Signature Chiropractic
8345 W. Thunderbird Rd. #103 Peoria, AZ. 85381
(623) 334-4114

Personal Injury / Collision Medical History Intake Form

Please allow our staff to photocopy your driver's license and accident information exchange card

PLEASE PRINT CLEARLY Full Name_____

Email_____ Gender: M / F Age: _____ Birth Date:_____

Address_____City_____State_____Zip_____

Social Security #_____ Home Phone (____)_____ Cell phone (____) _____

Name of Spouse, Parent or Guardian_____Age____Birth Date_____SS#_____

Females: Are you or is there a possibility that you may be pregnant? ____Y / N

Employer_____ Occupation_____ Wk Phone_____

In case of emergency contact_____Relationship_____

Phone Number (___)_____ Cell (___)_____ Wk Phone (____)_____

Third Party Insurance

Insurance Company of the Person at Fault _____ **Name of Agent:** _____

Insurance Company Address: _____City_____ State _____Zip_____

Insurance Company Phone # _____ Agent's Phone # _____

Claim Number _____

Your Insurance Do you have MedPay? Y N

Your Insurance Company _____ **Name of Agent:** _____

Insurance Company Address: _____City_____ State _____Zip_____

Insurance Company Phone # _____ Agent's Phone # _____

Claim Number _____

What was the date of the collision?_____

What time did the collision occur? _____

What state did the collision occur in?_____

What city did the collision occur in? _____

How did the collision occur?_____

What is your: Height _____ Weight_____

Doctor:_____

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We want you to know how your Patient Health Information (PHI) will be used in this office and your rights concerning those records. In addition to how your PHI will be used, office policies regarding payment and collections, and consent to treat are listed below. By signing at the end of these policies, you agree to all stipulations.

1. The patient understands and agrees to allow Signature Chiropractic to use their PHI for the purpose of treatment, payment, health care operations, and coordination of care.
2. The patient has the right to obtain a copy of his/her own health records with a written request. Fulfillment of request may take up to 10 days. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A Patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. We reserve the right to destroy all patient records after the allowed 6 years of inactivity without notice.
6. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by Signature Chiropractic to assure that your records are not readily available to those who do not need them.
7. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
8. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

AUTHORIZATIONS, ASSIGNMENTS OF BENEFITS AND CONSENT TO TREAT

To: Signature Chiropractic, hereafter referred to as OFFICE

1. I authorize, assign and direct my insurance carrier, to pay directly to said OFFICE such sums as may be due and owing the OFFICE of services rendered me, now or hereafter, which are payable under my insurance contract, or contractual agreement.
2. Patient agrees, that in the event patient receives any checks, drafts or other payment subject to this agreement, patient agrees to act as fiduciary agent to the OFFICE. The OFFICE agrees to apply any proceeds to the patient's debt for services rendered.
3. I fully understand and agree insurance policies are an arrangement between the insurance carrier and myself. I will be responsible for expenses not paid by insurance. I understand and agree that either health insurance or automobile insurance may not pay all of the charges of the OFFICE for my treatment. I understand and agree to pay the customary charges of the OFFICE and agree that if my health insurance or automobile insurance does not pay for my treatment in full, I will be responsible for the remaining balance. I understand and agree that I will be charged for missed appointments and that it may be necessary for OFFICE to record a lien on my case to ensure payment. I agree to pay the charges associated with filing of the lien.
4. I understand that if necessary of OFFICE to employ collection counsel and/or an attorney on my bill, I the patient will be responsible for any said collection and/or attorney fees.
5. I understand that if I do not cancel a scheduled appointment 24 hours in advance of the appointment I may be charged a $25.00 cancellation fee. This includes both Massage and Chiropractic.
6. I agree the OFFICE has the right to call my home or place of employment regarding appointment or insurance issues.
7. I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy, nutritional assessment, and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic and/or licensed doctors of chiropractic who now or in the future treat me while employed by, or are associated with or serving as back-up for the doctor of chiropractic, including those working at the clinic or office or any other office or clinic.
8. I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to, fractures, disk injuries, strokes, dislocations and sprains. I do expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedures which the doctor feels at the time, based upon the facts then known, is in my best interests.
9. I have read, or have had read to me the above consent. I have also had an opportunity to ask questions about its consent, and by signing below I agree to the above-named procedures I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions(s) I seek treatment.
10. A photocopy of this form shall be as valid as original

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

_____ _____ HRN#_____

Patient's signature **Date** **Office use only**

_____ _____

Legal guardian if patient is a minor **Relationship to minor**

Doctor:_____

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201

This notice is effective as of March 03, 2003.

I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide with my authorization and consent to use and disclosed my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice.

_____
Patient's Name (print)

_____ _____
Patient's Signature Date

_____ _____
Authorized Facility Signature Date