GENERAL INFORMATION

Name_____ Today's Date ____/____/____

Address_____

City/State/Zip _____

Mobile Phone # _____ Other Phone # _____

Your Birthdate _____

Occupation_____ Employer _____

Relationship: *Single* *Married* *Partner* *Widow* Children: *Yes* *No*

How did you find us? Who can we thank for referring you? _____

AUTO INSURANCE INFORMATION

Your Info:

Insurance Company _____ Claim # _____

Adjuster's Name _____ Phone _____

Are you using an Attorney? If yes, Name _____ Phone _____

Other Driver's Info:

Insurance Company _____ Claim # _____

Adjuster's Name _____ Phone _____

ACCIDENT INFORMATION

Date and Time of Accident _____

What city did the accident take place in? _____

Number of people in your car: _____ Did you lose consciousness? ____ Yes ____ No

Driver of Car _____ Who owns the car? _____

Make and model of your car _____ Make and model of other car _____

Where were you seated? _____ Approximate damage to your car $_____

Type of Accident: ☐ Head-on collision ☐ Broad-side collision ☐ Rear-end collision ☐ Other_____

Did your head or any part of your body hit inside of the car? _____

Did you see the accident coming? __Yes __No Did you brace for impact? __Yes __ No

Were seatbelts worn? __ Yes __No Did your seat have a headrest? __ Yes __ No

If moving, about how fast were you going? _____MPH The other car? _____ MPH

Head position at the time of impact: ___ Turned to the Left ___ Turned to the Right ___ Head facing Forward

INJURY INFORMATION

Please mark all symptoms you have noticed since the accident:

☐ Headache	☐ Neck Pain	☐ Mid Back Pain	☐ Low Back Pain
☐ Shoulder Pain	☐ Dizziness	☐ Fainting	☐ Sleeping Problems
☐ Numbness in Legs	☐ Numbness in Toes	☐ Numbness in Arms	☐ Numbness in Fingers
☐ Muscle Soreness	☐ Fatigue	☐ Tension	☐ Irritability
☐ Depression	☐ Ears ringing/buzzing	☐ Loss of balance	☐ Breath Shortness
☐ Cold Hands	☐ Cold Feet	☐ Diarrhea	☐ Constipation
☐ Chest Pains	☐ Nervousness	☐ Cold Sweats	☐ Anxiousness
☐ Facial Pain	☐ Clicking or popping jaw	☐ Sensitive to Light	☐ Memory Loss

Any other changes have you noticed since the collision?

_____

Have you missed time from work? __ Yes __No If yes, from_____ to _____

Did you seek medical help immediately after the accident? ____ Yes ____No

Doctor or Hospital Name:_____ Visit date: _____

Were you examined? __ Yes __No Were X-rays taken? __ Yes __No Any fractures? __ Yes __No

Has the accident caused you to take any medications? ____ Yes ____No Name:_____

Please list any previous health conditions, surgeries or other information we should know about you:

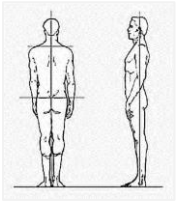
_____

(For office use only) Doctor Notes

VSC: Oc 1 2 3 4 5 6 7 1 2 3 4 5 6 7 8 9 10 11 12 1 2 3 4 5 S LIl RIl Ext _____

ROM: Cervical: F E RR LR RB LB Lumbar: F E RR LR RB LB

Posture:



Assignment of Insurance Payments

____ I assign and request insurance payments be made directly to Dr. Pete Haggenjos at Thrive Chiropractic for my care related to the accident.

____ Should insurance fail to pay for services I receive, I authorize the credit card which has been stored securely to be used as payment. I understand I will be notified before any charges would be applied to this card.

Voicemail Preferences

____ I agree that voice messages can be left on any of the phone numbers listed on first page of this form with details about my appointments and chiropractic care.

Email Preferences

Email Address: _____

____ I agree to receive personal emails regarding my care, appointments, and payments.

____ I would like to receive, or continue receiving, monthly email newsletters with health tips, research, recipes and information about Thrive Chiropractic events. I can easily unsubscribe at any time if I do not find these newsletters valuable.

Text Message Reminders

____ I would like to receive, or continue receiving, text message reminders 24 hours in advance of my scheduled appointments.

Cancellation Policy

____ I understand that Thrive Chiropractic requires 24-hour notice for canceling appointments. I may be charged $45 for any missed appointments if I fail to show up or fail to give 24-hour notice.

Signature: _____ Date: _____

Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as “informed consent” and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains.

With respect to strokes, there is a rare but serious condition known as an “arterial dissection” that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately, a percentage of these patients will experience a stroke.

The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events/per one million persons/year and risk of death has been estimated as 104 per one million users.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery.

Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: _____

Signature: _____

Date: _____

Parent / Guardian: _____

Signature: _____

Date: _____

Witness Name: _____

Signature: _____

Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Date: _____

You may refuse to sign this acknowledgement. In refusing, we *may not be allowed* to process your insurance claims.

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.

_____ _____

Print Patient Name **Signature** of Patient or Guardian

_____ _____

Legal Representative / Guardian Relationship to Patient

_____

Office Use Only

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

It was emergency treatment _____

I could not communicate with the patient _____

The patient refused to sign _____

The patient was unable to sign because _____

Other (please describe) _____

Signature of Privacy Officer: _____

AUTHORIZATION FOR USE/DISCLOSURE OF HEALTH INFORMATION

Authorization for Use/Disclosure of Information: I voluntarily consent to and authorize my health care provider Dr. Pete Haggenjos/Thrive Chiropractic to use or disclose my health information during the term of this Authorization to the recipient(s) that I have identified below.

Recipient: I authorize my health care information to be released to the following recipient(s): circle A and/or B below

a. My Insurance Company and/or Attorney

b. Other party or person:_____

Purpose: I authorize the release of my health information for the following specific purpose:

Processing Insurance Claims

Sharing with other named party or person listed above at my request.

Information to be disclosed: I authorize the release of the following health information: (circle A or B below; we suggest A)

a. All of my health information that the provider has in his or her possession, including information relating to any medical history, mental or physical condition and any treatment received by me.
b. Only the following records or types of health information:
_____.

Term: I understand that this Authorization will remain in effect: (Circle A, B or C below; we suggest "C")

a. From the date of this Authorization until the _____ day of _____, 20___.
b. Until the Provider fulfills this request.
c. Until I notify this office to withdraw my authorization.

Redisclosure: I understand that my health care provider cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

Refusal to sign/right to revoke: I understand that signing this form is voluntary and that if I don't sign, it will not affect the commencement, continuation or quality of my treatment at Thrive Chiropractic. If I change my mind, I understand that I can revoke this authorization by providing a written notice of revocation to Dr. Pete Haggenjos at the address listed below. The revocation will be effective immediately upon my health care provider's receipt of my written notice, except that the revocation will not have any effect on any action taken by my health care provider in reliance on this Authorization before it received my written notice of revocation.

Questions: I may contact Dr. Pete Haggenjos at Thrive Chiropractic, 3071 Madison Road, Cincinnati OH 45209, phone 513-723-1190, for answers to my questions about the privacy of my health information.

_____ _____ _____

Signature Date Signature of Witness

If Individual is unable to sign this Authorization, please complete the information below:

_____ _____ _____ _____

Name of Representative Legal Relationship Date Witness

NOTE: This Authorization does not extend to HIV test results, outpatient psychotherapy notes, drug or alcohol treatment records that are protected by federal law, or mental health records that are protected by the Lanterman-Petris-Short Act.