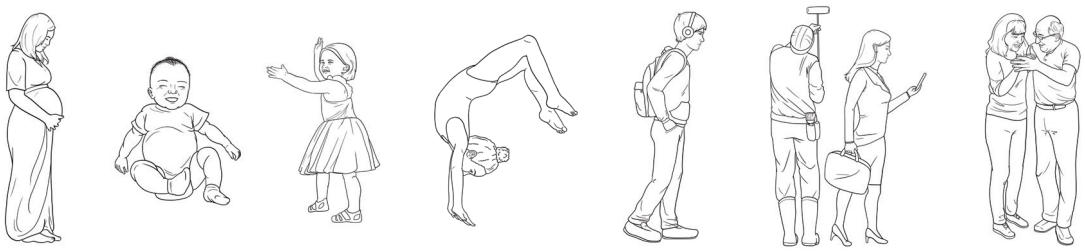


thrive CHIROPRACTIC
ADJUST. ADVANCE. THRIVE.

Auto Collision Form

General Information

Name _____ Today's Date _____

Address _____

City/State/Zip _____

Mobile Phone # _____ Other Phone # _____

Occupation _____ Employer _____

Your Birthdate _____ Relationship: ◯ *Single* ◯ *Married* ◯ *Partner* ◯ *Widow*

Do you have kids? ◯ *Yes* ◯ *No* Age(s) _____

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

Auto Insurance and/or Attorney Information

Insurance Company _____ Claim # _____

Adjuster's Name _____ Phone # _____

If using an attorney, 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/model of your car _____ Make/model of other car _____

Where were you seated _____ Approx. $ 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? _____

Were seatbelts worn? ◯ *Yes* ◯ *No* How fast were you going? ____ MPH The other car? ____ MPH

Did you see the accident coming? ◯ *Yes* ◯ *No* Did you brace for impact? ◯ *Yes* ◯ *No*

Injury Information

Please mark all symptoms you have noticed since the accident:

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

Any other changes you have noticed since the collision? _____

_____

Have you missed time from work? ◯ *Yes* ◯ *No* If yes, from _____ to _____

Did you seek medical help after the accident? ◯ *Yes* ◯ *No* Visit date _____

Doctor or Hospital Name _____

Were X-rays taken? ◯ *Yes* ◯ *No* Any fractures? ◯ *Yes* ◯ *No*

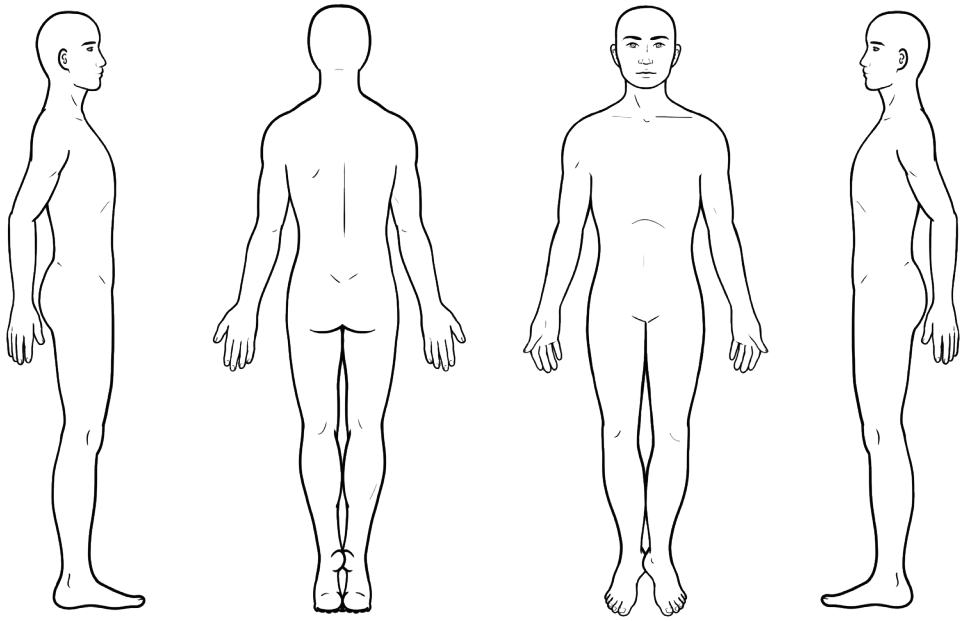
Has the accident caused you to take any medications? ◯ *Yes* ◯ *No*

Name of medications _____

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

Pain and Symptom Diagram

Use the Adobe Acrobat Highlight Text tool to highlight areas on the diagram where you may have pain or symptoms, or describe below:



Right Side Back Front Left Side

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.

Cancelation 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: _____

Acknowledgment of Receipt of Notice of Privacy Practices

Date: _____

You may refuse to sign this acknowledgment. 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

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: _____

Letter of Protection

I do hereby authorize Dr. Pete Haggenjos to furnish you, my attorney, with a full report of his examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I was recently involved.

I hereby authorize and direct you, my attorney, to pay directly to said doctor such sums as may be due and owing him for the medical service rendered me both by reason of this accident and by reason of any other bills that are due his office and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect and fully compensate said doctor. And I hereby further give a lien on my case to said doctor against any and all proceeds of my settlement, judgment or verdict which may be paid to you, my attorney, or myself, as the result of the injuries for which I have been treated or injuries in connection therewith.

I agree to never rescind this document and that a rescission will not be honored by my attorney. I hereby instruct that in the event another attorney is substituted in this matter, the new attorney honor this lien as inherent to the settlement and enforceable upon the case as if it were executed by him.

I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by him for service rendered me and that this agreement is made solely for said doctor's additional protection and in consideration of his awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

I agree to promptly notify said doctor of any change or addition of attorney(s) used by me in connection with this accident, and I instruct my attorney to do the same and to promptly deliver a copy of this lien to any such substituted attorney(s).

Please acknowledge this letter by signing below and returning to the doctor's office. I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment and may declare the entire balance due and payable.

Patient 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 and fully compensate said doctor named above.

Attorney Signature: _____ Date: _____