AUTOMOBILE ACCIDENT QUESTIONNAIRE

PLEASE ANSWER ALL QUESTIONS COMPLETELY Date_____

Patient _____ No._____

Sex_____ Marital Status_____ Date of Birth_____ Home Phone_____

Address_____City_____ State Zip_____

Email:_____Occupation_____

Social Sec. #_____ Business Phone_____ Company Name_____

Company Address_____

- Please explain in detail how your accident happened_____

_____

_____

Name of other vehicle driver (if any)_____ Their date of Birth_____

- Insurance Company_____ Address_____Phone No:_____
  Policy No._____
  Claim No._____
  Name of person who has made contact with you_____
  Name of driver of vehicle in which you were injured (self or other)_____
- Insurance Company_____Address_____ Phone No:_____
  Policy No._____
  Claim No._____
  Name of Person who has made contact with you_____

1. Have you retained an attorney? _ Yes _ No _ Not Yet If so, name & phone #_____

2. Give time and date present injury occurred_____ _ AM _ PM ____/____/____

3. Did your head strike windshield or object? _ Yes _ No

4. Were police notified? _ Yes _ No

Did you see the accident coming? _____
Was your head turned/positioned at the time of the accident?_____
You were heading? _ North _ South _ East _ West on_____(street or highway)
Were you knocked unconscious _ Yes _ No If so, for how long_____
You were struck from? _ Behind _ Front _ Left Side _ Right Side Number of people in your vehicle_____
You were? _ Driver _ Passenger _ Front seat _ Back seat _

5. Were you? _ Using seat belts _ Other protective devices

6. Did Airbags deploy?_ Yes _ No

7. Did you feel pain immediately after the accident? _ Yes _ No _

When did you feel pain?_____
Where did you feel pain immediately after the accident?_____

8. Where were you taken after the accident?_____
Was treatment given?_____
Was any doctor consulted after the accident? _ Yes _ No
If so, give doctor's name_____ D.C., _ M.D., _ D.O., _ D.D.S.
What treatment was given?_____
Doctor's Diagnosis_____
How often did you see the doctor?_____ How long did you see the doctor?_____

9. Have you ever had any complaints in the involved area before? _ Yes _ No
If so, what were the complaints?_____

10. Before the injury, were you capable of working on an equal basis with others your age? _ Yes _ No

11. Are your work activities restricted as a result of this accident? _ Yes _ No

12. Since the injury, are your symptoms _ Improving? _ Getting worse? _ The same?

13. Amount of damage to your car? $_____ totaled? _ Yes _ No Other car?_____ totaled? _ Yes _ No
What was the size of the other vehicle compared to yours? __Bigger__Smaller__Same ____make ____model

PATIENT Personal Injury

Today's Date: _____

PATIENT INFORMATION

Name: *(First MI Last)* _____ **Preferred Name**: _____

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

Home: _____ **Mobile:** _____ **Mobile Carrier:** _____ **Work:** _____

Email: _____ **Gender:** M / F **Marital Status:** Single / Married / Other

Social Security #:_____ **Date of Birth:** _____

Student Status: Full Student / Part Student / Non-Student **Employed:** Y / N

Ethnicity: Hispanic or Latino / Not Hispanic or Latino / Decline **Preferred Language:** English / Decline / Other: _____

Race: Asian / African American / American Indian or Alaskan Native / Other / Native Hawaii or Pacific Islander / White / Decline

***Referred By:** (*Name):* _____ Family / Friend / Co-Worker / Doctor / Other Source

EMERGENCY CONTACT INFORMATION

Name: *(First MI Last)* _____ **Primary Care Physician:** _____

Home: _____ **Mobile:** _____ **Doctor's Phone:** _____

Relationship: Child / Parent / Spouse / Other: _____

FINANCIAL INFORMATION

Insurance Worker's Comp Self-Pay *(Cash)* Personal Injury/Auto Other *(please explain)*:_____

PRIMARY INSURANCE

Insurance Name: _____

Relation to Insured: Self / Spouse / Parent / Child / Other

Other than Self:

Insured's Name: _____ **Gender:** M / F

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone: _____ **Date of Birth:** _____

SECONDARY INSURANCE

Insurance Name: _____

Relation to Insured: Self / Spouse / Parent / Child / Other

Other than Self:

Insured's Name: _____ **Gender:** M / F

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone: _____ **Date of Birth:** _____

RESPONSIBLE PARTY

Who is responsible for payment? Self / Other - *(Relationship)* _____

Other than Self:

Name: *(First MI Last)*_____

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

Phone: _____ **Email:** _____

It is Usual and Customary to Pay for Services as Rendered Unless Otherwise Arranged

Patient No: _____

CASE HISTORY

HISTORY OF CURRENT CONDITION

Describe Major Complaint: _____

Describe any Secondary Complaints: _____

Describe WHEN and HOW this began: _____

_____

_____

Grade Intensity/Severity of Complaint: None (0) / Mild (1-2) / Mild-Mod (2-4) / Moderate (4-6) / Mod-Severe (6-8) / Severe (8-10)

Quality of the complaint/pain: Sharp / Stabbing / Burning / Achy / Dull / Stiff & Sore / Other: _____

How frequent is the complaint present? Off & On / Constant

Does this complaint radiate/shoot to any areas of your body? No / Yes *(Describe)* _____

Head - Base of Skull / Forehead / Sides-Temple R / L / Both *Leg* - Hip / Thigh-Knee / Calf / Foot-Toes R / L / Both

Arm – Across Shoulder / Elbow / Hand-Fingers R / L / Both *Other Area:* _____

Does anything make the complaint better? Ice / Heat / Rest / Movement / Stretching / OTC / Other: _____

Does anything make the complaint worse? Sit / Stand / Walk / Lying / Sleep / Overuse / Other: _____

Which daily activities are being affected by this condition? *(Describe)* _____

For this CURRENT condition, have you:

- **Received any other treatment?** None / DC / MD / PT / Massage / ER / Other: _____ **Where?** _____
- **Had any diagnostic testing?** X-rays / MRI / CT / Other: _____ **When and Where?** _____

HEALTH HISTORY – (*PLEASE USE THE REVERSE SIDE OF THIS PAGE IF ADDITIONAL SPACE IS NEEDED*)

Medications and Supplements:

Allergies to Medications: ***NONE***

Name	Reaction

Current Medications & Supplements: ***NONE***

Name	Dosage	Frequency	Method

Past Health History: *(Please list any past…)*

Number of Falls in the last 24 months: _____**Injuries?** Y or N

Surgeries: ***NONE***

Date	Area of the Body	Reason

Major Injuries / Traumas / Hospitalizations: ***NONE***

Date	Describe

Family Health History: ***N/A***

List *relevant* major health problems of First degree relatives:

Problem	Parent (M or F)	Sibling (B or S)	Child (S or D)

Social and Occupational History:

Smoking/Tobacco Use: Every Day / Some Days / Former / Never

Habit	Type	Amount	Year Started
Smoking			
Tobacco			
Alcohol			
Caffeine			
Rec. Drugs			

Education: High School / College Grad. / Post Grad. / Other:

Lifestyle	Describe
Hobbies	
Recreation	
Exercise	
Diet	
Work	
Other	

Patient No: _____

Are you *currently* experiencing any of these symptoms? *(Check all the apply)*

Many of the following conditions respond to Chiropractic and Acupuncture treatment.

General: *(constitutional)*
- ☐ RecentWeight Change Fever
- ☐ Fatigue
- ☐ *None in this Category*

Musculoskeletal:
- ☐ Low Back Pain
- ☐ Mid Back Pain
- ☐ Neck Pain
- ☐ Arm Problems _____
- ☐ Leg Problems _____
- ☐ Painful Joints
- ☐ Stiff/Swollen Joints
- ☐ Sore/Weak Muscles or Joints Muscle Spasms/Cramps
- ☐ Broken Bones_____
- ☐ Other: _____
- ☐ *None in this Category*

Neurological:
- ☐ Numbness or tingling sensations Loss of Feeling
- ☐ Dizziness or light headed
- ☐ Frequent or Recurrent Headaches Convulsions or seizures
- ☐ Tremors Stroke
- ☐ Other: _____
- ☐ *None in this Category*

Mind/Stress:
- ☐ Nervousness Depression
- ☐ Sleep Problems
- ☐ Memory Loss or Confusion
- ☐ Other: _____
- ☐ *None in this Category*

Genitourinary:
- ☐ Sexual Difficulty Kidney Stones
- ☐ Burning/Painful Urination
- ☐ Change in force/strain w Urination Frequent Urination
- ☐ Blood in Urine
- ☐ Incontinence or Bed Wetting
- ☐ Other: _____
- ☐ *None in this Category*

Gastrointestinal:
- ☐ Loss of Appetite Blood in Stool
- ☐ Change in Bowel Movements Painful Bowel Movements Nausea or Vomiting
- ☐ Abdominal Pain Frequent Diarrhea Constipation
- ☐ Other:_____
- ☐ *None in this Category*

Cardiovascular & Heart:
- ☐ Chest Pains
- ☐ Rapid or Heartbeat changes Blood Pressure Problems
- ☐ Swelling of Hands, Ankles, or Feet Heart Problems
- ☐ Other: _____
- ☐ *None in this Category*

Respiratory:
- ☐ Difficulty Breathing Persistent Cough Coughing Blood
- ☐ Asthma or Wheezing Lung Problems
- ☐ Other: _____
- ☐ *None in this Category*

Eyes and Vision:
- ☐ Wear contacts/glasses Blurred or double vision Glaucoma
- ☐ Eye disease or injury
- ☐ Other: _____
- ☐ *None in this Category*

Ears, Nose and Throat:
- ☐ Bleeding gums / mouth sores Bad Breath or bad taste
- ☐ Dental Problems
- ☐ Swollen throat or voice change Swollen glands in neck
- ☐ Ringing in the ears
- ☐ Ear - Ache/Ringing/Drainage Sinus / Allergy problems
- ☐ Nose Bleeds Hearing Loss
- ☐ Other: _____
- ☐ *None in this Category*

Endocrine, Hematologic, and Lymphatic:
- ☐ Thyroid problems Diabetes
- ☐ Excessive Thirst or urination Cold Extremities
- ☐ Heat or Cold intolerance Change in hat or glove size Dry skin
- ☐ Glandular or hormone problem Swollen Glands
- ☐ Anemia
- ☐ Easily Bruise or Bleed Phlebitis
- ☐ Transfusion
- ☐ Immune system disorder
- ☐ Other: _____
- ☐ *None in this Category*

Skin and Breasts:
- ☐ Rash or Itching
- ☐ Change in Skin Color
- ☐ Change in hair or nails
- ☐ Non-healing sores
- ☐ Change of appearance of a mole
- ☐ Breast Pain
- ☐ Breast Lump
- ☐ Breast Discharge
- ☐ Other: _____
- ☐ *None in this Category*

Women Only:

Are you pregnant?

Yes - *Due Date* ___/____/____

No - *Last Menstrual Period*

___/____/____

- ☐ Infertility
- ☐ Painful or Irregular periods Vaginal Discharge
- ☐ Other: _____
- ☐ *None in this Category*

Pregnancies:

Date	Outcome

Comments:_____

_____

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office to provide me with chiropractic care, diagnostic testing, and/or therapeutic services, in accordance with this state's statutes.

Patient or Guardian Signature _____ Date_____

Treating Doctor Signature _____ Date_____

Functional Rating Index / One minute Index

Circle what describes your condition right now

	0 points	1 point	2 points	3 points	4 points
1. **Pain Intensity**	No Pain	Mild	Moderate	Severe	Worst Possible
2. **Sleep**	Perfect Sleep	Mild disturbed	Moderate	Severe	Totally disturbed
3. **Personal Care (washing dressing etc.)**	No pain	Mild	Moderate pain move slow	Moderate pain Some assistance	Severe pain 100% assistance
4. **Travel (driving etc.)**	No pain	Mild on long trips	Moderate on long trips	Moderate on short trips	Severe on short trips
5. **Work**	Can do all usual work	Can do usual work no extra work	50% of usual work	25% of usual work	Can't work
6. **Recreation**	Can do all activities	Most activities	Some activities	Few activities	No activities
7. **Frequency of pain**	None	25% (Occasional)	50% (Intermittent)	75% (Frequent)	100% (Constant)
8. **Lifting**	No pain	Increased pain with Heavy weight	Increased pain with Moderate weight	Increased pain with Light weight	Increased pain with Any weight
9. **Walking**	No pain	Increased Pain after 1 mile	Increased Pain after ½ mile	Increased Pain after ¼ mile	Increased Pain with all walking
10. **Standing**	No pain	Increased Pain after several hours	Increased Pain after 1 hour	Increased Pain after ½ hour	Increased Pain with any standing

Total Points_____

Patient's Signature: _____ Date: _____

Doctor's Signature: _____ Date: _____

1 =2.5%	11=27.5%	21=52.5%	31=77.5%
2= 5.0%	12=30.0%	22=55.0%	32=80.0%
3=7.5%	13=32.5%	23=57.5%	33=82.5%
4=10.0%	14=35.0%	24=60.0%	34=85.0%
5=12.5%	15=37.5%	25=62.5%	35=87.5%
6=15.0%	16=40.0%	26=65.0%	36=90.0%
7=17.5%	17=42.5%	27=67.5%	37=92.5%
8=20.0%	18=45.0%	28=70.0%	38=95.0%
9=22.5%	19=47.5%	29=72.5%	39=97.5%
10=25.0%	20=50.0%	30=75.0%	40=100%

DUTIES UNDER DURESS SUMMARY

Complete the following questionnaire as it relates to how your injury(s) affect your performance of your living and work duties. Place a check in front of the day-to-day living duties, which are painful or difficult for you to perform as a result of the injuries you sustained in the motor vehicle collision. Please checkmark the appropriate category designating reason for difficulty. Include those duties/responsibilities which require that you **reduce the time you are capable of performing them.**

JOB TITLE AND DESCRIPTION:_____

Work	**Reason for the difficulty**		
_____Lifting	( ) Increased Pain	( ) Restricted Movement	( ) Weakness
_____Bending	( ) Increased Pain	( ) Restricted Movement	( ) Weakness
_____Sitting	( ) Increased Pain	( ) Restricted Movement	( ) Weakness
_____Standing	( ) Increased Pain	( ) Restricted Movement	( ) Weakness
_____Walking	( ) Increased Pain	( ) Restricted Movement	( ) Weakness
_____Computer Duties	( ) Increased Pain	( ) Restricted Movement	( ) Fatigue
_____Other_____	( ) Increased Pain	( ) Restricted Movement	( ) Weakness

Studies/School	**Reason for the difficulty**		
_____Lifting	( ) Increased Pain	( ) Restricted Movement	( ) Weakness
_____Bending	( ) Increased Pain	( ) Restricted Movement	( ) Weakness
_____Sitting	( ) Increased Pain	( ) Restricted Movement	( ) Weakness
_____Standing	( ) Increased Pain	( ) Restricted Movement	( ) Weakness
_____Walking	( ) Increased Pain	( ) Restricted Movement	( ) Weakness
_____Computer Duties	( ) Increased Pain	( ) Restricted Movement	( ) Fatigue
_____Studying	( ) Increased Pain	( ) Restricted Movement	( ) Fatigue
_____Other_____	( ) Increased Pain	( ) Restricted Movement	( ) Weakness

Domestic Duties	**Reason for the difficulty**		
_____Vacuuming	( ) Increased Pain	( ) Restricted Movement	( ) Weakness
_____Child Care/Pet Care	( ) Increased Pain	( ) Restricted Movement	( ) Weakness
_____Cleaning	( ) Increased Pain	( ) Restricted Movement	( ) Weakness
_____Preparing Meals	( ) Increased Pain	( ) Restricted Movement	( ) Weakness
_____Dressing Yourself	( ) Increased Pain	( ) Restricted Movement	( ) Weakness
_____Laundry	( ) Increased Pain	( ) Restricted Movement	( ) Weakness
_____Other_____	( ) Increased Pain	( ) Restricted Movement	( ) Weakness

Household/Other Duties	**Reason for the difficulty**		
_____Yard Work	( ) Increased Pain	( ) Restricted Movement	( ) Weakness
_____Transportation (driving)	( ) Increased Pain	( ) Restricted Movement	( ) Weakness
_____Shopping	( ) Increased Pain	( ) Restricted Movement	( ) Weakness
_____Taking Out Trash	( ) Increased Pain	( ) Restricted Movement	( ) Weakness
_____Sit to Stand Motion	( ) Increased Pain	( ) Restricted Movement	( ) Weakness
_____Other_____	( ) Increased Pain	( ) Restricted Movement	( ) Weakness

Please describe any other tasks that you were able to perform before the accident and have difficulty performing now:

_____

_____ _____

Patient's Signature Date

Patient name:_____ Today's Date: ___/___/_____DOA:_____

LOSS OF ENJOYMENT OF LIFE SUMMARY

Complete the following questionnaire as it relates to the activities (work related or otherwise) you normally would be ENJOYING – but are currently NOT ENJOYING as a result of your injury(s).

Include all activities which you:

- **can no longer do** or perform and/or
- **cannot do or perform** as often as you did before your injury

LIST HOBBIES/ACTIVITIES "for fun":_____

Work	**Reason for the limitation**		
_____Lifting	( ) Increased Pain	( ) Restricted Movement	( ) Weakness or fatigue
_____Bending	( ) Increased Pain	( ) Restricted Movement	( ) Weakness or fatigue
_____Sitting	( ) Increased Pain	( ) Restricted Movement	( ) Weakness or fatigue
_____Standing	( ) Increased Pain	( ) Restricted Movement	( ) Weakness or fatigue
_____Walking	( ) Increased Pain	( ) Restricted Movement	( ) Weakness or fatigue
_____Computer Duties	( ) Increased Pain	( ) Restricted Movement	( ) Weakness or fatigue
_____Other_____	( ) Increased Pain	( ) Restricted Movement	( ) Weakness or fatigue

Studies/School	**Reason for the limitation**		
_____Lifting	( ) Increased Pain	( ) Restricted Movement	( ) Weakness or fatigue
_____Bending	( ) Increased Pain	( ) Restricted Movement	( ) Weakness or fatigue
_____Sitting	( ) Increased Pain	( ) Restricted Movement	( ) Weakness or fatigue
_____Standing	( ) Increased Pain	( ) Restricted Movement	( ) Weakness or fatigue
_____Walking	( ) Increased Pain	( ) Restricted Movement	( ) Weakness or fatigue
_____Computer Duties	( ) Increased Pain	( ) Restricted Movement	( ) Weakness or fatigue
_____Studying	( ) Increased Pain	( ) Restricted Movement	( ) Weakness or fatigue
_____Other_____	( ) Increased Pain	( ) Restricted Movement	( ) Weakness or fatigue

Domestic Duties	**Reason for the limitation**		
_____Vacuuming	( ) Increased Pain	( ) Restricted Movement	( ) Weakness or fatigue
_____Child Care/Pet Care	( ) Increased Pain	( ) Restricted Movement	( ) Weakness or fatigue
_____Cleaning	( ) Increased Pain	( ) Restricted Movement	( ) Weakness or fatigue
_____Preparing Meals	( ) Increased Pain	( ) Restricted Movement	( ) Weakness or fatigue
_____Dressing Yourself	( ) Increased Pain	( ) Restricted Movement	( ) Weakness or fatigue
_____Laundry	( ) Increased Pain	( ) Restricted Movement	( ) Weakness or fatigue
_____Other_____	( ) Increased Pain	( ) Restricted Movement	( ) Weakness or fatigue

Household/Other Duties	**Reason for the limitation**		
_____Yard Work	( ) Increased Pain	( ) Restricted Movement	( ) Weakness or fatigue
_____Transportation (driving)	( ) Increased Pain	( ) Restricted Movement	( ) Weakness or fatigue
_____Shopping	( ) Increased Pain	( ) Restricted Movement	( ) Weakness or fatigue
_____Taking Out Trash	( ) Increased Pain	( ) Restricted Movement	( ) Weakness or fatigue
_____Sit to Stand Motion	( ) Increased Pain	( ) Restricted Movement	( ) Weakness or fatigue
_____Other_____	( ) Increased Pain	( ) Restricted Movement	( ) Weakness or fatigue

Sports

Name Sport:_____ ( ) Increased Pain ( ) Restricted Movement ( ) Weakness or fatigue

Pre-accident level of participation: ( ) Social ( ) Competitive ( ) Professional

Please describe any other activities that you were able to ENJOY before the accident and have difficulty enjoying now:

_____

_____ _____

Patient's Signature Date

I the patient _____ am directing payment by assigning this Lien Agreement.
Parent/Guardian/Patient Signature:_____Date_____Witness_____

Provider/Patient Assignment, Lien, Records Release and Payment Agreement

THIS AGREEMENT, entered into this date by and between _____, hereinafter called "Patient," and Rostberg Chiropractic & Acupuncture, hereinafter called "Provider."
WHEREAS Patient desires to receive healthcare services from Provider and desires to assign certain rights and benefits to Provider as an inducement to cause Provider to wait for the payment of such benefits, it is hereby agreed:
SECTION 1. Patient assigns to Provider any and all benefits payable by Patient's insurance or healthcare plan(s) as a result of charges incurred by Patient for services rendered by Provider. Patient also assigns to Provider any and all contractual rights Patient has against any insurance company, healthcare benefit plan, or any other party contractually liable to Patient for payment of healthcare costs incurred by Patient as a result of services rendered by Provider. This assignment of benefits and contractual rights relating to those benefits include, but are not limited to health insurance, auto insurance, etc. This assignment of benefits and contractual rights to those benefits will not exceed the total amount of charges incurred by Patient for service rendered by Provider. Patient agrees that payment for services rendered by Provider is due upon receipt of said services and that Provider may revoke this assignment at any time.
SECTION 2. Patient hereby grants Provider a lien against any proceeds resulting from any claim Patient has or may have against any party whose negligence may have caused Patient's injuries or illnesses. Patient also hereby grants a lien against the proceeds of any insurance policy or healthcare plan to which Patient is entitled as a result of services rendered to Patient by Provider. Said liens will not exceed the total amount of expenses incurred by Patient for services rendered by Provider.
SECTION 3. Patient hereby directs all insurers and other persons responsible for Patient's healthcare costs to make all payments for healthcare services rendered by Provider directly to Provider.
SECTION 4. Patient agrees that in the event Patient receives any check, draft, or other payment subject to this Agreement, Patient agrees to act as fiduciary agent for Provider and will immediately deliver said check, draft, or payment to Provider. Provider agrees to apply the proceeds from said check, draft or payments to Patient's debt for services rendered.
SECTION 5. Provider agrees to submit a copy of this Agreement with the initial claim form(s) which Provider submits to third party payers(s) as notice to the third party payer(s) of the assignment and other agreements contained herein. A copy of this document will be as binding as the document bearing original signatures. At the time each claim is submitted, a copy of the claim will be stored for safekeeping in Patient's file and may be picked up by the Patient/insured at any time or will, upon request by Patient/insured, be mailed to a designated address.
SECTION 6. Patient agrees to be responsible for insurance or health plan deductibles and co-payments. For the cost of services not covered by said insurance or healthcare plan(s). With the above exception, Provider agrees to accept as payment in full, for services rendered, the proceeds of insurance or healthcare plan benefits.
A. This Section is void if applicable insurance or health care plans do not provide coverage for chiropractic care.
B. This Section is void if prohibited by law or the terms of the Patient's insurance policy or health care plan.
C. Both Provider and Patient have the right to terminate the provisions of this Section at any time by providing written notice to the other. Such termination will have no effect on assignments, assumptions, or payments due, prior to said notice of termination.
SECTION 7. In the event that any Section or provision of the Agreement is legally void, invalid, or unenforceable, all other Sections and provisions of this Agreement will remain in full force and effect.
SECTION 8. The assignments and agreements contained in this document may not be revoked by Patient without the express written consent of the Provider, with the exception of the provision of Section 6.
IN WITNESS WHEREOF, this Agreement has been entered into the day and year set forth below.

_____ _____
Date Patient

_____ _____
Witness Provider

Rostberg Chiropractic & Acupuncture 10520 Barkley Street Suite 9 Overland Park KS 66212 913-381-9355

Patient Name: _____ D.O.B: _____ Date: _____

Before this office begins any health care operations we require you to read and sign this form stating that you understand the below item. If you refuse to sign this form the doctor reserves the right to refuse care.

AUTHORIZATION• By signing below you authorized this office/provider to complete a consultation and examination.

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES• We are very concerned with protecting your personnel health information. There may be times our office may need to contact you regarding office matters. By signing below you have authorized this office to contact you for office related matters in the following manner: phone—work—home or mobile, e—mail and regular mail. Messages may be left on an answering device/voicemail, or with the person answering your phone—home—work—mobile. Also in accordance with the Health Insurance Portability and Accountability act of 1996 (HIPAA), this office is obliges to supply you with a copy of the office privacy policies and procedures upon request This document outlines the use and limitations of the disclosure of your personal health information and your rights as a patient. By signing below you have acknowledged that you have been offered a copy of our HIPPA document. We keep an electronic copy.

AUTHORIZATION FOR X-RAY WITH RELEASE IF NEEDED• By signing below you have declared, to the best of your knowledge, that there is no chance you are pregnant at this time. By signing below you have declared that you have no known limitations that would be contraindicated for an x-ray evaluation & consent to x-rays if there is a determined need.

ACKNOWLEDGMENT OF ASSIGNMENT OF BENEFITS• By signing below you have acknowledged that you are fully responsible for all services rendered. You agree to the following conditions, covenants and terms regarding the assignment of health benefits appearing in policy issued by your insurance company. By signing below you hereafter referred to as the "Patient", policy holder, understands and voluntarily agrees requests, orders and directs to assign all applicable health provisions pertaining to payments or benefits appearing in my insurance policy to paid directly to this office/provider by your third-party payer, e.g. insurance company, attorneys, etc with Rostberg Chiropractic & Acupuncture in consideration for treatment rendered by Anthony Rostberg, hereafter referred to as "Doctor" the sum due to the Doctor for treatment rendered as a result of illness/injuries the Patient. By signing below you furthered acknowledge understanding that your health and accident insurance information policies are an contract between you and your carrier, and that you may be required to pay some or all of the fees charged to your account here by assign. By signing below you agree that this is a non-rescindable agreement and failure to fulfill this obligation will be considered a breach of contract between you and this office. The Patient gives the doctor the exclusive right to secure the funds assigned to the patient, including the right of securing counsel to represent the Doctor in collecting all sums due for treatment rendered. The Doctor and Patient hereby enter into this assignment of benefits freely and voluntarily and evidenced by the signature appearing below. The Patient and Doctor warrant that they have read this assignment of benefits and that each understand the legal effect of the same, and agree that each shall be bound by the covenants, terms and conditions appearing herein.

ACKNOWLEDGEMENT OF CONTACT: By signing below you understand that you can be contacted by text, email or phone regarding appointments and notifications.

ACKNOWLEDGEMENT OF CHARGES: Fees are the same amount regardless if to auto insurance or to health insurance. Examinations $25-$165 Adjustments $35-$65 Modalities $35-$50 X-rays $25-$250

ACKNOWLEDGEMENT OF CLINICAL SUMMARY REPORT (CCR) REGARDING EHR: By signing below you understand that a clinical summary report is created after each visit for the purpose of EHR and is available for my review. I am asking this office to save them for me and not print them each visit. I understand that, given time, these reports are available to be printed or emailed to me for review.

ACKNOWLEDGEMENT OF TREATMENT PLAN: By signing below I acknowledge that, if accepted for care, I may be presented with a chiropractic treatment plan resulting in one or more of the following services: chiropractic adjustments, examinations, and supportive therapies and procedures.

ACKNOWLEDGEMENT• By signing below you have acknowledge that you understand and agree with the policies and procedures outlined in this TERMS of ACCEPTANCE form. By signing below you acknowledge and certify that all the information given to the office/provider in the INTAKE forms are a true and accurate to the best of you knowledge.

Signature of Patient: _____ Cell phone: _____

Informed Consent

TO THE PATIENT: You have a right to be informed about your condition, the recommendation of treatment & the potential risks involved with the recommended treatment as well as receiving no treatment. *To make better informed decision to consent to treatment, please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions & make notes before you sign if there is anything that is unclear.*

Like all forms of health care, there are certain risks. While the risks are most often very minimal, in rare cases, complications including but not limited to for example: needle acupuncture- bleeding, infection, soreness, increased or no improvement in pain & symptoms, sprain/strain injuries, irritation of a condition, dislocation, temporary minor dizziness, nausea, nerve or vascular injury. Fractures are rare occurrences and generally result from some underlying weakness of the bone which is checked for during the taking of your history and during examination and X-ray. The causes of stroke, cerebral vascular accident (CVA), vertebral artery dissection are the subject of tremendous disagreement and debate. The incidences of CVA are exceedingly rare and are estimated to occur between <u>one in one million and one in five million</u> in debated relation to cervical adjustments. Although some reports have associated with different techniques of high velocity manipulation with a certain kind of stroke, or vertebral artery dissection, there is not yet a clear understanding of the connection. In our office we provide soft gentle treatment.

<u>"OTHER treatment options" -availability and nature of for your condition may include:</u>

1. Doing nothing – which may cause the condition to progressively worsen.
2. Self-administered, over-the-counter analgesics and rest – which may cause the condition to progressively worsen.
3. Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers
4. Hospitalization & injections
5. Surgery

If you chose to use any of the above noted <u>"OTHER treatment" options</u>, you should be aware that there are risks:

- ✓ Worsening of condition
- ✓ Side effects from drugs & operations
- ✓ Including death
- ✓ These risks vs. benefits you may wish to discuss these with your primary medical physician.

The provider will make every reasonable effort during the examination to screen for contraindications to care; however, if the patient has a condition that would otherwise not come to the doctor's attention, it is the patient's responsibility to inform the doctor. Although a reasonable effort has been made, I the patient do not expect the doctor to be able to anticipate and explain all risks and complications. I also understand that no guarantees or promises have been made to me concerning the results expected from the treatment.

TREATMENT AVAILABLE: Consultation• Examination •X-rays •Chiropractic •Therapies • Acupuncture

Having read or had read the consent, I the patient have had the opportunity to ask questions & discuss with Dr. Rostberg, my diagnosis, the nature and purpose of my chiropractic treatment, the risks and benefits of my chiropractic treatment, alternatives to my chiropractic treatment, and the risks and benefits of alternative treatment, including no treatment at all. All of my questions have been answered to my satisfaction. After talking with the doctor, I request and consent to chiropractic adjustments and other chiropractic & acupuncture procedures I agree to, including various modes of therapy and diagnostic X-rays. The chiropractic & acupuncture treatment may be performed by Dr. Rostberg.

By signing below, I consent to the treatment. I also intend this consent form to cover my entire clinical course of treatment here.

Print Patient Name_____

Patient Signature_____Date signed_____

Print Patient Representative_____Relationship to Patient_____

(if a minor) Signature of Parent or Guardian _____Date signed_____

Staff Witness to above signature_____Date_____

Check box if ☐ decline consent to any & all treatment Signature _____Date_____