Auto / Work Related Accident

About You

Today's Date:_____/_____/_____
Name______________________________
Address____________________________
____
Home Telephone ____________________
Birthdate__________________________
Social Security #____________________

Work Related Accident

Date of Accident ______/______/______
Time of Accident ____________________
Address of employer
____
____
____
____
Employers Telephone ________________
Name of your supervisor:
____
Have you reported your accident to your employer?
Yes No
Briefly describe the events that occurred just before and during your accident:__________
____
____
____
____
____
____
____
____
____
____
____
____

Have you had an accident before? Y N

____

Auto Related Accident

Date of Accident___________________________
Time of Accident___________________________
Were you the: 1- Driver 2-Front Passenger
3-Rear Passenger 4-Pedestrian
How many people were in your car? __________
Was a police report filed? __________________
Were you wearing a seat belt? _______________
Did your car strike the other car? Y N
Did the other car strike your car? Y N
If Yes, from which side were you struck from? (circle one)
Rear Front Rt. Side Lt. side
Who received a traffic violation?
____
Make & Model of the car you were occupying?__________________________
____
Make & Model of the other person's car:
____
____
During impact, were you facing: (circle one)
Right, Left, Forward, I don't remember
Were you aware or surprised by the impact?
____

Did any part of your body collide with any part of the inside of the car? Please describe.__________________________
____
____

In your words, please describe the accident
____
____
____
____
____
____
____
____
____
____
____
____
____
____
____
____
____
____
____
____
____
____

After the Injury

Did the accident render you unconscious?
Yes No

Please describe how you felt immediately after the accident?

_____

_____

_____

_____

Have you gone to a hospital? Y N
How did you get there?
Ambulance or private transportation
Describe any treatment you received:

_____

_____

_____

Was medication prescribed? Y N
Have you missed any days work? If yes, list the dates.

_____

_____

Place an X next to the symptoms that are a result of this accident:

	Neck Pain		Numbness in legs
	Mid-back Pain		Numbness in Arms
	Low-back Pain		Numbness in Hands
	Headaches		Difficulty Sleeping
	Shoulder Pain		Pins & Needles in Arms
	Leg Pain		Pins & Needles in Legs
	Foot/Ankle Pain		Chest Pain
	Nervousness		Dizziness
	Fatigue		Nausea
	Loss of Balance		General Tension
	Jaw Pain		Depression
	Buzzing in Ears		Stomach Upset
	Loss of Memory		Shortness of Breath

Indicate your degree of comfort while performing the following activities by placing an X in the box:

	No Pain	Uncomfortable	Painful
Lying on back			
Lying on side			
Lying on stomach			
Sitting			
Standing			
Stretching			
Walking			
Running			
Bending			
Kneeling			
Pulling			
Pushing			
Reaching			

Recovery

Please place an X in the box next to your daily job duties and any activities that you are occasionally asked to perform:

Hours per day	1-4	4-6	6-8
Standing			
Sitting			
Kneeling/Squatting			
Twisting			
Bending/Stooping			
Pushing/Pulling			
Overhead reaching			
Other reaching			
Grasping/Squeezing			
Typing			
Climbing stairs/ladders			
Walking			
Running			
Operating equipment			
Crawling			
Lifting			
Answering the telephone			

While in recovery, is there any light duty work you could request?

_____

_____

How many hours are in your normal workday?

_____

I hereby swear that all the information given is factual.

_____
Print Name

_____
Signature **Date**

New Mexico Chiropractic Center

Confidential Patient Health Record

Date:_____/_____/_____

Name:_____ Social Security #:_____
Home Phone:_____ Cell Phone:_____
Address:_____
City:_____ State:_____ Zip:_____
E-mail Address: _____ Fax # _____
Age:_____ Birth Date:_____ Gender: Male____ Female____ Race:_____ Marital: M S W D

Occupation:_____ Employer:_____
Employer's Address:_____ Office Phone:_____
Spouse:_____ Occupation:_____ Employer:_____
How Many Children?_____ Ages of Children:_____

Emergency Contact:_____ Phone:_____
Relationship to You:_____

How were you referred to our office?_____

Family Medical Doctor:_____ Phone:_____
When doctors work together it benefits you. May we have your permission to update your medical doctor regarding your care at this office? Yes No

WOMEN ONLY:

Are you pregnant or is there any possibility you may be pregnant? ☐ Yes ☐ No ☐ Uncertain

Date of last Menses / / My menses is ☐ Regular ☐ Irregular

Are you currently taking an oral contraceptive (birth control pill)? ☐ Yes ☐ No

PAST MEDICAL HISTORY:

Have you ever been diagnosed as having or have suffered from any of the following? (Place a check mark by conditions that apply to you.)

☐Broken or Fractured Bones
☐Strokes
☐Eating Disorder
☐Circulatory Problems
☐Alcoholism
☐Pace Maker
☐High/Low Blood Pressure
☐HIV Positive
☐A Congenital Disease
☐Ruptures
☐Diabetes
☐Asthma
☐Kidney Stones
☐Mental Illness
☐Lung Disease
☐Chills
☐Fever
☐Blurred Vision
☐Headaches
☐Numbness
☐Limb Weakness
☐Abdominal Pain
☐Osteoarthritis
☐Cancer
☐Ulcers
☐Epilepsy
☐Coughing Blood
☐Drug Addiction
☐Seizures/Convulsions
☐Excessive Bleeding
☐Gall Bladder
☐Depression
☐Tuberculosis
☐Kidney Disease
☐Liver Disease
☐Heart Disease
☐Rheumatoid Arthritis
☐Unintentional Weight Loss
☐Night Sweats
☐Dizziness
☐Slurred Speech
☐Facial Weakness
☐TMJ Problems
☐Blood Clots

Please explain any checked conditions:

Do you have a history of stroke or hypertension? ☐ Yes ☐ No
Have you had any major illness, hospitalization, injury, fall, auto accident or surgery? ☐ Yes ☐ No
If yes, explain:

Women, please include information about childbirth (include dates):
Have you been treated for any health condition by a physician in the last year? ☐ Yes ☐ No
If yes, explain:
What medications or drugs are you taking?
Do you have any allergies to any medications, nutritional products or food? ☐ Yes ☐ No
If yes, describe:
Do you have any allergies of any kind? ☐ Yes ☐ No
If yes, describe:
Please list any other health problems you have, no matter how insignificant they may be:

SOCIAL HISTORY:

Do you drink alcoholic beverages? ☐ Yes ☐ No: If yes, how many drinks per week?
Do you use any tobacco products? ☐ Yes ☐ No: If yes, what kind:_____
Do you smoke? ☐Yes ☐ No: If yes, how many packs per day:_____
Do you take vitamin supplements? ☐Yes ☐No: If yes, please list:_____

Do you consume caffeine? ☐ Yes ☐ No If yes, how much per day:
Do you exercise? ☐ Yes ☐ No If yes, what is the frequency and type of exercise?

What are your hobbies?

What percentage of time during the day (at home or at your job away from home) do you spend:

Lifting_____ Sitting_____

Bending _____ Working at a computer_____

FAMILY HISTORY:

Father: ☐living ☐ deceased
Current age if still living: Cause of death and age at death if deceased:
Mother: ☐living ☐ deceased
Current age if still living: Cause of death and age at death if deceased:_____ Check if applicable to you: ☐As an adopted child, little is known of birth parents or family.
Do you have any family members who suffer from the same condition you do? ☐ Yes ☐ No
If yes, please list:

FAMILY HISTORY:

Father: ☐ living ☐ deceased
Current age if still living: Cause of death and age at death if deceased:
Mother: ☐ living ☐ deceased
Current age if still living: Cause of death and age at death if deceased:
Check if applicable to you: ☐ As an adopted child, little is known of birth parents or family.
Do you have any family members who suffer from the same condition you do? ☐ Yes ☐ No
If yes, please list:

FAMILY DISEASES: (Check if applicable and indicate Father, Mother, Sister or Brother):

☐ Tuberculosis
☐ Cancer
☐ Mental Illness
☐ Diabetes
☐ Asthma

☐ Heart Disease
☐ Stroke
☐ Kidney Disease
☐ Lung Disease
☐ Arthritis

☐ Liver Disease
☐ Other
Explain:

Patient's Signature: _____ Date: _____

Guardian's Signature Authorizing Care: _____ Date: _____

Notice of Informed Consent

New Mexico Chiropractic Center

Every type of health care is associated with some risk of a potential problem. This includes chiropractic care. We want you to be informed about chiropractic care and the potential problems associated with it before consenting to treatment.

Subluxation is a medical term that describes what occurs when one or more of the spinal (vertebral) joints have moved out of their normal alignment. This can occur through recent or remote trauma as well as unusual positions we may find ourselves in throughout the day or night. A subluxation has also been described as an incomplete dislocation of a joint, and, as such, is not treated with drugs or surgery. Chiropractors treat vertebral subluxation with spinal manipulations (adjustments performed by hand or with the use of a specific tool) in order to gently reposition the misaligned segments. Frequently, adjustments create a popping or a clicking sensation in the area being treated.

Stroke: Recent reports have shown an elevated incidence of stroke is seen equally in chiropractic and medical physician offices (Cassidy, 2008); supporting the theory that patients are presenting with a stroke, and not that chiropractors or medical physicians are causing a stroke.

Disc Herniation: Disc herniations that create pressure on the spinal nerves or the spinal cord in the neck or low back are treated successfully by chiropractors with adjustments and spinal decompression. Occasionally, these treatments can irritate this problem. Patients are thoroughly examined to determine the best course of treatment. Disc herniation complications occur so rarely there are no available statistics to quantify their probability.

Soft Tissue Injury: Soft tissue refers primarily to the muscles, tendons, and ligaments. Muscles move bones, and ligaments limit joint movement. Rarely, a chiropractic adjustment, traction, massage, and other treatments may strain some muscle or ligament fibers. These possible injuries also occur so rarely there are no available statistics to quantify their probability.

Rib Fractures: Your ribs are attached to the thoracic spine in the middle back. They extend from your back to the front of your chest. Rarely, a chiropractic adjustment may break a rib. This could possibly occur only to those patients with weakened bones. It is your responsibility as the patient to inform your doctor of any history of osteoporosis, prolonged steroid use, or other bone-weakening diseases. Rib fractures also occur so rarely there are no available statistics to quantify their probability.

Physical Therapy Irritations: Some therapeutic machines and analgesic balms generate heat. Different forms of heat and ice may be applied in the office and occasionally recommended for use at home. Rarely will

heat or ice irritate the skin. However, everyone's skin has a different sensitivity to these modalities and the application of such may cause a temporary increase of skin pain and possibly some blistering. These possible irritations also occur so rarely there are no available statistics to quantify their probability. **Please be sure to follow the doctor's specific instructions for home application if prescribed.**

Soreness: It is not uncommon for spinal adjustments, Active Release Therapy, exercise, and other therapies to result in a temporary increase in soreness to the area being treated. This is nearly always a temporary symptom that occurs while your body is undergoing therapeutic change. It is not dangerous, but please inform the doctor if you experience soreness.

At New Mexico Chiropractic Center (NMCC) we employ highly-trained staff to assist the doctors with portions of your consultation, examination, x-rays, physiotherapy, exercise instruction, and other treatments. Occasionally, when your doctor is not available, another NMCC doctor will be available to treat you.

Any questions on the above information should be directed to your doctor. When you have a full understanding of this material, please sign and date below.

Authorize to Treat: I, the undersigned, hereby authorize all NMCC doctors and whomever they designate to administer chiropractic, physical therapy, and/or therapeutic treatment or medical procedures they consider necessary on the basis of findings during the set course of treatment.

Patient Name:_____ **Date:**_____

Patient Signature:_____ **Witness:**_____

Consent for Treatment of a Minor: I, the undersigned, hereby authorize all NMCC doctors and whomever they designate to administer chiropractic, physical therapy, and/or therapeutic treatment or medical procedures they consider necessary on the basis of findings during the set course of treatment to:

Minor Child's Name:_____ **Date:**_____

Parent/Guardian Name:_____

Parent/Guardian Signature:_____ **Witness**_____

X-RAY PREGNANCY WAIVER

I hereby acknowledge New Mexico Chiropractic Center has informed me prior to being x-rayed of the risk and the probable consequences of receiving x-rays during pregnancy. Prior to being x-rayed, I state of my own volition I am not pregnant and do hereby release and hold harmless New Mexico Chiropractic Center from any legal action or responsibility associated with the x-ray procedure.

_____
Printed Name of Patient

_____ _____
Signature of Patient/Authorized Rep. of Patient Date

_____ _____
Witness Date

Patient Acknowledgement and Receipt of Notice of Privacy Practices Pursuant to HIPAA and Consent for Use of Health Information

Name_____ Date_____
Print Patient's Name

The undersigned does hereby acknowledge that he or she has received a copy of New Mexico Chiropractic Center's Notice of Privacy Practices Pursuant To HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request.

The undersign does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State law and Federal Law.

Dated this _____ day of _____, 20___

By_____
Patient's Signature

If patient is a minor or under a guardianship order as defined by State law:

By_____
Signature of Parent/Guardian (circle one)

New Mexico Chiropractic Center

10555 Montgomery Blvd. NE Bldg. 1 Suite 30

Albuquerque, NM 87111

PH: 505-299-6622 Fax: 505-323-4419

Office Policies for Personal Injury Patients

This office will accept you as a new patient based on our clinical examination and belief that chiropractic care will be effective for the treatment of you injuries. Your responsibility to this office will be to follow the doctor's recommend treatment plan and to provide the appropriate financial information so that payment for services can be received.

Patients need to bring the following by the second visit

1. Name of insurance company for the responsible party
2. Claim number
3. Adjusters name and phone number
4. Name and phone number of attorney if one has been retained-(if at any point an attorney is retained or if a change of representation occurs, it is your responsibility to inform our office)

If you need to miss an appointment, it is your responsibility to make up that appointment within 7 days or your case may be terminated and released from our care.

Following completion of you treatment and care in this office, your bill will be forwarded to the appropriate party (third party insurance/ attorney). Please note that this account is still your responsibility and will be subject to monthly interest charges of 2.5% effective immediately after the date of any settlement made with non-payment to our office.

Name: _____

Signature:_____ Date: _____

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Motor Vehicle Accident coverage

(Check each that apply to your personal injury case)

_____ **Liability** (this is the other persons insurance/responsible party)

Name of Insured: _____

Name of Insurance Co.: _____

Claim #: _____

Claims Adjuster name: _____

Adjuster phone #: _____

Insurance mailing address: _____

_____

_____ **Medical payments** (benefit under your own auto insurance)

Name of Insured: _____

Name of Insurance Co.: _____

Claim #: _____

Claims Adjuster name: _____

Adjuster phone #: _____

Insurance mailing address: _____

_____

_____ **Attorney Representation** (must have letter of representation by third visit)

Law Firm: _____

Phone #: _____ Contact Person: _____

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To any insurance company with coverage applicable to my claim(s) and to any attorney representing me:

IN CONSIDERATION of the willingness of **New Mexico Chiropractic Center** to treat me on credit without demand for payment at the time the services are rendered, I hereby agree and stipulate as follows: I irrevocably assign to **New Mexico Chiropractic Center** any proceeds or compensation that I am or may become entitled to receive as a result of my injuries that occurred on _____ to the extent of the chiropractic services rendered. I make this agreement without prejudice to any rights I may have to prosecute legal claims against any party who may be liable for my injuries, but I hereby authorize and instruct you to directly pay **New Mexico Chiropractic Center** from any disability benefits, medical payments benefits, Liability benefits, health and accident benefits, workers compensation benefits, judgments, settlements, or proceeds of any kind that would otherwise be payable to me, such sums as are due to **New Mexico Chiropractic Center** for its services rendered

I appoint **New Mexico Chiropractic Center** as my attorney in fact to affix my name as an endorsement upon the reverse of any check or draft upon which I am the named payee and to deposit said check or draft and apply the proceeds to any unpaid balance I may have with **New Mexico Chiropractic Center**. I authorize **New Mexico Chiropractic Center** to release to any insurer with applicable coverage or to my attorney or successor attorney any information regarding my injuries, prior medical history, or treatment as may be necessary to facilitate collection of proceeds under this assignment. I acknowledge that I remain personally liable for the total amount due to **New Mexico Chiropractic Center** for services rendered, including any balance remaining after the application of insurance payments and settlement or judgement proceeds. If New Mexico Chiropractic Center is required to take legal action against me to recover any unpaid balance on my account, I agree to reimburse **New Mexico Chiropractic Center** for its cost of recovery, including reasonable attorney's fees.

Patient: _____ Date: _____

Witness: _____ Date: _____

Pursuant to N.C.G.S 44-49 and 44-50, New Mexico Chiropractic Center hereby asserts and gives notice of a lien upon any sums recovered in damages for personal injury in any civil action and also upon all funds paid to the above named patient in compensation for or settlement of injuries sustained, whether in litigation or otherwise. New Mexico Chiropractic Center hereby requests that if its claim is not paid in full from the foregoing proceeds, a full discloser and accounting of proceeds be provided in conformity with N.C.G.S 44-50. New Mexico Chiropractic Center agrees to be bound by any confidentiality agreements regarding the contents of accounting

Patient: _____ Date: _____

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Medical Payments (Medpay) Information

A lot of people have benefits (Medpay) included as an extra benefit on their automobile insurance policies and don't even realize it. Our office highly recommended that you use your Medpay coverage, if you have it, in the event that you have been injured in an automobile accident, regardless of who's at fault.

Here are 3 reasons why we recommend that we file to your Medpay.

1. **Medpay is similar to regular health insurance. It is an extra payment you make on top of your regular premium**-The benefits is usually in the amount of 5,10,20 or 25 thousand. Please inform us of the amount available to you so we make keep track during the course of treatment. Using your Medpay benefits will not cause your rate to increase like a bodily injury claim would. If your rates increase, it is not because you filed to your Medpay, its most likely because a) it was determined the accident was your fault, b) you received the police citation or ticket, or c) you've been involved in numerous reported auto accidents within a brief period of time and therefore are now considered "high-risk".
2. **Filing your Medpay doesn't relieve the other party form having to pay in full for your loss.** On the contrary, by filing your Medpay, when you collect from the other driver's liability insurance, a greater amount of settlement will go directly to you because your bill in our office may* be paid in full by your Medpay. If the other driver's liability insurance refuses to make payment to you for whatever reason, filing to you Medpay will help to insure that you are not stuck with all the medical bills.
3. **If you have Medpay coverage and choose not to file it, then you are paying for an extra option and not receiving the benefit.**

Name: _____ Date: _____

Signature: _____

*if the total balance for services rendered is more than your medical payments and the Medpay is exhausted we may still be able to file the remaining to a liable third party. If the accident was deemed your fault then the remainder of the bill after medical payments is your responsibility.

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Election to Pursue Liability Claim and NOT Health Insurance Claim

The staff of New Mexico Chiropractic Center has advised me that the cost of any treatment for injuries subsatined in an automobile accident that occurred on _____ may be covered in whole or part by both my own health insurance and by the liability insuance of the party at fault.

The clinic staff has informed me that if I file to my own health insurance, I will be responsible for paying deductibles, Co-insurance and Co-payments according to your insurance benefits and that any such payment is due at the time treatment is received. The office will be required to inform your insurance that the claims are due to an auto accident. The staff has also informed that if my health insurance makes any payments towards the cost of treatment and I sucessfuly pursue a claim against the liable party, I will be required to reimburse my health insurer for any sums it has paid either to me or to my treating physicians.

I have decided that I do not wish to file any claims on my own health insurance. I hereby direct and authorize the clinic to send bills and treatment records only to my attorney, or the liability insurance carrier, or to my own automobile insurer for the purpose of receiveing payment under my Medical Payments, Uninsured or Under-Insured motorist coverage is applicable.

I understand that the clinic will rely on my decision and render treatemtne based on the assumption that payment will be recvied from sources other than my health insurance. I will not be expected to pay deductible and co-payments, and third-party payers will be billed at the clinic's usual rates rather that at a discounted rate that may apply to in-network providers.

I understand for that if for any reason, my liability cliam is ultimately denied, compromised or ligated unsuccessfully, I will remain personally liable for the reasonable value of the treatment rendered to me by the clinic.

Patient signature: _____ Date: _____

Witness: _____

Agreement for Chiropractic Services (Personal Injury)

_____(hereinafter referred to as "Patient"), in consideration of the terms and conditions set forth herein, agrees to accept full financial responsibility for all professional services rendered by New Mexico Chiropractic Center including but limited to chiropractic treatments, examinations, adjustments, x-rays, computer-related analysis, treatments, other therapies and supplies. In the event payment is not received within 45 days of a Patient's release from care, Patient hereby authorizes New Mexico Chiropractic Center to charge the Patient's credit card noted below in full the outstanding balance owed by Patient plus a 2.5% processing fee. By signing below, Patient acknowledges and agrees the authorization to charge Patient's credit card shall automatically transfer to any successors or assigns of New Mexico Chiropractic Center. In the event the outstanding balance due is not satisfied in full from Patient's credit card, the Patient agrees to pay the outstanding balance upon demand by New Mexico Chiropractic Center. Patient agrees to pay attorney fees and costs incurred by New Mexico Chiropractic Center in connection with efforts to collect any balance owed by Patient along with interest at the rate of 1 ½ percent per month on the outstanding balance due from the date of last service or treatment until paid in full.

Patient name on credit card:_____

Billing address:_____

_____

Type of card: Visa, Mastercard, Discover

Card Number:_____**Expiration Date:**_____

Three digit verification code from back of card:_____

Authorized Signature:_____ **Date:**_____