Achieve Health Chiropractic Clinic

AUTOMOBILE ACCIDENT HISTORY

Name_____Date of Birth_____
Driver License #_____
Insurance Company_____Name of Agent_____Phone #_____
Address of Insurance Company_____Claim #_____
Have you retained an attorney?_____Name, Address & Phone # of Attorney_____
_____

General Symptoms

Did you hit any part of your body during the collision, for example: head on dash board, chest on steering wheel? Yes_____ No_____ If yes, which part?_____
_____
Were you hospitalized? Yes_____No_____If yes, how long?_____
Did you receive care from any other doctor or health care specialist?_____
If yes, what is the doctor, or specialist's name, address and phone number?_____
_____
What type of care were you given and for how long?_____
What are your current symptoms?_____
Please rate your current pain: *lowest* 0 1 2 3 4 5 6 7 8 9 10 *highest*
Has the pain increased, decreased or stayed the same since your accident?_____
Have you ever been injured in a similar manner? Yes____No____If yes, when and how?_____
_____

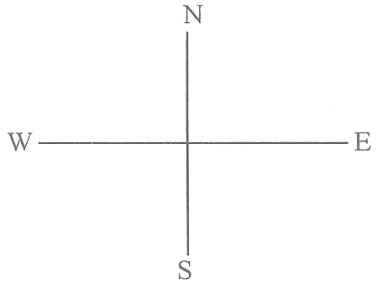
Accident History

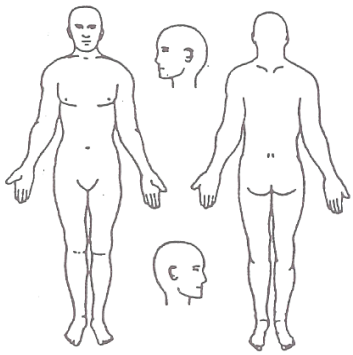
Date of Accident_____ Time of accident_____
State how the accident happened in your own words_____
_____
_____
What type of vehicle were you in? Make_____Year_____
Were you driving?_____Was it your car?_____If not whose?_____
Were you a passenger? _____If yes what seat were you in?_____
Other people in the car?_____Names of other people_____
_____
Were seat belts on?_____Shoulder harness?____What was the posted speed limit?_____
Were you at a stop sign?_____Traffic light_____Intersection_____Highway_____Other_____
Was your car hit on the front?_____Back_____Left Side_____Right Side_____
What damage was done to your car? Inside_____
Outside_____
Any other details_____

Did your vehicle strike anything?_____If yes, another car_____Sign_____Tree_____
Bridge_____Hedge_____An Embankment_____Other_____
Were you completely conscious after the inpact?_____Do you remember the impact?_____
Did your vehicle go off the road?_____If so did it go into a ditch?_____Embankment_____
Other_____
Was the vehicle involved in the accident a car?_____Truck____Motorcycle____Other_____
What was the size and make of the involved vehicle?_____
Was an accident report made?_____Police of: City_____County_____State____

Were any tickets given?_____For what?_____
Have you had any time loss from work?_____If yes, from_____to_____

Please draw the accident





Mark the area of pain
+++ Burning
000 Stabbing
- - - Sharp
I I I Constant

Medical History

If female, are you pregnant or is there a chance you could be pregnant?_____
What medications are you currently on?_____
_____
What medical conditions or surgeries have you had in the past or currently have now?_____
_____
_____
Have you been in any other accidents?_____Explain_____
_____
_____
Have you ever been hospitalized?_____Explain_____
_____
_____

Signature_____Date_____

Achieve Health Chiropractic Clinic
Personal Injury Policy

Achieve Health Chiropractic Clinic is committed to the care and health of you and your injury whether from an automobile accident or personal injury. Your care is very important to us and our goals for you are a life brimming with health and vitality.

Personal injuries are handled somewhat differently at our office as we will be dealing with your auto insurance, your health insurance and possibly an attorney. It is important when obtaining our services, that you seek the assistance of an attorney to help you with your personal injury.

To best serve you and your needs, our office requires that we have the following information when you become a patient at our practice.

1. Valid Driver's license
2. Auto insurance information
3. Health insurance information
4. Current major credit card on file
5. Lien signed by you and your attorney

Once your care begins here, we will submit all bills to your auto insurance company. If at any time a bill is denied, on hold, or either of us receives a letter from your insurance company that your benefits have been terminated, we will then set up a payment plan for your future care. Ultimately, all expenses incurred by you for your care are your financial responsibility. Any and all outstanding balances, at the end of the month will be deducted on your credit card on file or your payment plan will be utilized. It is very important that you become an active advocate of your health care. Our office is committed to providing you with the best care possible and we will do everything we can to help you achieve your health goals.

Print Name: _____

Sign Name: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Witness: _____ Date: _____

FINANCIAL STATEMENT

Dear Patient:

Automobile Accidents and Worker's Compensation: For automobile, under Minnesota no-fault law and if/when your auto insurance carrier establishes liability; they will pay 100% of covered services directly to your practitioner's office. For all insurances in this category, you are responsible for paying for any non-covered services, supplies or supplements which are due at the time the charges are incurred. In the event that your insurance denies liability or your benefits end, payment for services rendered becomes your responsibility, if you provide us with a copy of the denial letter and if you have other health insurance coverage, we will submit your claims to your health insurance company. Coverage would then fall under the guidelines of the type of insurance you have.

I have read, understand and agree to abide by the information stated above as it applies to my coverage. If special payment arrangements are necessary, they would have to make through the clinics' billing manager.

Printed Name_____

Signature_____ Date_____

DOCTOR'S LIEN AND INSTRUCTIONS TO COUNSEL

I, the undersigned, understand that all past, present and future bills incurred at the Doctor/Clinic noted below, are my responsibility for payment. I hereby ratify my agreement to pay all bills incurred during my health care at this Clinic.

In consideration for the below named Doctor/Clinic having agreed to treat me without payment at the time of service and enabling me to obtain treatment for my accident/injury/illness, without financial hardship, I give you a lien on any settlement, claim, judgment. Verdict or result of said accident/injury/illness and I agree to irrevocably instruct my attorney to pay you in full from any proceeds of settlement, claim or judgment related to this accident/injury/illness.

I also understand that if the settlement does not cover my entire bill at this Clinic, I am still responsible for the remainder and the payment by me of this bill is not contingent on any settlement, claim or judgment with I may eventually recover.

Furthermore, in consideration for the below named Doctor/Clinic refraining from attempting to collect immediate payment for services rendered for my accident/injury/illness, I do hereby waive and toll any applicable statute of limitations on the collection of my account until I notify the Doctor/Clinic of the conclusion of my efforts to obtain a settlement or judgment through the assistance of my attorney and for a period of three (3) months thereafter.

Jennifer Schommer, D.C.
Achieve Health Chiropractic Clinic
13911 Ridgedale Dr. Ste. 200
Minnetonka, MN 55305
T 952.545.3839 **F** 952.546.0168

Doctor/Clinic Name and Address

_____ _____
Patient Name (Please Print)

_____
Patient Signature

_____
Date

* * * * * *

INTRUCTIONS TO COUNSEL

I do hereby irrevocably instruct you, my Attorney, named below, to pay Doctor/Clinic named above in full for services to me for my accident/injury/illness from any proceeds of settlement, claim or judgment regarding said accident/injury/illness. You are to pay the Doctor/Clinic prior to distributing any proceeds to me and I instruct you not to attempt to reduce by means of negotiation my doctor's bill for the services that have been provided to me for the accident/injury/illness which I have agreed to pay in full.

_____ _____
Firm Name Patient Signature

_____ _____
Attorney Name Date

* * * * * *

ATTORNEY'S ACCEPTANCE OF LIEN

Being the attorney of record or authorized representative, I acknowledge receipt of my client's instructions to Counsel and Lien and agree to honor the same.

_____ _____
Attorney Signature Date

Monthly Travel Report and Expense

Name: _____
Beginning Period: _____
Ending Period: _____

Date	From	To	Doctor/Hospital/Etc. Purpose of Visit	Number of Miles

Expense Summary: (Verify with your insurance for the reimbursement rate)

Mileage: _____
Parking: $ _____
Total: $ _____

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CHIROPRACTIC INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of chiropractic procedures, including various modes of physio therapy, diagnostic x-rays, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic indicated below and/or other licensed doctors of chiropractic and support staff who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the Doctor of Chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and procedures.

I understand and I am informed that, as is all Healthcare treatments, results are not guaranteed and there is no promise to cure. I further understand and I am informed that, as is with all Healthcare treatments, in the practice of chiropractic there are some risks to treatment, including, but not limited to, muscle spasms for short periods of time, aggravating and/or temporary increase in symptoms, lack in improvement of symptoms, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I further understand that Chiropractic adjustments and supportive treatment is designed to reduce and/or correct subluxations allowing the body to return to improved health. It can also alleviate certain symptoms through a conservative approach with hopes to avoid more invasive procedures. However, like all health modalities, results are not guaranteed and there is no promise to cure. Accordingly, I understand that all payment(s) for treatment(s) are final and no refunds will be issued. However, prorated fees for unused, prepaid treatments will be refunded if I wish to cancel the treatment.

I further understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include, but not limited to self-administered, over the counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; physical therapy; steroid injections; bracing; and surgery. I understand and have been informed that I have the right to a second opinion and secure other options if I have concerns as to the nature of my symptoms and treatment options.

I have read, or have read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedure. I intend this consent to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Name of Patient:_____

Signature of Patient:_____

Name Printed of Guardian/Parental and Relationship to Patient:_____

Guardian/Parental Signature:_____

Date:_____

Doctor of Chiropractic Name:_____

Signature of Doctor of Chiropractic:_____

Date:_____

Achieve Health Chiropractic Clinic

Patient Health Information Consent Form

We want you to know how your Patient Health Information (**PHI**) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (**PHI**) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow their chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment and family members as needed. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions. There may be a reasonable cost-based fee for photocopying, postage and preparation.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our office manager about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.
8. In the future, we may contact you for appointment reminders, announcements and to inform you about our practice.
9. Our practice is required to abide by this notice. We have the right to change this notice in the future. Any revisions will be prominently displayed in a clearly visible location in our office.

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

_____

Signature **Date**

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