing an intersection / stopped at intersection / traveling at posted speed / turning

2. **How was YOUR vehicle hit:** head-on / left front / right front / rear-ended / left rear / right rear

3. **Head position at impact:** straight / tilted forward / turned left / turned right

4. **Body position at impact:** straight / turned to left / turned to right

5. **Place patient was seated in the vehicle:** driver / front passenger / back driver side / back passenger side

6. **Aware of approaching impact:** YES / NO

7. **Airbag deployed:** YES / NO

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

## SYMPTOMS

Patient Name \_\_\_\_\_ Date of Incident \_\_\_\_\_ Today's Date \_\_\_\_\_

RIVERMEAD POST-CONCUSSION SYMPTOMS QUESTIONNAIRE:

Compare none to severe change since collision (0 1 2 3 4)

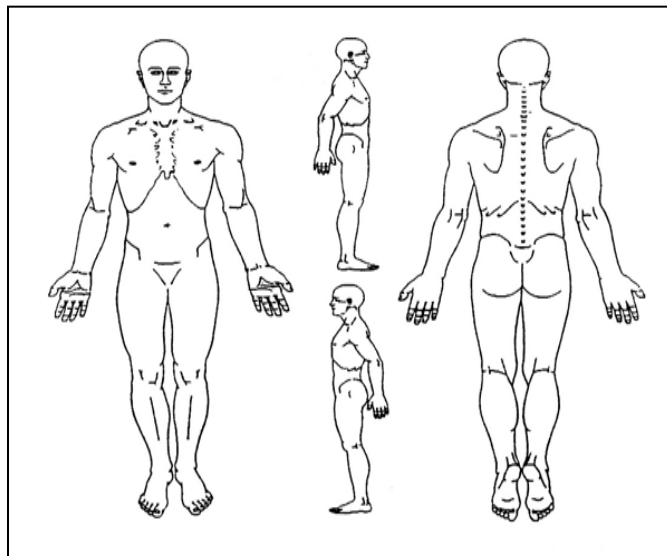
- Knocked out / unconscious      0 1 2 3 4
- Headaches                              0 1 2 3 4
- Dizziness                                0 1 2 3 4
- Nausea / vomiting                    0 1 2 3 4
- Noise sensitivity                      0 1 2 3 4
- Sleep disturbances                    0 1 2 3 4
- Fatigue                                  0 1 2 3 4
- Irritable, easily angered            0 1 2 3 4
- Depressed or tearful                0 1 2 3 4
- Frustrated or impatient              0 1 2 3 4
- Forgetfulness / poor memory       0 1 2 3 4
- Poor concentration                  0 1 2 3 4
- Taking longer to think               0 1 2 3 4
- Blurred vision                         0 1 2 3 4
- Light sensitivity                      0 1 2 3 4
- Double vision                         0 1 2 3 4
- Restlessness                          0 1 2 3 4

**CIRCLE ALL COMPLAINTS SINCE ACCIDENT**

- LACERATIONS, CUTS OR BRUISING:
  - Cuts: \_\_\_\_\_
  - Bruising: \_\_\_\_\_
- JAW INJURY:
  - Jaw pain
- NECK INJURY:
  - Pain / Numb / Tingling / Spasm
  - Radiates into arm RIGHT / LEFT / BOTH
- SHOULDER INJURY: RIGHT / LEFT / BOTH
  - Pain / Numb / Tingling / Spasm
  - Radiates into arm / hand
- UPPER ARM INJURY: RIGHT / LEFT / BOTH
  - Pain / Numb / Tingling / Spasm
  - Radiates into arm / hand
- ELBOW INJURY: RIGHT / LEFT / BOTH
  - Pain / Numb / Tingling / Spasm
  - Radiates into arm / hand
- FOREARM INJURY: RIGHT / LEFT / BOTH
  - Pain / Numb / Tingling / Spasm
  - Radiates into hand
- WRIST INJURY: RIGHT / LEFT / BOTH
  - Pain / Numb / Tingling / Spasm

- HAND INJURY: RIGHT / LEFT / BOTH
  - Pain / Numb / Tingling / Spasm
- MID BACK INJURY:
  - Pain / Numb / Tingling / Spasm
- LOW BACK INJURY:
  - Pain / Numb / Tingling / Spasm
  - Radiates into leg: RIGHT / LEFT / BOTH
- HIP INJURY: RIGHT / LEFT / BOTH
  - Pain / Numb / Tingling / Spasm
  - Radiates into leg
- UPPER LEG INJURY: RIGHT / LEFT / BOTH
  - Pain / Numb / Tingling / Spasm
  - Radiates down leg
- KNEE INJURY:
  - Pain: RIGHT / LEFT / BOTH
- LOWER LEG INJURY: RIGHT / LEFT / BOTH
  - Pain / Numb / Tingling / Spasm
- FOOT INJURY:
  - Pain: RIGHT / LEFT / BOTH
- ANKLE INJURY:
  - Pain: RIGHT / LEFT / BOTH
- OTHER SYMPTOMS: \_\_\_\_\_

Shade in all areas of pain or altered sensations (numb/tingling)



Signature \_\_\_\_\_

## Duties Performed Under Duress at Work and Home

Name \_\_\_\_\_ Signature \_\_\_\_\_ Injury Date \_\_\_\_\_ Today's Date \_\_\_\_\_

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

- |  |   |
|--|---|
| <input type="radio"/> I go to work but work in pain            | <input type="radio"/> I work in pain because I have bills to pay        |
| <input type="radio"/> I limit my work activities               | <input type="radio"/> I can't take time off because I would lose my job |
| <input type="radio"/> Bending at work hurts                    | <input type="radio"/> I keep working so I don't lose status at company  |
| <input type="radio"/> Stooping at work hurts                   | <input type="radio"/> My business would fail if I took time off         |
| <input type="radio"/> Sitting at work hurts                    | <input type="radio"/> I believe in working even when I'm in pain        |
| <input type="radio"/> Using the computer at work hurts         | <input type="radio"/> I feel obligated to work even though I'm in pain  |
| <input type="radio"/> Pushing at work hurts                    | <input type="radio"/> My business would lose money if I took time off   |
| <input type="radio"/> Kneeling at work hurts                   | <input type="radio"/> My work is not as good as it was before accident  |
| <input type="radio"/> I have lost status in my company         | <input type="radio"/> My boss reprimanded me for poor performance       |
| <input type="radio"/> I have lost job security                 | <input type="radio"/> I got a different job within the same company     |
| <input type="radio"/> I didn't get a promotion                 | <input type="radio"/> I got a different job in another company          |
| <input type="radio"/> I don't enjoy work as much as before     | <input type="radio"/> I make less money than before the accident        |
| <input type="radio"/> I doze off at work                       | <input type="radio"/> I cannot do the same work/job as before accident  |
| <input type="radio"/> I take unpaid time off work to go to Dr. | <input type="radio"/> I can't concentrate as well at work               |
| <input type="radio"/> I daydream at work more than before      | <input type="radio"/> I take paid time off to go to Dr.                 |
| <input type="radio"/> I feel tired at work                     | <input type="radio"/> I hide my poor work performance from my boss      |
| <input type="radio"/> _____                                    | <input type="radio"/> _____   |

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

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

## LOSS OF ENJOYMENT OF LIFE

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

- I take walks & have pain while walking
- I no longer take walks
- 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 have gained \_\_\_\_\_ pounds since the accident
- I had to quit my sports team after the accident
- I don't enjoy my sports anymore
- I didn't enjoy sports for \_\_\_\_ weeks

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

- My hobby was affected by accident
- Hobby: \_\_\_\_\_
- I can't do my hobby anymore
- I do my hobby but in pain
- I have lost money from not doing my hobby
- I didn't do my hobby for \_\_\_\_\_ weeks

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

- Business / 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
- I did not go on planned travel
- I went, but did not enjoy travel as much
- I went and the accident had no effect on travel
- I missed time w/ family/friends b/c I can't travel

### Please check all the DAILY LIVING activities that cause you pain because of the accident

- Dressing
- Putting on pants / shirt / shoes
- Drying / Combing my hair
- Bathing / Washing my hair
- Brushing my teeth
- Drying with a towel after bathing
- Lying in bed
- Sleeping
- Riding in a car
- Driving to/from work
- Closing the trunk on my car
- Opening doors
- Sitting in church / movie theatre
- Playing with my children
- Caring for my children
- Exercising
- Stooping / Squatting / Kneeling
- Leaning forward
- Going out with my friends
- Sitting at a restaurant
- Shopping Eating
- Standing to cook
- Opening a jar
- Lifting a pan when cooking
- Sitting in my favorite chair
- Using my home computer
- Talking on the phone
- Reading / Writing / Watching TV
- Climbing stairs
- Sexual activity
- Turning my head left or right
- Holding my head up all day
- It's a chore to do usual things

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

- School was affected by the wreck
- I am in the \_\_\_\_\_ year/grade
- I was  full time  part time
- I'm now  full time  part time
- I had to take fewer classes
- I missed \_\_\_\_\_ days of school
- I dropped out of school
- My grades are lower
- I have pain carrying my books
- I hurt sitting in class
- Neck hurts when I look dn to read
- I don't learn as quickly as before
- I don't learn as well as before
- It's difficult concentrating in class
- It takes longer to do my studies

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Today's date

# PAIN CONSULTATION

Patient Name \_\_\_\_\_ Injury Date \_\_\_\_\_ Today's Date \_\_\_\_\_

I am having **FUNCTIONAL DIFFICULTIES** because of NECK PAIN since the collision.

Describe how NECK PAIN is affecting your normal daily activities \_\_\_\_\_

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I am having **FUNCTIONAL DIFFICULTIES** because of UPPER BACK PAIN since the collision.

Describe how UPPER BACK PAIN is affecting your normal daily activities \_\_\_\_\_

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I am having **FUNCTIONAL DIFFICULTIES** because of LOW BACK PAIN since the collision.

Describe how LOW BACK PAIN is affecting your normal daily activities \_\_\_\_\_

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I am having **FUNCTIONAL DIFFICULTIES** because of SHOULDER / ARM PAIN since the collision.

Describe how SHOULDER / ARM PAIN is affecting your normal daily activities \_\_\_\_\_

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I am having **FUNCTIONAL DIFFICULTIES** because of LEG / KNEE PAIN since the collision.

Describe how LEG / KNEE PAIN is affecting your normal daily activities \_\_\_\_\_

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## EXACERBATING FACTORS (Check all below that make your NECK hurt worse)

- |                                  |                                    |                                   |                                |
|----------------------------------|------------------------------------|-----------------------------------|--------------------------------|
| <input type="radio"/> Lying down | <input type="radio"/> Turning head | <input type="radio"/> Bathing     | <input type="radio"/> Computer |
| <input type="radio"/> Sleeping   | <input type="radio"/> Bending      | <input type="radio"/> Dressing    | <input type="radio"/> Work     |
| <input type="radio"/> Sitting    | <input type="radio"/> Twisting     | <input type="radio"/> Grooming    | <input type="radio"/> Sports   |
| <input type="radio"/> Standing   | <input type="radio"/> Lifting      | <input type="radio"/> Home chores | <input type="radio"/> Driving  |

## ALLEVIATING FACTORS (Check all below that make your NECK feel better)

- |                             |                                  |   |
|-----------------------------|----------------------------------|---|
| <input type="radio"/> Sleep | <input type="radio"/> Heat       | <input type="radio"/> Over-the-counter medication |
| <input type="radio"/> Rest  | <input type="radio"/> Meditation | <input type="radio"/> Prescription medication     |
| <input type="radio"/> Ice   | <input type="radio"/> Massage    |   |

## EXACERBATING FACTORS (Check all below that make your UPPER BACK hurt worse)

- |                                  |                                    |                                   |                                |
|----------------------------------|------------------------------------|-----------------------------------|--------------------------------|
| <input type="radio"/> Lying down | <input type="radio"/> Turning head | <input type="radio"/> Bathing     | <input type="radio"/> Computer |
| <input type="radio"/> Sleeping   | <input type="radio"/> Bending      | <input type="radio"/> Dressing    | <input type="radio"/> Work     |
| <input type="radio"/> Sitting    | <input type="radio"/> Twisting     | <input type="radio"/> Grooming    | <input type="radio"/> Sports   |
| <input type="radio"/> Standing   | <input type="radio"/> Lifting      | <input type="radio"/> Home chores | <input type="radio"/> Driving  |

## ALLEVIATING FACTORS (Check all below that make your UPPER BACK feel better)

- |                             |                                  |   |
|-----------------------------|----------------------------------|---|
| <input type="radio"/> Sleep | <input type="radio"/> Heat       | <input type="radio"/> Over-the-counter medication |
| <input type="radio"/> Rest  | <input type="radio"/> Meditation | <input type="radio"/> Prescription medication     |
| <input type="radio"/> Ice   | <input type="radio"/> Massage    |   |

## PAIN CONSULTATION, continued

### EXACERBATING FACTORS (Check all below that make your LOW BACK hurt worse)

- |                                  |                                    |                                   |                                |
|----------------------------------|------------------------------------|-----------------------------------|--------------------------------|
| <input type="radio"/> Lying down | <input type="radio"/> Turning head | <input type="radio"/> Bathing     | <input type="radio"/> Computer |
| <input type="radio"/> Sleeping   | <input type="radio"/> Bending      | <input type="radio"/> Dressing    | <input type="radio"/> Work     |
| <input type="radio"/> Sitting    | <input type="radio"/> Twisting     | <input type="radio"/> Grooming    | <input type="radio"/> Sports   |
| <input type="radio"/> Standing   | <input type="radio"/> Lifting      | <input type="radio"/> Home chores | <input type="radio"/> Driving  |

### ALLEVIATING FACTORS (Check all below that make your LOW BACK feel better)

- |                             |                                  |   |
|-----------------------------|----------------------------------|---|
| <input type="radio"/> Sleep | <input type="radio"/> Heat       | <input type="radio"/> Over-the-counter medication |
| <input type="radio"/> Rest  | <input type="radio"/> Meditation | <input type="radio"/> Prescription medication     |
| <input type="radio"/> Ice   | <input type="radio"/> Massage    |   |

### EXACERBATING FACTORS (Check all below that make your SHOULDER / ARM hurt worse)

- |                                  |                                    |                                   |                                |
|----------------------------------|------------------------------------|-----------------------------------|--------------------------------|
| <input type="radio"/> Lying down | <input type="radio"/> Turning head | <input type="radio"/> Bathing     | <input type="radio"/> Computer |
| <input type="radio"/> Sleeping   | <input type="radio"/> Bending      | <input type="radio"/> Dressing    | <input type="radio"/> Work     |
| <input type="radio"/> Sitting    | <input type="radio"/> Twisting     | <input type="radio"/> Grooming    | <input type="radio"/> Sports   |
| <input type="radio"/> Standing   | <input type="radio"/> Lifting      | <input type="radio"/> Home chores | <input type="radio"/> Driving  |

### ALLEVIATING FACTORS (Check all below that make your SHOULDER / ARM feel better)

- |                             |                                  |   |
|-----------------------------|----------------------------------|---|
| <input type="radio"/> Sleep | <input type="radio"/> Heat       | <input type="radio"/> Over-the-counter medication |
| <input type="radio"/> Rest  | <input type="radio"/> Meditation | <input type="radio"/> Prescription medication     |
| <input type="radio"/> Ice   | <input type="radio"/> Massage    |   |

### EXACERBATING FACTORS (Check all below that make your LEG / KNEE hurt worse)

- |                                  |                                    |                                   |                                |
|----------------------------------|------------------------------------|-----------------------------------|--------------------------------|
| <input type="radio"/> Lying down | <input type="radio"/> Turning head | <input type="radio"/> Bathing     | <input type="radio"/> Computer |
| <input type="radio"/> Sleeping   | <input type="radio"/> Bending      | <input type="radio"/> Dressing    | <input type="radio"/> Work     |
| <input type="radio"/> Sitting    | <input type="radio"/> Twisting     | <input type="radio"/> Grooming    | <input type="radio"/> Sports   |
| <input type="radio"/> Standing   | <input type="radio"/> Lifting      | <input type="radio"/> Home chores | <input type="radio"/> Driving  |

### ALLEVIATING FACTORS (Check all below that make your LEG / KNEE feel better)

- |                             |                                  |   |
|-----------------------------|----------------------------------|---|
| <input type="radio"/> Sleep | <input type="radio"/> Heat       | <input type="radio"/> Over-the-counter medication |
| <input type="radio"/> Rest  | <input type="radio"/> Meditation | <input type="radio"/> Prescription medication     |
| <input type="radio"/> Ice   | <input type="radio"/> Massage    |   |

Name \_\_\_\_\_

Signature \_\_\_\_\_



## WHIPLASH STUDIES

- In 1964, the Journal of Bone and Joint Surgery (American) published a study where the author followed 145 whiplash-injured patients for more than two years. The author reported that after a minimum of two years, **45%** of the injured patients continued to suffer from pain.
- In 1989, the journal Neuro-Orthopedics published a 12.5-year (mean duration) study on whiplash-injured patients. The authors reported that **62%** continued to suffer from significant pain symptoms attributed to the motor vehicle collision 12.5 years later.
- In 2000, the Journal of Clinical Epidemiology published a 7-year study on whiplash-injured patients. The authors reported that **39.6%** continued to suffer from neck-shoulder pain 7 years after injury. This 39.6% chronic pain rate was three times greater than the pain noted in the matched control populations.
- In 2005, the journal Injury published a 7.5 year prospective study on whiplash-injured patients. The authors reported that 21% of these patients continued to suffer from clinically relevant pain 7.5 years after injury. An additional **48%** continued to suffer from nuisance pain at the 7.5-year analysis.
- In 1990, the Journal of Bone and Joint Surgery (British) published a 10.8 year study on whiplash-injured patients. The authors reported that **40%** of these patients continued to suffer from clinically significant pain 10.8 years after injury. An additional 40% continued to suffer from nuisance pain at the 10.8-year analysis.
- In 1996, the Journal of Bone and Joint Surgery (British) published a 15.5-year study on whiplash-injured patients. The authors reported that **43%** of these patients continued to suffer from clinically significant pain 15.5 years after injury. An additional **28%** continued to suffer from nuisance pain at the 15.5-year analysis.
- In 2002, the European Spine Journal published a 17-year study on whiplash-injured patients. The authors reported that **55%** of these patients continued to suffer from residual pain 17 years after injury. Of those with residual symptoms, **25%** suffered from neck pain every day, and **23%** had pain radiating into their arm daily.
- In 2006, the Journal of Bone and Joint Surgery (British) published a 30-year study on whiplash-injured patients. The authors reported that **15%** of these patients continued to suffer from clinically significant pain 30 years after injury; their pain was such that they still required ongoing treatment. An additional **40%** continued to suffer from nuisance pain at the 30-year analysis.

\*\*\* These studies show that symptoms from this type of injury last years or even decades. Since a cervical sprain/strain injury will only last 4-6 weeks, then other structures were obviously damaged. Fifty percent of all disability is due to ligament damage. X-Rays may be taken of your spine to assess / demonstrate Alteration of Motion Segment Integrity which, according to AMA guidelines is a permanent injury.

Patient Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# INFORMED CONSENT

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. If anything is unclear, please ask questions before you sign.

## The nature of the chiropractic adjustment

The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

## Analysis / Examination / Treatment

As a part of the analysis, examination, and treatment, you are consenting to the following procedures:

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> spinal manipulative therapy | <input type="checkbox"/> palpation            | <input type="checkbox"/> vital signs                |
| <input type="checkbox"/> range of motion testing     | <input type="checkbox"/> orthopedic testing   | <input type="checkbox"/> basic neurological testing |
| <input type="checkbox"/> muscle strength testing     | <input type="checkbox"/> postural analysis    | <input type="checkbox"/> exercise therapy           |
| <input type="checkbox"/> massage therapy             | <input type="checkbox"/> radiographic studies | <input type="checkbox"/> mechanical traction        |

## The material risks inherent in chiropractic adjustment.

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

## The probability of those risks occurring.

Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the taking of your history and during examination and X-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

## The availability and nature of other treatment options

Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers
- Hospitalization
- Surgery

If you chose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

## The risks and dangers attendant to remaining untreated

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

**I have read and understand the above explanation of the chiropractic adjustment and related treatment. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.**

PATIENT NAME: \_\_\_\_\_

DATE: \_\_\_\_\_

PATIENT / PARENT / GUARDIAN SIGNATURE: \_\_\_\_\_



**IRREVOCABLE ASSIGNMENT OF PROCEEDS AND CONVEYANCE OF LIEN INTEREST**

Re: Medical Reports and Lien for Undersigned Patient.

I do hereby authorize Hall Chiropractic located at 1171 Market Street, Suite 104, Fort Mill, SC 29708, which is the health care facility at which I am receiving, or have received, health care services for the injuries I sustained in an accident upon which my case is pending to furnish my attorney and/or any and all insurance carrier(s) with a complete report of any medical records relating to my examination, diagnosis, treatment and prognosis for the need of future medical treatment, if any, including notes, x-rays, and other medical data, relating to the health care services I have been provided by Hall Chiropractic as a result of the accident or other contributing incident giving rise to my need for such health care services.

**ASSIGNMENT, LIMITED POWER OF ATTORNEY AND CONVEYANCE OF LIEN INTEREST**

I hereby execute and provide this **Irrevocable Lien Interest and Assignment of Proceeds** in favor of Hall Chiropractic. This **Irrevocable Lien Interest and Assignment of Proceeds** shall apply to all monetary proceeds from any third party liability insurance coverage Medical Payment insurance coverage to which I am entitled, or to which may become entitled at some time in the future, through my asserted claim(s) for personal injuries and/or losses against any person or persons, or their insurance representatives/coverage, arising as a result of injuries I have sustained as a result of the accident or incident referenced above. Through this assignment and conveyance of lien interest that I do grant and convey in favor of Hall Chiropractic, I do hereby direct that any and all insurance proceeds to which I am entitled, or to which I may become entitled, that are paid or intended to be paid to me as compensation for the injuries I sustained as a result of the accident or contributing incident giving rise to my need for such health care services, be remitted directly to Hall Chiropractic or its designee, in the amount and to the extent of any unpaid monetary balance that remains due and owing by me to Hall Chiropractic for such services. I do hereby grant and convey a limited power of attorney to the owner(s) of Hall Chiropractic for purpose of directing the disbursement of such insurance proceeds and for the purpose of receiving the remittance of any such insurance proceeds from any monetary settlement or award to which I may become entitled, including future proceeds to which I may become entitled, in an amount sufficient to satisfy the full, unpaid, balance of my account owed to Hall Chiropractic. I do direct that all such settlement proceeds to be paid as compensation for the cost of my medical services be remitted directly to and in the name of Hall Chiropractic.

As consideration for my execution of this **Irrevocable Lien Interest and Assignment of Proceeds** I represent that said doctor and/or treating facility has provided me professional services upon my request, that I am aware of the nature and expense of all such services so provided and that as consideration for his forbearance of his legal right to require payment by me at the time such services were rendered, said doctor and treating facility relied upon my express declaration and intention to execute and instruct that this **Irrevocable Lien Interest and Assignment of Proceeds** apply to all insurance proceeds to which I am or may become entitled and direct that the amount of such proceeds required to satisfy my outstanding balance with said doctor and/or treating facility be remitted directly to the doctor and/or treating facility at such time as I receive an insurance settlement or other monetary settlement/award.

In the event my insurance settlement proceeds are paid directly to my attorney, I hereby instruct my attorney to withhold all such sums and amounts as are determined to be owed, due and payable on my account to such named doctor and treating facility and remit payment of all such sums directly to such named doctor and/or treating facility upon receipt my settlement award(s).

I fully understand and stipulate that I am ultimately and directly responsible to the doctor and/or treating facility for payment of all medical bills incurred by me for those services rendered to me, or on my behalf or request, and that this agreement is made solely for the benefit of the doctor and treating facility, as additional protection and in consideration of the treating facility's agreement to forgo its legal right to require immediate collection of payment for those chiropractic services rendered to me or on my behalf. It is my understanding that the Doctor will off-set any monies received through insurance or otherwise against the remaining debt owed by me.

I hereby direct that my attorney furnish to Hall Chiropractic any and all settlement papers, settlement disbursement breakdowns or other documentation relating to any insurance settlement, monetary award or judgment that I have received or have become entitled, as a result of the above described accident or incident for which Hall Chiropractic has provided to me the above referenced health care services.

SIGNED: \_\_\_\_\_ DATE: \_\_\_\_\_

Printed Name of Patient: \_\_\_\_\_

For or On Behalf of the Minor Child(ren): \_\_\_\_\_, I do hereby assume full financial responsibility for the expense and payment of all services provided to me and to my minor child(ren), if any. I acknowledge that I am independently liable for the cost of all medical/chiropractic services so provided regardless of the existence of insurance coverage or payments.

SIGNED: \_\_\_\_\_ DATE: \_\_\_\_\_

### Acknowledgements

To set clear expectations, improve communication and help you get the best results in the shortest amount of time, please read each statement and initial your agreement.

\_\_\_\_\_  
Initials

I instruct Dr. Hall to deliver the care that, in his professional judgement, can best help me in the restoration of my health. I understand that the care offered in this practice is based on the best available evidence and designed to reduce or correct body posture and motion thus reducing many symptoms. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity. I certify that no guarantee or assurance has been made to the results that may be obtained.

\_\_\_\_\_  
Initials

I authorize Dr. David Hall and whomever he may designate as his assistant to perform diagnostic tests and to administer treatment deemed necessary to treat my problem (illness). I understand that diagnostic X-rays may be advisable in my case so that a complete analysis can be made of my problem. I authorize Dr. Hall to perform such x-ray exams necessary to diagnose my present condition. I realize that X-ray may be hazardous to an unborn child and I certify to the best of my knowledge that I am NOT pregnant.

\_\_\_\_\_  
Initials

I grant Hall Chiropractic permission to send and/or receive my complete patient file, including information relating to any medical history, mental or physical condition and any treatment received by me for the purpose of consultation, collaboration or transfer of care to another health care provider.

\_\_\_\_\_  
Initials

I grant Hall Chiropractic permission to contact me via phone, email or text to confirm or reschedule an appointment and to be sent occasional correspondents to me as an extension of my care in this office. I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.

\_\_\_\_\_  
Initials

I understand and agree that health and accident insurance policies are an arrangement between my insurance carrier or attorney and myself. Furthermore, I understand that this office will help prepare necessary reports and forms, as a courtesy, to assist me in making collection from the responsible Insurance Company and that any monies authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse remittances for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment.

\_\_\_\_\_  
Initials

I authorize Hall Chiropractic to release my medical / health information necessary to process my insurance and/or personal injury claim(s) and also certify that all insurance information I give to Hall Chiropractic is correct and complete.

\_\_\_\_\_  
Initials

I authorize any and all insurance companies and/or attorney to pay directly to Hall Chiropractic, 1171 Market Street, Fort Mill SC 29708. The expense benefits allowable and otherwise payable to me under my current policy, as payment toward the total charges for professional services rendered. I have agreed to pay, in a current manner, any balance of said applicable charges. I agree that this office be given limited power of attorney to endorse/sign my name to any and all drafts of payment of my bill.

**Patient (or Guardian) Signature** \_\_\_\_\_ **Today's Date** \_\_\_\_\_