Motor Vehicle Accident History

(Please Print)

Patient Information **Claim #_______________**

Dr./Mr./Mrs./Ms./Mss (circle one) Marital status (circle one) M S W D

____

Last Name First Name Middle Initial Nick Name

____

Address City State Zip Code

Home Phone #______________ Cell Phone _______________ Alternate Phone ______________

Cell Phone carrier (for text reminder calls):__________________ E-mail________________________

Social Security No.___________________________ Date of Birth________________ Sex ☐M ☐F

Occupation_________________________________ Employer______________________________

Work Address____ Work Phone______________

Person to contact in an emergency____________________________ Phone #_________________

Responsible Party

Name of person responsible for payment of this account____________________________________

Relationship to patient______________________________________ Phone #_________________

____

Address City State Zip Code

Insurance Information

Please give your photo ID and any insurance information to the staff person assisting you.

Accident/Injury History

1. Date of Collision:____________ Time of Day: ___________ Road Condition: ☐ Dry ☐ Wet
2. Were you: ☐ Driver ☐ Passenger ☐ Front Seat ☐ Back Seat
3. Number of people in your vehicle?______________
4. Were you wearing a seat belt? ☐ Yes ☐ No *If No, go to question #6*
5. If yes, were you wearing a lab belt? ☐ Yes ☐ No Lab belt & shoulder harness ☐ Yes ☐ No
6. What direction were you headed? ☐ North ☐ South ☐ East ☐ West
   On (name of street and city):____
7. What direction was the other vehicle headed? ☐ North ☐ South ☐ East ☐ West
   On (name of street and city):____

8. Were you struck from: ☐ Behind ☐ Front ☐ Left Side ☐ Right Side
   Other combination, please describe:____

9. What was the position of your head during the collision?
   ☐ Straight Ahead ☐ Turned Right ☐ Turned Left ☐ Other____________________

10. Did any part of your body strike/hit anything inside of your vehicle (steering wheel, dashboard, etc.)? ☐ Yes ☐ No If yes, please describe:_______________________________________

11. Did any items become displaced in the vehicle (rearview mirror, phone, packages, etc.)?
    ☐ Yes ☐ No If yes, please describe:____

12. Approximate speed of your car:________mph Estimate speed of the other car:_______mph

13. Make/model of your car:_________________ Make/model of other car:_________________

14. Were the police notified? ☐ Yes ☐ No Please provide this office with a copy of the police report.

15. In your own words, please describe the collision:_____________________________________
    ____

16. Did you have any physical complaints BEFORE the collision? ☐ Yes ☐ No
    If yes, please describe in detail:____

17. Please describe how you felt:
    a. DURING the accident:____
    b. IMMEDIATELY AFTER the accident:____
    c. LATER THAT DAY:____
    d. THE NEXT DAY:____

18. Were you knocked unconscious? ☐ Yes ☐ No If yes, for how long?____________________

19. Where were you taken after the collision?____

20. Have you been treated by another doctor since this accident? ☐ Yes ☐ No
    If yes, please list the doctor’s names and locations:___________________________________
    What type of treatment did you receive?____

21. Did this collision occur while you were performing your regular job duties? ☐ Yes ☐ No

22. How do you feel now, what is your number one problem or the one area of greatest pain?____

23. Please rate the level of this pain on the following scales: 0 = no pain, 10 = severe pain
    If your pain varies from day to day, please circle two numbers to indicate a range of your pain.

    0 1 2 4 5 6 7 8 9 10

24. Since this injury occurred, is your pain: ☐ improving ☐ Getting worse ☐ Staying the same

PATIENT FULL NAME & ID # (DOB: _______) **DOI:________ CLAIM #:__________________** DATE INITIAL EXAM: _______

25. How often do you experience the pain?
    ____1-2 hours per day ____About half the day ____Most of the day ____The pain never goes away

26. How does the pain affect your daily activities?
    ____It does not affect my daily activities ____I have had to change how I do things
    ____I have had to stop doing some of my daily activities ____I am unable to perform daily activities

27. What increases your pain?____
28. What decreases your pain?____

29. Have you ever experienced this problem before? ☐ Yes ☐ No
30. Do you have a previous illness/disease which affects your present condition? ☐ Yes ☐ No
    If yes, please describe:____

31. List any other complaints currently bothering you and rate your pain level for each.
    a. ____________________________ 0 1 2 3 4 5 6 7 8 9 10
    b. ____________________________ 0 1 2 3 4 5 6 7 8 9 10
    c. ____________________________ 0 1 2 3 4 5 6 7 8 9 10
    d. ____________________________ 0 1 2 3 4 5 6 7 8 9 10

32. Have you lost time from work as a result of this accident? ☐ Yes ☐ No
    a. Type of employment:______________________
    b. Last day worked: _________________________

33. Have you ever been involved in an accident before? ☐ Yes ☐ No
    a. If yes, when?________________________
    b. Describe the accident(s):____
    c. Were you injured? ☐ Yes ☐ No Explain:____________________________

34. Lit all medications you are currently taking (prescribed and over the counter):_______________
    ____

35. List all surgeries you have had (with dates):____

36. If you have experienced any of the following conditions in the past mark "P" on the line provided. If you are currently experiencing any of the following conditions mark a "C" on the line provided (check all that apply):

___heart attack	___stroke	___arthritis	___gall bladder trouble
___diabetes	___glaucoma	___fainting spells	___kidney stones
___difficulty with urination	___bloody stools	___difficulty with bowel movements	
___prostate trouble	___anemia	___cancer	___asthma
___AIDS	___ulcers	___diverticulitis	___menstrual cramps
___dizziness	___loss of memory	___chest pain	___shortness of breath
___constipation	___diarrhea	___general fatigue	___sudden weight loss
___nausea	___muscle cramping	___soreness in joints	___loss of hearing
___ears ringing	___headache	___migraine	___epilepsy
___gout	___tuberculosis	___syphilis	___sprained ankle □ R □ L
___knee/hip replacement	___broken bones (specify)	___other_____________________	

General Activities

37. Check all apply

___sleep on waterbed
___sleep on stomach
___sewing
___exercise___x per week
___swim
___read in bed
___needle point/knitting
___lift weights
___jog___x per week
___watch television___hrs per day
___fall asleep on recliner/on couch
___use two or more pillows to sleep with
___play video games:___hrs per day
___computer use:___hrs per day

38. Please add anything else you would like the doctor to know:____________________________
____
____

39. Draw a diagram of the auto collision with direction and location of impact (North, East, South, West):

Authorization

I certify that I have read and I understand the above information to the best of my knowledge. The questions above have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize this office to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such chiropractic care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to this office benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payments of all services rendered on my behalf or my dependents.

Patients Signature____ Date_______________

Doctors Comments:____
____
____
____
____
____

ASSIGNMENT, LIEN, RELEASE & POWER OF ATTORNEY

THIS AGREEMENT, entered into this date and between ___________________ called "PATIENT" and Spine & Scoliosis Clinic.

WHEREAS Patient desires to receive chiropractic services from Spine & Scoliosis Clinic and desires to assign certain rights and benefits to Spine & Scoliosis Clinic as consideration for Spine & Scoliosis Clinic awaiting of such benefits.

Accordingly, it is hereby agreed:

A. Patient hereby authorizes Spine & Scoliosis Clinic to furnish a full report and records regarding case history, examination, diagnosis, treatment and prognosis, x-rays, laboratory reports and the results of all tests of any type of character of patients such persons as Spine & Scoliosis Clinic deems appropriate.

B. Patient's assigns to Spine & Scoliosis Clinic any and all benefits payable by Patient's insurance or health care plan(s) as a result of charges incurred by Patients for services rendered by Spine & Scoliosis Clinic. Patient also assigns to Spine & Scoliosis Clinic any and all contractual rights Patient has against insurance company, health care benefit plan, or any other party possibly liable to Patient for payment of health care costs incurred by Patient as a result of services rendered by Spine & Scoliosis Clinic.

C. Patient fully understands that Patient is directly and fully responsible to Spine & Scoliosis Clinic for all bills submitted for services rendered and that this agreement is made solely for additional protection and consideration for a waiting payment. Patient further understands that such payment is not contingent on any settlement, claim, judgment, or verdict, which Patient may eventually recover. In the event of non-payment by any insurance company, health care benefit plan, or any other party possibly liable to Patient for payment of health care costs incurred by Patient as a result of services rendered by Spine & Scoliosis Clinic, Patient agrees to be responsible for any such outstanding balance, including interest at a rate of 9%, reasonable attorney's fees and costs.

D. Patient fully understands that the lien and assignment given to Spine & Scoliosis Clinic herein is irrevocable.

E. By executing this agreement, Patient hereby instructs and directs any attorney- representing Patient to honor the above lien and assignments and make payment under the lien and assignment directly to Spine & Scoliosis Clinic. Patient directs that attorney be bound by this lien and treat it, irrevocably, as an assignment due to Spine & Scoliosis Clinic. Spine & Scoliosis Clinic is relying upon this lien, assignment and directive to any attorney, and as a result of such reliance, Spine & Scoliosis Clinic is providing care and treatment for which this lien, assignment and directive provides security for payment. *Moreover*, Patient agrees that Spine & Scoliosis Clinic is to be viewed as a third party beneficiary of this direction to Patient's attorney and it is Patient's intent to impose upon Patient's attorney an obligation to comply with the terms of this directive.

F. Patient hereby directs all insurers and other persons possibly responsible for Patient's healthcare costs to make all payments for healthcare services rendered by Spine & Scoliosis Clinic directly to Spine & Scoliosis Clinic.

G. 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 Spine & Scoliosis Clinic and will immediately deliver said check, draft, or payment to Spine & Scoliosis Clinic to be applied to Patient's debt for services rendered.

H. Patient hereby appoints Spine & Scoliosis Clinic as Patient's tur and lawful attorney, irrevocable, and with full power of substitution, for Patient and in Patient's name, to ask, demand, sue for, collect, endorse, sign and receive rendered to Patient by Spine & Scoliosis Clinic. Spine & Scoliosis Clinic is not obligated or compelled to exercise such powers but may do sin in Spine & Scoliosis Clinic sole discretion. Patient agrees to fully cooperate with Spine & Scoliosis Clinic in collecting said amounts.

I. Spine & Scoliosis Clinic agrees to submit a copy of this agreement with the initial claim form(s) which Spine & Scoliosis Clinic submits to third party payor(s) as notice to the third party payor(s) of the assignment and other agreements contained herein. 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, upon reasonable request and during normal business hours, or upon written request by Patient, be mailed to designated address.

J. Patient hereby authorized Spine & Scoliosis Clinic to receive a complete copy of Patient's insurance policy, including any endorsements, conditions, limitations or exclusions.

K. A copy of these documents shall be as binding as the document bearing the original signatures.

L. Patient hereby authorizes Spine & Scoliosis Clinic to obtain a copy of any final disbursement/settlement sheet from the patient's attorney.

___________________	______________________
Date	Patient's Signature
___________________	______________________
Date	Spine & Scoliosis Clinic
___________________	______________________
Date	Attorney

REFERENCES:

Valley State Bank v. Dean, 97 Colo. 151, 47 P.2nd 924 (1935)
Fort Lupton State Bank v. Muranta, 626 P.2d 757 (Colo. App. 1981)
Barcucas v. Bohemia Import Co., Inc., 518 P.2d 850 (Colo. App. 1974)
Thomas v. Oken, 699 P.2d (Colo. App. 1984)

PATIENT FULL NAME & ID # (DOB: _______) **DOI:________ CLAIM #:__________________** DATE INITIAL EXAM: **_______**

ACCEPTANCE OF PERSONAL INJURY CASE AT SPINE & SCOLIOSIS CLINIC

Here at Spine & Scoliosis Clinic we Value our quality of care we give each of our patients. Due to the volume of work load Personal Injury Cases add to the Doctor and Staff we limit our acceptance of Personal Injury Clients. Because of this limitation it is our office policy to enforce the following before taking your case:

1. You must sign a lien. A lien states that you will be responsible for your bill if for some reason your Personal Injury Case does not pay out. We do charge our full fees for all services rendered during your care under your Personal Injury Case.

2. If you do not have Personal Injury Protection (PIP) you must have an attorney.
A. Your attorney must sign our lien before care can be given.
B. You must pay $30 towards your settlement per visit unless other arrangements have been made between you and the doctor.

3. If you are an active patient your current Non-personal injury case will be placed on hold. Once the personal injury case is closed you may resume your Non-personal injury care plan. If you have a balance due on your plan you must pay in full before we will accept your personal injury case for services already rendered (unless other arrangements have been made with the Doctor).

4. You must make your appointments recommended by the Doctor. Failure to make your recommended appointments could lead to early termination of your Personal Injury Case at Spine & Scoliosis Clinic.

5. We have a 24 hour cancellation policy in place for missed appointments, if you miss your appointment you will be charged $25 for Spine & Scoliosis Clinic appointments and Personal Training appointments. Your Personal injury case will not pay for these missed appointment fees and will be your responsibility.

6. Most supplements, supports, and products will not be covered by your personal injury case.

Please sign below that you have read and understand the above:

____ ___________________________

Signature Date

PATIENT FULL NAME & ID # (DOB: ________) **DOI:________** **CLAIM #:___________________** DATE INITIAL EXAM: **_______**

PATIENT FULL NAME & ID # (DOB: _______) **DOI:________ CLAIM #:__________________** DATE INITIAL EXAM: _______

INSTRUCTION: This set of questions asks for your views about your health. This information will help keep track of how you feel and how well you are able to do your usual activities. Answer every question by marking the answer as indicated. If you are unsure about how to answer a question give the best answer you can.

SF 36 Health Survey

1. In general, would you say your health is: **(Please tick one box.)**
   □ Excellent □ Very good □ Fair □ Poor

2. Compared to one year ago, how would you rate your health in general now? **(Please tick one box.)**
   □ Much better than one year ago
   □ Somewhat better now than one year ago
   □ About the same as one year ago
   □ Somewhat worse now than one year ago
   □ Much worse now than one year ago

3. The following questions are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much? **(Please circle one number on each line.)**
   Activities: Yes, limited a lot = 1 Yes, limited a little = 2 Not limited at all = 3

	Activities			
a.	**Vigorous activities**, such as running, lifting heavy, objects participating in strenuous sports:	1	2	3
b.	**Moderate activities**, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf:	1	2	3
c.	Lifting or carrying groceries:	1	2	3
d.	Climbing **several** flights of stairs:	1	2	3
e.	Climbing **one** flight of stairs:	1	2	3
f.	Bending, kneeling, or stooping:	1	2	3
g.	Walking **more than a mile**:	1	2	3
h.	Walking **several blocks**:	1	2	3
i.	Walking **one block**:	1	2	3
j.	Bathing or dressing yourself:	1	2	3

4. During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health? **(Please circle one number on each line.)**

		Yes = 1	No = 2
a.	Cut down on the **amount of time** you spent on work or other activities:	1	2
b.	Accomplished less than you would like:	1	2
c.	Were limited in the **kind** of work or other activities:	1	2
d.	Had **difficulty** performing the work or other activities (for example took extra effort):	1	2

5. During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (e.g. feeling depressed or anxious)? **(Please circle one number on each line.)**

		Yes = 1	**No = 2**
a.	Cut down on the **amount of time** you spent on work or other activities	1	2
b.	Accomplished less than you would like:	1	2
c.	Didn’t do work or other activities as carefully as usual	1	2

PATIENT FULL NAME & ID # (DOB: _______) **DOI:________ CLAIM #:__________________** DATE INITIAL EXAM: _______

6. During the past 4 weeks, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbors, or groups? **(Please tick one box.)**
   □ Not at all □ Slightly □ Moderately □ Quite a bit □ Extremely

7. How much physical pain have you had during the past 4 weeks? **(Please tick one box.)**
   □ None □ Very mild □ Moderate □ Severe □ Very Severe

8. During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework.)? **(Please tick one box.)**
   □ Not at all □ Slightly □ Moderately □ Quite a bit □ Extremely

9. These questions are about how you feel and how things have been with you during the past 4 weeks. Please give the one answer that is closest to the way you have been feeling for each item. **(Please circle one number on each line.)**

1 = All of the time **2 = Most of the time** **3 = A good bit of the time**
4 = Some of the time **5 = A little of the time** **6 = None of the time**

a.	**Did you feel full of life?____**	**1**	**2**	**3**	**4**	**5**	**6**
b.	**Have you been a very nervous person? __________________________**	**1**	**2**	**3**	**4**	**5**	**6**
c.	**Have you felt so down in the dumps that nothing could cheer you up?**	**1**	**2**	**3**	**4**	**5**	**6**
d.	**Have you felt calm and peaceful? ______________________________**	**1**	**2**	**3**	**4**	**5**	**6**
e.	**Did you have a lot of energy? __________________________________**	**1**	**2**	**3**	**4**	**5**	**6**
f.	**Have you felt downhearted and blue? ___________________________**	**1**	**2**	**3**	**4**	**5**	**6**
g.	**Did you feel worn out? _______________________________________**	**1**	**2**	**3**	**4**	**5**	**6**
h.	**Have you been a happy person? ________________________________**	**1**	**2**	**3**	**4**	**5**	**6**
i.	**Did you feel tired? ____**	**1**	**2**	**3**	**4**	**5**	**6**

10. During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives etc.) (Please tick one box.)
   □ All of the time □ Mot of the time □ Some of the time □ A little of the time □ None of the time

11. How TRUE or FALSE is each of the following statements for you? **(Please circle one number on each line.)**
   1 = Definitely True **2 = Mostly True** **3 = Don't know** **4 = Mostly False** **5 = Definitely False**

a.	**I seem to get sick a little easier than other people**	**1**	**2**	**3**	**4**	**5**
b.	**I am as healthy as anybody I know _____________**	**1**	**2**	**3**	**4**	**5**
c.	**I expect my health to get worse_______________**	**1**	**2**	**3**	**4**	**5**
d.	**My health is excellent_______________________**	**1**	**2**	**3**	**4**	**5**

Signature____ **Date ___________________**

Thank you!

PATIENT FULL NAME & ID # (DOB: _______) **DOI:________** **CLAIM #:__________________** DATE INITIAL EXAM: _______

NECK PAIN Disability Index Questionnaire

Age ____ Date of Birth ___________ Occupation_____________________

How long have you had **neck pain**? ____ Years ____ Months ____ Weeks

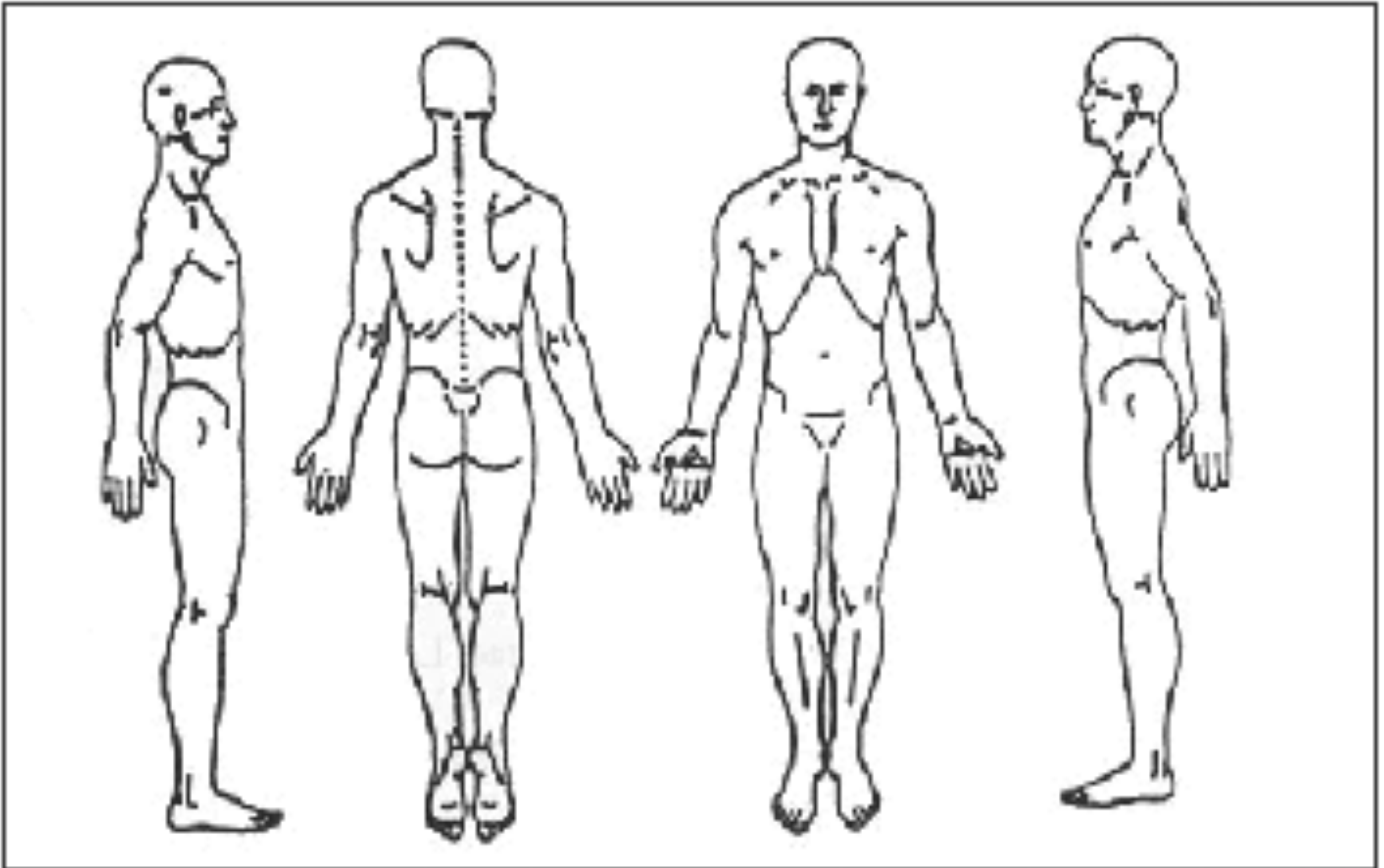
Is this your first episode of **neck pain**? ____ Yes ____ No

Use the letters below to indicate the type and location of your sensations right now

(Please remember to complete both sides of this form.)

A = Aches B = Burning N = Numbness

P = Pins & Needles S = Stabbing O = Other



OVER PLEASE

PATIENT FULL NAME & ID # (DOB: _______) **DOI:________ CLAIM #:__________________** DATE INITIAL EXAM: _______

NECK PAIN Disability Index Questionnaire

Please Read: This questionnaire is designed to enable us to understand how much your neck pain has affected your ability to manage your everyday activities. Please answer each section by circling ONE CHOICE that most applies to you. We realize that you may feel that more than one statement may relate to you, but PLEASE JUST CIRCLE THE ONE CHOICE THAT MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.

SECTION 1 – Pain Intensity

A I have no pain at the moment.
B The pain is mild at the moment.
C The pain is moderate at the moment.
D The pain is fairly severe at the moment.
E The pain is very severe at the moment.
F The pain is the worst imaginable at the moment.

SECTION 2 – Personal Care (Washing, Dressing, etc.)

A I can look after myself normally, without causing extra pain.
B I can look after myself normally, but it causes extra pain
C It is painful to look after myself and I am slow and careful.
D I need some help, but manage most of my personal care.
E I need help every day in most of my personal care.
F I do not get dressed, I wash with difficulty and stay in bed.

SECTION 3 – Lifting

A I can lift heavy weights without extra pain.
B I can lift heavy weights, but it causes extra pain.
C Pain prevents me from lifting heavy weights off the floor, But I can manage if they are conveniently positioned, e.g., on a table.
D Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
E I can lift very light weights.
F I cannot lift or carry anything at all.

SECTION 4 – Reading

A I can read as much as I want to with no pain in my neck.
B I can read as much as I want to with slight pain in my neck.
C I can read as much as I want with moderate pain in my neck.
D I cannot read as much as I want because of moderate pain in my neck.
E I cannot read as much as I want because of severe pain in my neck.
F I cannot read at all.

SECTION 5 – Headaches

A I have no headaches at all.
B I have slight headaches with come infrequently.
C I have moderate headaches with come infrequently.
D I have moderate headaches with come frequently.
E I have severe headaches with come frequently.
F I have headaches almost all of the time.

After Vernon & Minor, 1991

SECTION 6 – Concentration

A I can concentrate fully when I want to with no difficulty.
B I can concentrate fully when I want to with slight difficulty.
C I have a fair degree of difficulty in concentrating when I want to.
D I have a lot of difficulty in concentrating when I want to.
E I have a great deal of difficulty in concentrating when I want to.
F I cannot concentrate at all.

SECTION 7 - Work

A I can do as much work as I want to.
B I can only do my usual work, but no more.
C I can do most of my usual work, but no more.
D I cannot do my usual work.
E I can hardly do any work at all.
F I cannot do any work at all.

SECTIION 8 – Driving

A I can drive my car without any neck pain.
B I can drive my car as long as I want with slight pain in my Neck.
C I can drive my car as long as I want with moderate pain in my neck.
D I cannot drive my car as long as I want with moderate pain in my neck.
E I can hardly drive at all because of severe pain in my neck.
F I cannot drive my car at all.

SECTION 9 - Sleeping

A I have no trouble sleeping.
B My sleep is slightly disturbed (less than 1 hour sleepless).
C My sleep is mildly disturbed (1-2 hours sleepless).
D My sleep is moderately disturbed (2-3 hours sleepless).
E My sleep is greatly disturbed (3-5 hours sleepless).
F My sleep is completely disturbed (5-7 hours sleepless).

SECTION 10 – Recreation

A I am able to engage in all of my recreational activities, with no neck pain at all.
B I am able to engage in all of my recreational activities, with some pain in my neck.
C I am able to engage in most, but not all of my usual recreational activities because of pain in my neck.
D I am able to engage in a few of my usual recreational activities because of pain in my neck.
E I can hardly do any recreational activities because of pain in my neck
F I cannot do any recreational activities at all.

Comments:____

Patient Signature:_______________________________________ **Date:**_____________________

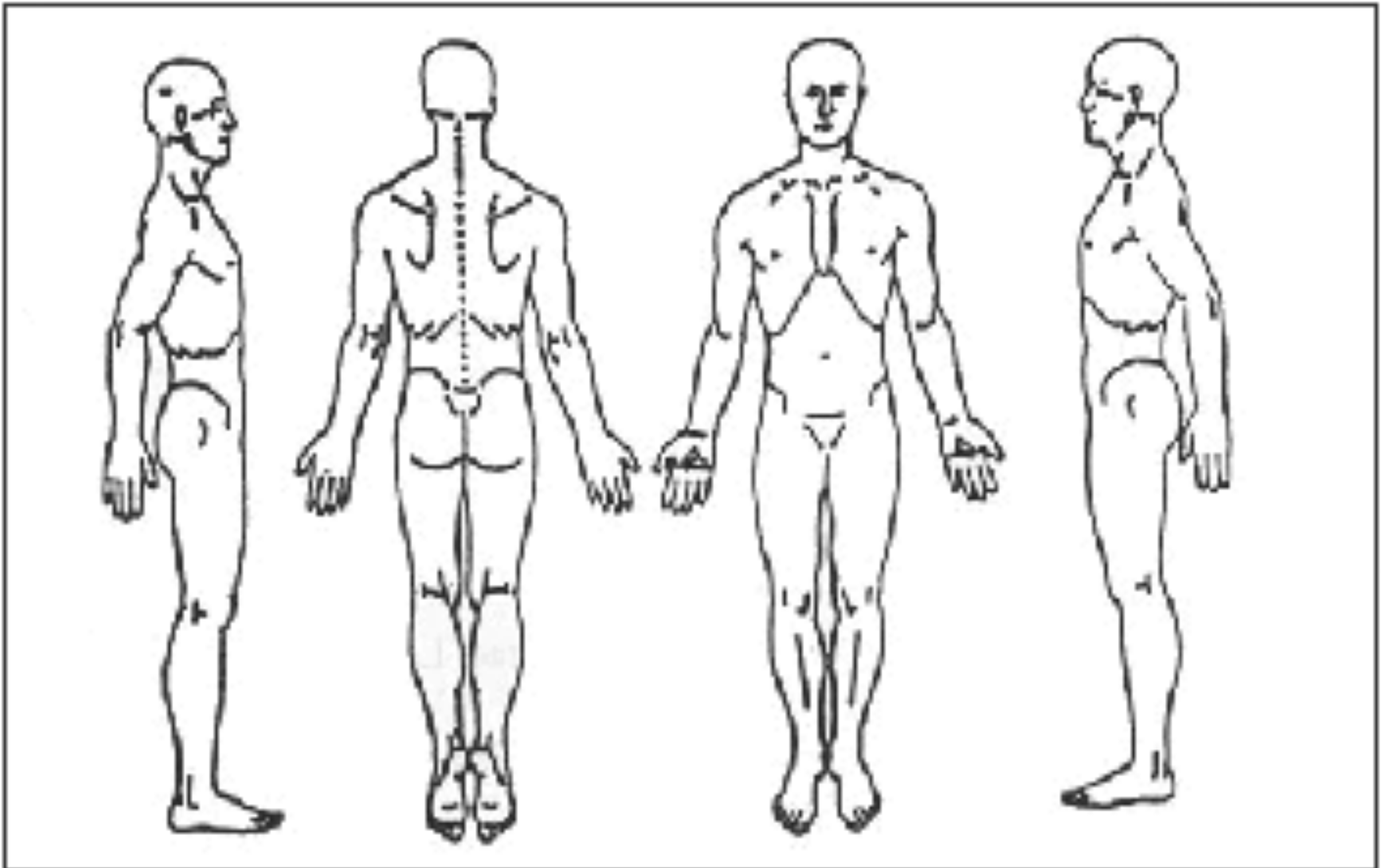
PATIENT FULL NAME & ID # (DOB: _______) **DOI:________ CLAIM #:__________________** DATE INITIAL EXAM: _______

Revised Oswestry Chronic **LOW BACK** Disability Index Questionnaire

Age ____ Date of Birth ___________ Occupation_____________________
How long have you had **low back** pain? ____ Years ____ Months ____ Weeks
Is this your first episode of **low back** pain? ____ Yes ____ No

Use the letters below to indicate the type and location of your sensations right now
(Please remember to complete both sides of this form.)

A = Aches B = Burning N = Numbness
P = Pins & Needles S = Stabbing O = Other



OVER PLEASE

PATIENT FULL NAME & ID # (DOB: _______) **DOI:________ CLAIM #:__________________** DATE INITIAL EXAM: **_______**

Revised Oswestry Chronic **LOW BACK** Disability Index Questionnaire

Please Read: This questionnaire is designed to enable us to understand how much your low back pain has affected your ability to manage your everyday activities. Please answer each section by circling ONE CHOICE that most applies to you. We realize that you may feel that more than one statement may relate to you, but PLEASE JUST CIRCLE THE ONE CHOICE THAT MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.

SECTION 1 – Pain Intensity

A The pain comes and goes and is very mild.
B The pain is mild and does not vary much.
C The pain comes and goes and is moderate.
D The pain is moderate and does not vary much.
E The pain comes and goes and is severe.
F The pain is severe and does not vary much.

SECTION 2 – Personal Care

A I would not have to change my way of washing or dressing in order to avoid pain.
B I do not normally change my way of washing or dressing even though it causes some pain.
C Washing and dressing increases the pain, but I manage not to change my way of doing it.
D Washing and dressing increases the pain and I find it necessary to change my way of doing it.
E Because of the pain, I am unable to do some washing and dressing without help.
F Because of the pain, I am unable to do any washing or

SECTION 3 – Lifting

A I can lift heavy weights without extra pain.
B I can lift heavy weights, but it causes extra pain.
C Pain prevents me from lifting heavy weights off the floor.
D Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g., on a table.
E Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
F I can only lift very light weighs, at the most.

SECTION 4 – Walking

A Pain does not prevent me from walking any distance.
B Pain prevents me from walking more than one mile.
C Pain prevents me from walking more than ½ mile.
D Pain prevents me from walking more than ¼ mile.
E I can only walk while using a cane or on crutches.
F I am in bed most of the time and have to crawl to the toilet.

SECTION 5 – Sitting

A I can sit in any chair as long as I like without pain.
B I can only sit in my favorite chair s long as I like.
C Pain prevents me from sitting more than one hour.
D Pain prevents me from sitting more than ½ hour.
E Pain prevents me from sitting more than ten minutes.
F Pain prevents me from sitting at all.

From: N. Hudson, K. Tome-Nicholson, A. Breen;1989

Comments:____
____

Patient Signature **Date**
____

SECTION 6 – Standing

A I can stand as long as I want without pain.
B I have some pain while standing, but it does not increase with time.
C I cannot stand for longer than one hour without increasing pain.
D I cannot stand for longer than ½ hour without increasing pain.
E I cannot stand for longer than ten minutes without
F I avoid standing, because it increases the pain straight away.

SECTION 7 – Sleeping

A I get no pain in bed.
B I get pain in bed, but it does not prevent me from sleeping well.
C Because of pain, my normal night's sleep is reduced by 25%.
D Because of pain, my normal night's sleep is reduced by 50%.
E Because of pain, my normal night's sleep is reduced by 75%.
F Pain prevents me from sleeping at all.

SECTION 8 – Social Life

A My social life is normal and gives me no pain.
B My social life is normal, but increases the degree of my pain.
C Pain has no significant effect on my social life apart from limiting my more energetic interests e.g. dancing, etc.
D Pain has restricted my social life and I do not go out very often.
E Pain has restricted my social life to my home.
F I have hardly any social life because of the pain.

SECTION 9 – Traveling

A I get no pain while traveling.
B I get some pain while traveling, but none of my usual Forms of travel make it any worse.
C I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
D I get extra pain while traveling which compels me to Seek alternative forms of travel.
E Pain restricts all forms of travel.
F Pain prevents all forms of travel except if lying down.

SECTION 10 – Changing Degree of Pain

A My pain is rapidly getting better.
B My pain fluctuates, but overall is definitely getting better.
C My pain seems to be getting better, but improvement is slow at present
D My pain is neither getting better nor worse.

E My pain is gradually worsening.
F My pain is rapidly worsening.

PATIENT FULL NAME & ID # (DOB: _______) **DOI:________ CLAIM #:__________________** DATE INITIAL EXAM: _______

OFFICE POLICY
SPINE & SCOLIOSIS CLINIC/CALLEN'S ESSENTIALS, P.C.

When we accept you as a patient it is important that you understand the objectives of our care. Chiropractors provide a unique service that other healthcare providers do not offer. Chiropractors specialize in the location and correction of vertebral subluxations for the purpose of improving the health and function of your spine and nervous system.

A Vertebral Subluxation is a misalignment or distortion of your spinal column and/or related structures that can affect your health and overall body functioning. Chiropractors spend years studying how to locate and correct this destructive condition. The correction is performed using specialized techniques called "chiropractic or spinal adjustments" over a period of time. When your spine is free of the nerve and musculoskeletal stress caused by subluxations your body can function more efficiently and your body's natural ability to heal can work more optimally.

It is not our objective to medically diagnosis or treat any disease, symptom or condition. If you desire diagnosis or treatment for a specific symptom or treatment of a specific symptom, disease or condition or advice on taking or stopping medications, we recommend you consult a healthcare provider who specializes in that area.

If we discover unusual findings during the course of our chiropractic examination(s) we will let you know of them. You may then decide whether you wish to investigate further and discuss your healthcare options with other health professionals. We will cooperate with you and them in your goals. It is our sole objective to improve and maintain the health and normal function of your spine and nerve system to the maximum degree possible for you.

X-Ray Consent Form – In the event that x-rays are needed:
The doctor will explain that x-rays are to analyze the spine for vertebral subluxations and to determine the appropriateness of chiropractic spinal adjustments. If the doctor discovers a non-chiropractic "unusual finding" when reviewing x-ray, you will be informed. You then must determine if you should seek the services of an additional health care provider for advice, diagnosis, or treatment for the unusual finding. I understand that seeking advice from another type of health care provider should not interfere with the subluxation corrective care provided by this office.

Diagnostic X-rays may be recommended by the doctor. You will be given a prescription to get your x-rays/images done by Callen Chiropractic, Mt Baker Imaging or a different imaging center. When you choose to get those x-rays done you fully understand and consent to chiropractic spinal x-rays to be taken.

Regaining Your Youth and Vitality Workshop: is a brief workshop to go over your spinal health after you have completed a minimum of three (3) office visits. You will meet with the doctor or practice manager to review your options of care in the office. We encourage bringing your friends and family.

Financial Policy: We are pleased that you have chosen us for your healthcare needs and are committed to providing you with the best possible care. We are happy to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship.

Your Appointment time (s) is reserved exclusively for you. If you are unable to keep this appointment, please give us **48 hours' notice phone call** (**NOT by text** – we will not accept a cancellation notice by text) so that we may accommodate another patient. If you fail to give us notice, there will be a **$25 charge** automatically deducted from your credit card on file, which will not be covered by your Health Insurance Company or coupon.

Patients under a "Crisis or Corrective or Lifestyle Care Plan" Office Visit Time for Chiropractic and/or Rehab is reserved exclusively for you. If you are unable to keep this appointment, we would like you to make up your appointment the week of the missed appointment. Please give us 48 hours' notice so that we may accommodate another patient.

PATIENT FULL NAME & ID # (DOB: _______) **DOI:________** **CLAIM #:__________________** DATE INITIAL EXAM: _______

Staying on track with your care plan will allow you to obtain your optimal pain management, healing and correction of your spine. If you do not maintain the recommended visit frequency you may not achieve your goals or the spinal correction estimated.

Full Attention: We are going to give you our full attention whenever you have a visit with us. We also want you to be able to give us your full attention. **We therefore ask you to turn off all cell phones before your visit. We also ask for your consideration in not bringing food, candy, or non-water beverage to your visit with us.**

Children in the office: Please no food, drink or candy in the office. For the safety of your children, all children under 10 years of age are not permitted to be unattended without adult supervision in our office.

Insurance: Please scan or take a picture of your insurance card **prior to your appointment** and email to us or we can copy your insurance card at your first appointment. Please advise the office if your insurance coverage changes. For those of you who do not have insurance coverage, we offer affordable time of service plans or extended care plans which will be arranged by you and the doctor or practice manager.

Patients are responsible for all charges not covered by their insurance plan, including co-payments and deductibles. Payments are due at time of service with the exception of extended care plan agreements between you and the Doctor or practice manager. Patients understand that any unpaid balance may be turned over to a collection agency. The patient is responsible for all costs of collections, including attorney's fees, collection fees and court costs. Any unpaid balance will be assessed interest at the rate of 18% per annum (1.5% monthly).

If your insurance company has not paid a claim within sixty (60) days, you will be responsible for following up on the status of payment or you will be responsible for the payment.

We accept cash, checks and Visa/MasterCard/Discover/American Express as payment for our services. On your first visit the Front Desk will ask you to file your credit/debit card or checking/savings account in our secure database.

Checks: There is a $35.00 charge for returned checks. Our practice manager will contact you if a check does not clear the bank. The amount of the returned check and the $35.00 service charge must be paid in cash or money order within five (5) days of the notification.

Copies of your medical records are provided to each patient upon receipt of a signed release form or letter. There will be a charge for copying.

We sincerely appreciate the opportunity to provide you with quality services at the Spine & Scoliosis Clinic. We trust you will feel free to contact us with any concerns or questions you may have concerning your account or care.

____

Responsible Party **Print** Name Date

____

Responsible Party **Signature** Date

PATIENT FULL NAME & ID # (DOB: _______) **DOI:________ CLAIM #:___________________** DATE INITIAL EXAM: **_______**

NOTICE OF PRIVACY PRACTICES

Elizabeth Callen, D.C.

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE REVIEW IT CAREFULLY AND SIGN.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted by law.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time.

Uses and Disclosures of Protected Health Information Based Upon Your Written Consent
You will be asked by your chiropractor to sign this consent/acknowledgment form. By signing the consent/acknowledgment form, your chiropractor, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you may also use and disclose your protected health information to pay your health care bills and to support the operation of the chiropractor's office.

Following are examples of the types of uses and disclosures of your protected health care information that the chiropractor's office is permitted to make once you have signed this consent/acknowledgment form:

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your chiropractic care and any related services. This includes the coordination or management of your chiropractic care with a third party that has already obtained your permission to have access to your protected health information.

Payment: Your protected chiropractic information will be used, as needed, for your chiropractic services. This may include certain activities that your chiropractic insurance plan may undertake before it approves or pays for the chiropractic services we recommend for you such as; making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your chiropractor's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of chiropractic students, substitute chiropractors, doctors who observe our practice, licensing, marketing, fundraising activities, and conducting or arranging for other business activities.

In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may also call you by name in the waiting or adjusting room. We may use your health information to call you to remind you of, cancel or re-schedule an appointment. We may leave a message on your answering machine or voice mail. To promote a less stressful, family friendly and time efficient environment, most office visits are performed in an open area where complete privacy of your name and health information will be respected but cannot be guaranteed. Special appointment times are available by request for discussion of private or confidential matters. We may mail appointment reminders, announcement or greeting cards to your home. Your name or picture may be used on a "Thank You for Referring", "Welcome to Our Office" or office bulletin board unless you specifically request us not to do so. Your private information will be used when we bill insurance claims for you or need to collect an outstanding balance using an outside collection agency.

We may share your protected health information with third party "business associates" that perform various activities (e.g., billing transcription services) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also use and disclose your protected health information for other marketing activities. For example, your name and address may be used to send you a newsletter about our practice and the services we offer. We may also send you information about products or services that we believe may be beneficial to you. You may contact our Privacy Contact to request that these materials not be sent to you.

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You nay revoke this authorization, at any time, in writing, except to the extent that your chiropractor or the chiropractic practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Other Permitted and Required Uses and Disclosures That May Be Made with Your Consent, Authorization or Opportunity to Object

We may use and disclose your protected health care information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your chiropractor may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

NOTICE OF PRIVACY PRACTICES CONTINUED

Others Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your chiropractic care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

Emergencies: We may use or disclose your protected health information in an emergency treatment situation. If this happens, your chiropractor shall try to obtain your consent as soon as reasonably practicable after the delivery of treatment. If your chiropractor or another chiropractor in the practice is required by law to treat you, and the chiropractor has attempted to obtain your consent, but is unable to obtain your consent, he or she may still use or disclose your protected health information to treat you.

Communication Barriers: We may use and disclose your protected health information if your chiropractor or staff member in the practice attempts to obtain consent from you but is unable to do so due to substantial communication barriers and the chiropractor or staff member determines, using professional judgment, that you intend to consent to use or disclosure under the circumstances.

We may use or disclose your protected health information in the following situations without your consent or authorization:
When required By Law, Public Health, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration, Legal Proceedings, Law Enforcement, Funeral Directors, and Organ Donation, Criminal Activity, Military Activity, Inmates and National Security:

Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance.

You have the right to inspect and copy your protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment, health operations or additional uses listed above in paragraph 8. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your chiropractor is not required to agree to a restriction that you request. If your chiropractor believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. If your chiropractor does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for this request. Please make this request in writing to our Privacy Contact.

You may have the right to have your chiropractor amend your protected health information. This means you may request an amendment of protected health information about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint. The terms of this Notice may change. If the terms do change you may receive a revised Notice by contacting our Privacy Contact.

Privacy Contact: Dr. Elizabeth Callen, Office Manager / Production Manager (360) 305-3231

I have received a copy of this office's Notice of Privacy Practices and consent to the use and disclosure of protected health information by Dr. Elizabeth Callen, D.C., staff and business associates for treatment, payment, health care operations and additional uses listed above. I have reviewed, acknowledge, and understand the content of the Notice of Privacy Practices.

"You May Refuse to Sign This." THIS NOTICE WAS PUBLISHED AND BECOMES EFFECTIVE ON APRIL 14, 2003.

Printed Patient Name ____ Date ____________________________________

Signature ____

Printed Name of Parent/Guardian ____

Signature of Parent/Guardian ____

PATIENT FULL NAME & ID # (DOB: _______) **DOI:________** **CLAIM #:__________________** DATE INITIAL EXAM: _______

OUR PURPOSE….

Our purpose is to educate and adjust as many ***families*** as possible toward optimal health, with natural chiropractic care. We take pride in the fact that we only offer corrective chiropractic care – which allows us to return your spine back to its healthiest position. The adjustments are safe, effective, and specific to each individual's problems and needs. We know that you had the choice of choosing from several fine chiropractors in the area- ***Thank you for choosing us!***

ENTRANCE CONSULTATION & EXAM

In order to find out if you have vertebral subluxation (misaligned vertebrae) a specific chiropractic exam is performed on all new patients during their initial visit. These tests involve a postural examination, orthopedic & neurological testing, complete range of motion exam, and a specific history and consultation regarding your spinal health. If necessary, we will perform two to seven x-rays which will help determine the amount of time you have been suffering from vertebral subluxation. Your Doctor's Report will be on the second visit.

READING YOUR X-RAYS AND BEGINNING CARE

After we have had a chance to develop and analyze your x-rays we will know if we can accept your case for care. **On your second visit, we will go over the result of our recent exam and x-rays. We will do this with you and your "support team", a spouse or whoever shares your health concerns, so that you both best understand your problem and its severity. If you are a candidate for chiropractic care, we will begin care immediately**. How you respond to your initial adjustments will help us determine how much care will be necessary to correct your problem. **Recommendations for your specific case and correction rehabilitation cost will be presented to you after our Youth and Vitality Workshop.** The Youth and Vitality Workshop is exclusively for you and your family. Please schedule during your first weeks of care.

HOW LONG? HOW OFTEN? HOW MUCH?

After your initial adjustments, we can: determine how long your correction will take, how often you will need to be adjusted, and how much the total correction will cost. **If you are not the sole financial decision maker in your household, it is imperative that your spouse or whoever handles your finances attends these appointments with you. It is here when our best recommendation for care will be provided, and all financial decisions will be made.**

- If you have insurance, we will gladly verify your coverage for you. Insurances we will bill out include: Blue Cross Blue Shield, Cigna, Aetna, United Health Care and many more.
- If you do not have insurance, we have affordable payment plans available (Ask about our Platinum Plan). Major credit and debit cards accepted.

We look forward to giving you the safest and most effective care available today. Thank you for making your health a priority!

Dr. Betty Callen, D.C. & Cory Callen, C.A. & Team

PATIENT FULL NAME & ID # (DOB: ________) **DOI:_________ CLAIM #:____________________** DATE INITIAL EXAM: _______

NEW PATIENT WORKSHOP HEALTH GOALS

As you now know, our office is completely unique and different. The system is a predictable and the person who has control over its predictability is YOU!

The only way you will make permanent changes in your health is if you chart a course. Please ponder what your true health goals are by answering the questions below. We anticipate phenomenal results. So should you.

1. **Where do you want your health to be in the next 20-50 years?**

____
____
____

2. **What do you want your life to look like?**

____
____
____

3. **What do you want your activity levels to be like?**

____
____
____

4. **Write down your goals.**

____
____
____