PERSONAL INJURY QUESTIONAIRE

PATIENT INFORMATION

Name: _____ Date: _____
Phone: ( ) _____ Cell: ( ) _____ Preferred #: ( ) _____
Address: _____
City: _____ State: _____ Zip: _____
Age: _____ Birthdate: _____ SS#_____
Sex: Male____ Female____ Marital Status: Single____ Married____ Legally Separated_____ Other_____
E-mail Address: _____
Employers Name: _____ Work Phone: ( ) _____
Employers Address: _____
Insurance Company: _____
Policy # _____ Agent: _____
Name on Policy (if other than self): _____
Responsible Party's Name: _____
Address: _____
Policy Holder's Name: _____ Policy #: _____

ATTORNEY INFORMATION

Name: _____ Phone: ( )_____
Address: _____
City: _____ State: _____ Zip: _____

NATURE OF ACCIDENT

Date of Accident: _____ Time of Day: _____
Where were you in the vehicle: ____Driver ____ Passenger____ Front Seat ____ Back Seat____
Number of People in your vehicle: _____ Were you wearing a seat belt? _____
What direction was you headed? _____ North _____ South _____ East _____ West
Name of Street: _____ Were there any witnesses? _____Yes _____ No
What direction was the other vehicle headed? _____ North _____ South _____ East _____ West
Where were you struck from? _____Behind _____Front _____Left Side_____ Right Side
What was the approximate speed of your vehicle? _____Mph Other Vehicle? _____Mph
Were you knocked unconscious? _____Yes _____No If yes, for how long? _____
Were the police notified? _____ Yes _____No
In Your Own Words, please describe the accident: _____
_____
_____
_____

Did you have any physical complaints **BEFORE THE ACCIDENT**? _____ Yes _____ No
If yes, Please describe: _____
_____
_____

_____

Name:_____ **Date:**_____

Please describe how you felt?

IMMEDIATELY AFTER the accident: _____

LATER THAT DAY: _____

THE NEXT DAY: _____

What are your present complaint(s) and symptom(s)? _____

_____

_____

Where were you taken after the accident? _____

Was it by ambulance? _____ Yes _____ No

Do you have any congenital (from birth) factors which relate to this problem? _____ Yes _____ No

If yes, please describe: _____

Do you have any previous illnesses which relate to this case? _____ Yes _____ No

If yes, please describe: _____

Have you ever been involved in an accident before? _____ Yes _____ No

If yes, please include date(s) and type(s) of accident(s) and the injuries received: _____

_____

_____

Have you ever been treated by another doctor since the accident? _____ Yes _____ No

If yes, list doctor's name and address: _____

_____

_____

What type of treatment did you receive? _____

_____

Since this injury occurred, are your symptoms: _____Improving _____Getting Worse _____ Same

CHECK SYMPTOMS YOU HAVE NOTICED SINCE THIS ACCIDENT:

___Headaches	___Irritability	___Numbness in Toes	___Face Flushed
___Neck Pain	___Chest Pain	___Shortness of Breath	___Buzzing in Ears
___Neck Stiff	___Dizziness	___Fatigue	___Loss of Balance
___Sleeping Problems	___Head Seems Heavy	___Depression	___Fainting
___Back Pain	___Pins and Needles in Arms	___Lights Bother Eyes	___Loss of Smell
___Nervousness	___Pins and Needles in Legs	___Loss of Memory	___Loss of Taste
___Tension	___Numbness in Fingers	___Ears Ring	___Diarrhea
___Feet Cold	___Hands Cold	___Stomach Upset	___Constipation
___Cold Sweats	___ Other: _____		

Have you lost time from work as a result of this accident? _____ Yes _____ No If yes, please complete:

a. Last Day Worked:_____
b. Type of Employment:_____
c. Present Salary:_____
d. Are you being compensated for lost time at work? _____ Yes _____ No
e. If yes, please explain:_____

Do you notice any activity restrictions as a result of this injury? _____ Yes _____ No

If yes, please explain: _____

_____

Other pertinent information: _____

_____

Patient's Signature: _____ **Date:**_____

Review of Systems:
Please check all that apply

PATIENTS NAME:_____
DATE:_____

Cardiovascular				Respiratory				Allergic			
	Past	Present	No		Past	Present	No		Past	Present	No
Poor Circulation				Asthma				Hives			
Hypertension				Tuberculosis				Immune Disorder			
Aortic Aneurism				Short of Breath				HIV/AIDS			
Heart Disease				Emphysema				Allergy Shots			
Heart Attack				Cold/Flu				Cortisone Use			
Chest Pains				Cough							
High Cholesterol				Wheezing							
Pace Maker											
Irregular Heartbeat				Eyes				Ear/Nose/Throat			
Swelling of Legs					Past	Present	No		Past	Present	No
				Glaucoma				Difficulty Swallowing			
				Double Vision				Dizziness			
Genitourinary				Blurred Vision				Hearing Loss			
	Past	Present	No					Sore Throat			
Kidney Disease				Psychiatric				Nosebleeds			
Burning Urination					Past	Present	No	Bleeding Gums			
Frequent Urination				Depression				Sinus Infection			
Blood in Urine				Anxiety							
Kidney Stones				Stress				Gastrointestinal			
Lower Side Pain									Past	Present	No
				Endocrine				Gall Bladder			
Neurologic					Past	Present	No	Bowel Problems			
	Past	Present	No	Thyroid				Constipation			
Stroke				Diabetes				Liver Problems			
Seizures				Hair Loss				Ulcers			
Head Injury				Menopause				Diarrhea			
Brain Aneurysm				Menstrual				Nausea			
Numbness								Vomiting			
Severe Headaches				Hematologic				Bloody Stool			
Pinched Nerves					Past	Present	No	Poor Appetite			
Parkinson's				Hepatitis				Musculoskeletal			
Carpal Tunnel				Blood Clots					Past	Present	No
Vertigo				Cancer				Gout			
				Bruising				Arthritis			
Constitutional				Bleeding				Joint Stiffness			
	Past	Present	No	Fever/Chills				Muscle Weakness			
Weight Loss				Sweating				Osteoporosis			
Weight Gain								Broken Bones			
Low Energy								Joint Replacement			
Female				Male							
	Past	Present	No		Past	Present	No				
Menstrual Irregularity				Prostate Problems							
Menstrual Cramping				Sexual Dysfunction							
Vaginal Pain/Infections											
Breast Pain/Lumps											

PATIENT INITIALS_____

DOCTOR INITIAL'S_____

Dr. Lena K. Fugate, D.C., CICE

Dr. Josh B. Bakun, D.C.
M.S. Sport Health Science

Fugate Family Chiropractic

PHONE: 606-439-3399 * FAX: 606-487-9280 * 100 Veterans Dr. * HAZARD, KY 41701

Name: _____ Date: _____

Patient Demographics:

Race: _____

Preferred Language: _____

Gender: _____Male _____Female

Ethnicity: _____

Preferred Contact Method: ___Phone ___Email ___Cell Phone Number: _____

Emergency Contact Information: Contact Name _____

Contact Number _____

Do you smoke? ___YES ___ NO If so, how much? _____

PLEASE DESCRIBE MEDICATIONS YOU ARE CURRENTLY TAKING:

(Name, Strength, Dose, Frequency, How is it taken, and date started)

1. _____
2. _____
3. _____
4. _____
5. _____

PLEASE DESCRIBE ALLERGIES YOU HAVE, THE REACTION, AND THE ONSET DATE:

1. _____
2. _____
3. _____
4. _____
5. _____

OFFICE USE ONLY

PATIENT VITALS:

Height: _____ Right Arm BP: _____/_____ Pulse: _____

Weight: _____ Left Arm BP: _____/_____

NAME:_____ DATE:_____

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Consent for Purposes of Treatment, Payment, and Health Operations

I consent to the use or disclosure of my protected health information by Fugate Family Chiropractic for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Fugate Family Chiropractic. I understand that diagnosis or treatment of me by Dr. Fairlena K. Fugate, DC or Dr. Joshua B. Bakun, DC may be conditioned upon my consent as evidence by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practices. Fugate Family Chiropractic is not required to agree to the restriction that I may request. However, if Fugate Family Chiropractic agrees to a restriction that I requested, the restriction is binding on Fugate Family Chiropractic and Dr. Fairlena K. Fugate, DC and Dr. Joshua B. Bakun, DC.

I have the right to revoke this consent, in writing, at any time, except to the extent that Dr. Fairlena K. Fugate, DC and Dr. Joshua B. Bakun, DC or Fugate Family Chiropractic has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physicians, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present, or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review Fugate Family Chiropractic's Notice of Privacy Practices prior to signing this document. Fugate Family Chiropractic's Notice of Privacy Practices has been provided to me. This Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Fugate Family Chiropractic. The Notice of Privacy Practices also describes the rights and Fugate Family Chiropractic's duties with respect to my protected health information.

Fugate Family Chiropractic reserves that right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____
Signature of Patient or Personal Representatives

_____
Name of Patient or Personal Representative

_____
Description of Personal Representatives Authority

_____
Date

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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review that notice prior to signing this consent.
- The right to object to the use of my health information for directory purposes.
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

_____ _____

Patient Signature (or Parent/Legal Guardian) Date

Our office, at the discretion of the Doctors, routinely discloses information such as, but not limited to, appointment time and date, account information (financial), and treatment information to family members (i.e.: spouse, parent, or sibling). Information of extremely private nature is never disclosed to anyone. Please indicate below should you wish information shared or restricted:

Share appointment information with spouse _____ Yes _____ No
Share appointment information with family members' _____ Yes _____ No
Share treatment information with spouse _____ Yes _____ No
Share treatment information with family members' _____ Yes _____ No
Share financial information with spouse _____ Yes _____ No
Other allowed disclosure or restriction: _____

_____ _____

Signature of Patient or Legal Guardian Date

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PHYSICIANS LIEN

TO ATTORNEY: _____

PATIENT/CLIENT: _____

I hereby authorize the above named provider to furnish you, my attorney, with a full report of their examinations, diagnosis, treatments, prognosis, etc., of myself in regard to the accident in which I was involved.

I hereby authorize and direct you, my attorney, to pay directly to said provider such sums as may be due and owing them for professional services rendered me by reason of this accident and to withhold such sums from any settlement, judgment, or verdict as may be necessary to adequately protect said provider. I hereby further give a lien on my case to said provider against any and all proceeds of any settlement, judgment, or verdict which may be paid to myself as a result of the injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly responsible to said provider for all professional bills submitted by said provider for services rendered to me and that this agreement is made solely for them awaiting payment and is not contingent on any settlement, judgment, or verdict by which I may eventually recover said fee.

PATIENT'S SIGNATURE: _____ **DATE:** _____

The undersigned, being attorney of record for the above patient does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment, or verdict as may be necessary to adequately protect said provider.

ATTORNEY'S SIGNATURE: _____ **DATE:** _____

AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Complete all Sections, Date, and Sign

I. I, _____ hereby voluntarily authorize the disclosure of information from my health record.

II. The information is to be disclosed by: And to be provided to:

NAME OF FACILITY:	NAME OF RECIPIENT:
ADDRESS:	ADDRESS:
CITY/STATE:	CITY/STATE:
PHONE NUMBER:	PHONE NUMBER:

Patient Name: _____ Date of Birth: _____
Social Security Number: _____

III. The purpose(s) or need for this disclosure is:

- o Further Medical Care
- o Personal Use
- o Attorney
- o Insurance Use
- o Other:_____

IV. The information to be disclosed from my health record (check all that apply)

___ Inpatient Progress Notes	___Laboratory Test(s)	___ Same Day Surgery Record
___ History & Physical	___ Radiology Report(s)	___ Other:
___Outpatient Clinic Records	___ Pathology Report(s)	
___Emergency Record	___ Complete Medical Records	

Period of time of event(s) from _____ to _____

If you would like any of the following sensitive information disclosed, initial the space next to the source.

_____ HIV/AIDS Related Treatment/Tests _____ Psychotherapy Notes _____ Genetic Testing

_____ Alcohol/Drug Abuse Treatment/Referral _____ Sexually Transmitted Diseases

V. Expiration: This authorization shall become effective immediately and shall remain in effect until (enter specific date) _____ If no date is given, the authorization shall be valid for one year from the date of signing.

VI. Rights: I understand: I have the right to revoke this authorization by written request at any time; my revocation will be effective upon receipt, but will have no impact on uses or disclosures made while my Authorization was valid; my records may be subject to re-disclosure by recipient(s) and unprotected by Federal or State law; I may inspect a copy of my Protected Health Information to be used or disclosed under this Authorization; I may refuse to sign this Authorization and my refusal will not affect my eligibility for care or condition treatment; and a copy of this signed, dated Authorization shall be effective as the original.

SIGNATURE OF PATIENT: _____ **DATE:** _____

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NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Uses and Disclosures

We may use or disclose your protected health information without your written consent, written authorization, or oral agreement for the following purposes:

Treatment: We may use your health information within our office to provide health care services to you or we may disclose your health information to another provider if it is necessary to refer you to them for services.

Payment: We may disclose your health information to a third party such as an insurance carrier, an HMO, a PPO, or your employer, in order to obtain payment for services provided to you.

Health Care Operations: We may use your health information to conduct internal quality assessment and improvement activities and for business management and general administrative activities.

We may use or disclose your protected health information without your written consent, written authorization, or oral agreement under the following circumstances:

If we provide services to you while you are an inmate.

If we provide services to you in an emergency treatment situation.

If we are required by law to provide services to you and we were unable to obtain you consent after attempting to do so.

If there are substantial barriers to communicate and we determine, in the exercise or our professional judgment, that you intend for us to treat you.

If we need to notify, or assist in the notification of, a family member, personal representative, or another person responsible for your care or your location, general condition or death.

If we are required by law to disclose your health information to a public health authority that is authorized to receive information for the purposes of preventing or controlling disease, injury, or disability.

If we are required by law to disclose your health information to a public health or other government authority that is authorized to receive reports of child abuse or neglect.

If we are required to disclose your health information to the Food and Drug Administration.

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If we are required to disclose your health information to your employer to evaluate whether you have a work-related injury or illness.

If we are required by law to disclose your health information to a government authority authorized to receive reports of abuse, neglect, or domestic violence.

If we are required to disclose your health information to a health oversight agency for oversight activities required by law.

If we are required to disclose your health information in response to a court order or a subpoena.

If we are required to disclose health information to a law enforcement official.

If we are required to disclose your health information to a coroner, medical examiner, or funeral director.

For research purposes.

If we, in good faith, believe that the use or disclosure of your health information is necessary to prevent a serious threat to the health or safety of others.

If we are authorized by law to disclose your health information to comply with laws established to provide benefits for work-related injuries or illnesses.

WITH THE EXCEPTION OF THE ABOVE CIRCUMSTANCES, ANY USE OR DISCLOSURE OF YOUR HEALTH INFORMATION WILL BE MADE ONLY WITH YOUR WRITTEN AUTHORIZATION. YOUR WRITTEN AUTHORIZATION MAY BE REVOKED, IN WRITING AT ANY TIME EXCEPT TO THE EXTENT THAT WE HAVE PROVIDED SERVICES OR TAKEN ACTION IN RELIANCE ON YOUR AUTHORIZATION.

II. Your Rights

Right to Request Restrictions. You have the right to request restrictions on certain uses and disclosures of your health information. However, we are not required to agree to the requested restrictions. Your request to limit the use and/or disclosure of your health information must be made in writing to our Privacy Official.

Right to Receive Confidential Communications. You have the right to receive confidential communications concerning your health information. Your request to receive confidential communications must be made in writing to our Privacy Official. We will accommodate all reasonable requests by you to receive your health information at a place other than your home address or by means other than regular mail.

Right to inspect and/or Copy. You have the right to inspect and/or copy certain health information for as long as that information remains in your record. Your request to inspect and/or copy your health information must be made in writing to our Privacy Official.

Right to Amend. You have the right to request that we amend certain health information for as long as that information remains in your record. Your request to amend your health information must be made in writing to our Privacy Official and you must provide a reason to support the requested amendment.

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Right to Receive an Accounting. You have the right to receive an accounting of your disclosures of your health information made six years prior to the date of your request. We will provide you with the first accounting in any 12 month period at no charge. There will be a fee charged for any subsequent request. Your request to receive an accounting must be made in writing to our Privacy Official. The accounting will not include the following disclosures:

Disclosures made to carry out treatment, payment and health care operations;
Disclosures made to you;
Disclosures made to our facility directory;
Disclosures made to individuals involved with your care;
Disclosures made for national security or intelligence purposes;
Disclosures made to correctional institutions or law enforcement officials; and
Disclosures made prior to the compliance date of the HIPAA Privacy Rule.

Right to Receive Notice: You have the right to receive a paper copy of this Notice, upon request.

III. Our Duties

We are required by law to maintain the privacy of protected health information and to provide you with notice of our legal duties and privacy practices with respect to your protected health information.

We must abide by the terms of this Notice while it is in effect. However, we reserve the right to change the terms of this notice and to make the new notice provisions effective for all of the protected health information that we maintain. If we make a change in the terms if this Notice, we will notify you in writing and provide you with a paper copy of the new Notice, upon request.

IV. Complaints

You may complain to us and to the Secretary of Health and Human Services if you believe your privacy rights have been violated. You may file a complaint with us by writing to our Privacy Official at the address that follows. We will not take any action against you for filing a complaint.

Fugate Family Chiropractic
100 Veterans Dr.
Hazard, KY 41701

V. How to Contact Us

If you would like further information about our privacy practices, please contact:

Fugate Family Chiropractic
100 Veterans Dr.
Hazard, KY 41701
Phone: (606) 439-3399
Fax: (606) 487-9280