PATIENT INTRODUCTION CARD

No:____________________ Date:______________________

Name (Mr. Mrs. Miss Ms.):____Phone: (Home):_______________________

Address:____Cell#______________________
(Street, City, State, Zip Code)

Married___Single___Other_________ E-Mail (for Newsletter)___________________________Date of Birth ___/____/____

Occupation:_______________________Employer:_____________________________________SS #___________________

Office Address: ____Phone (Office)__________________

Previous Chiropractic Care: ____Yes _____ No Doctor's Name:____

Name of your insurance company: ____

Policyholder Name:_________________________________ SS # __________________________ Date of Birth____/____/____

Major Complaint____

Who (or what Source) referred you?____

It is Usual and Customary to Pay for Services as Rendered Unless Otherwise Arranged

AUTOMOBILE ACCIDENT QUESTIONNAIRE

PLEASE ANSWER ALL QUESTIONS COMPLETELY

Date ____________________

Patient ____________________ No. ____________________

Sex ______ Marital Status ________ Date of Birth ________ Home Phone ________

Address ____________________ City ____________ State ______ Zip ______

Occupation ____________________

Who referred you to our office? ____________________

Social Sec. # ____________ Business Phone ____________ Company Name ____________

Company Address ____________________

Please explain in detail how your accident happened? ____________________

____

____

Driver of other vehicle (if any) ____________________ Date of Birth ____________

Insurance Company ____________ Address ____________ Phone No: ____________

Policy No. ____________________

Claim No. ____________________

Name of person who has made contact with you ____________________

Name of driver of vehicle in which you were injured (self or other) ____________________

Insurance Company ____________ Address ____________ Phone No: ____________

Policy No. ____________________

Claim No. ____________________

Name of Person who has made contact with you ____________________

Have you retained an attorney? ❑ Yes ❑ No ❑ Not Yet

If so, his/her name, address & phone # ____________________

Give time and date present injury occurred ____________ ❑ AM ❑ PM ____/____/____

You were heading? ❑ North ❑ South ❑ East ❑ West on ____________ (street or highway)

Number of people in your vehicle ____________

Were police notified? ❑ Yes ❑ No Did head strike windshield or object? ❑ Yes ❑ No

Were you knocked unconscious ❑ Yes ❑ No If so, for how long ____________

You were struck from? ❑ Behind ❑ Front ❑ Left Side ❑ Right Side

You were? ❑ Driver ❑ Passenger ❑ Front seat ❑ Back seat ❑ Using seat belts ❑ Other protective devices

Did you feel pain immediately after the accident? ❑ Yes ❑ No ❑ Later that day ❑ Next day ❑ When ________

Where did you feel pain immediately after the accident? ____________________

Where were you taken after the accident? ____________________

Was treatment given? ____________________

Was any doctor consulted after the accident? ❑ Yes ❑ No

If so, give doctor's name ____________ ❑ D.C., ❑ M.D., ❑ D.O., ❑ D.D.S. ______

Doctor's Diagnosis ____________________

What treatment was given? ____________________

How often did you see the doctor? ____________________

How long did you see the doctor? ____________________

Have you ever had any complaints in the involved area before? ❑ Yes ❑ No

If so, what were the complaints? ____________________

Before the injury, were you capable of working on an equal basis with others your age? ❑ Yes ❑ No

Are your work activities restricted as a result of this accident? ❑ Yes ❑ No

Since the injury, are your symptoms ❑ Improving? ❑ Getting worse? ❑ The same?

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HEALTH QUESTIONNAIRE

PLEASE CHECK MARK EACH OF THE CONDITIONS BELOW THAT YOU ARE CURRENTLY EXPERIENCING

Date: ______________

Patient: ______________________________ No.: ______________

MUSCULO SKELETAL SYSTEM

- ❑ Low back pain
- ❑ Mid back pain
- ❑ Pain between shoulders
- ❑ Neck pain
- ❑ Arm problems
- ❑ Leg problems
- ❑ Swollen joints
- ❑ Painful joints
- ❑ Stiff joints
- ❑ Sore muscles
- ❑ Weak muscles
- ❑ Walking problems
- ❑ Spasms
- ❑ Broken bones
- ❑ Shoulder pain

GENITO-URINARY SYSTEM

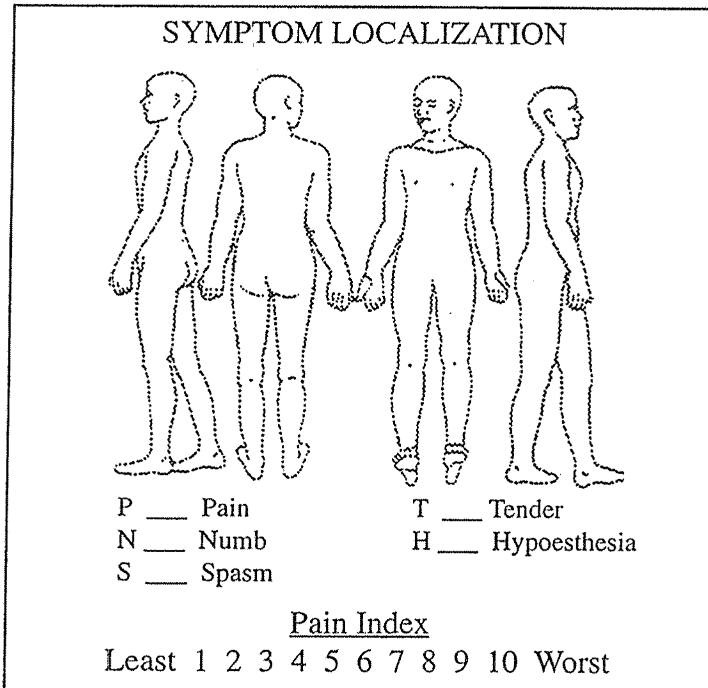
- ❑ Bladder trouble
- ❑ Excessive urination
- ❑ Scanty urination
- ❑ Painful urination
- ❑ Discolored urine

FEMALE

- ❑ Vaginal discharge
- ❑ Vaginal bleeding
- ❑ Vaginal pain
- ❑ Breast pain
- ❑ Lumps on the breast

ARE YOU PREGNANT? ❑ YES ❑ NO

SYMPTOM LOCALIZATION



P ___ Pain
N ___ Numb
S ___ Spasm
T ___ Tender
H ___ Hypoesthesia

Pain Index

Least 1 2 3 4 5 6 7 8 9 10 Worst

GASTRO-INTESTIONAL SYSTEM

- ❑ Poor appetite
- ❑ Excessive hunger
- ❑ Difficult chewing
- ❑ Difficult swallowing
- ❑ Excessive thirst
- ❑ Nausea
- ❑ Vomiting Blood
- ❑ Abdominal pain
- ❑ Diarrhea
- ❑ Constipation
- ❑ Black stool
- ❑ Bloody stool
- ❑ Hemorrhoids
- ❑ Liver trouble
- ❑ Gall bladder problems
- ❑ Weight trouble

NERVOUS SYSTEM

- ❑ Numbness
- ❑ Loss of feeling
- ❑ Paralysis
- ❑ Dizziness
- ❑ Fainting
- ❑ Headaches
- ❑ Muscles jerking
- ❑ Convulsions
- ❑ Forgetfulness
- ❑ Confusion
- ❑ Depression
- ❑ Insomnia

HABITS

- ❑ Cigarettes
- ❑ Alcohol Abuse
- ❑ Coffee or Tea
- ❑ Excercise
- ❑ Drug Abuse
- ❑ ______________

CARDIO-VASCULAR RESPIRATORY

- ❑ Chest pain
- ❑ Pain over heart
- ❑ Difficult breathing
- ❑ Persistent cough
- ❑ Coughing phlegm
- ❑ Coughing blood
- ❑ Rapid heartbeat
- ❑ Blood pressure problems
- ❑ Heart problems
- ❑ Lung problems
- ❑ Varicose veins

EYE, EAR, NOSE AND THROAT

- ❑ Eye strain
- ❑ Eye inflammation
- ❑ Vision problems
- ❑ Ear pain
- ❑ Ear noises
- ❑ Ear discharge
- ❑ Hearing loss
- ❑ Nose pain
- ❑ Nose bleeding
- ❑ Nose discharge
- ❑ Difficult breathing through nose
- ❑ Sore gums
- ❑ Dental problems
- ❑ Sore mouth
- ❑ Sore throat
- ❑ Hoarseness
- ❑ Difficult speech
- ❑ Sinus
- ❑ Allergy
- ❑ Jaw Pain

Patient's Signature ______________________

• DO NOT WRITE BELOW THIS LINE •

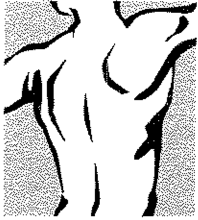
____

____

____

____

Patient Accepted? ❑ Yes ❑ No Doctor's Signature ______________________



TERESA HAZELWOOD, D.C.

77 Charleston Square
Saint Charles, MO 63304
Telephone: (636) 939-3990
Fax: (636) 939-3909

ASSIGNMENT OF BENEFITS / CLINIC LIEN

I was involved in an accident on or around_____________________ [date] in which I was injured for which I have or may have a claim

against another person(s) for causing my injuries (including ____)
[Name of person at fault]

(Referenced as 'My Claim') who is insured by ____

In consideration of the agreement of Healthy Solutions (referenced as the 'Clinic') to delay billing me personally for medical treatment rendered until resolution of My Claim:

1. Please note that Healthy Solutions recognizes **Med-Pay Insurance as primary coverage, Liability as secondary, and health insurance coverage as third.** This office will accept assignment of benefits for insurance coverage at time of settlement or up to six months following your release from care for this injury. At that time your account will need to be paid in full.
2. I now assign, without any right to later revoke, a part of any proceeds from my claim equal to the fees incurred by me to this Clinic for all treatment and other services rendered by the Clinic. I am not assigning any legal cause of action in My Claim above, but only prospective proceeds. I also assign to the Clinic my right to enforce the obligation of any insurance company to pay settlement proceeds for **any** settlement agreement made by or for me in exchange for my signing such insurance company's release of claim. Prior to settlement or other disposition of My Claim. I understand and permit Clinic to pursue payment from any other source but me personally, including medical payments coverage in an automobile policy.
3. This Assignment and related documents, which I have signed in connection with it, states the entire agreement and my complete understanding regarding the Clinic's Fees. I have not relied on any statements by the Clinic or the Doctor or other information before making this Assignment. **I understand that I remain responsible for any Clinic fees not paid out of My Claim.**
4. I understand that it is my responsibility during treatment to remain aware of my cumulative account balance for services rendered. I have received a schedule of treatment fees for this Clinic, or if I have not, will request this Clinic for one in writing.
5. I understand that this is an express contract to pay for the services rendered by this Clinic. I agree to pay my account balance in full and/or direct its payment from My Claim proceeds regardless of whether any other person or entity attempts to or fails to fully reimburse me for it. If I dispute my account balance or treatment rendered, I agree that my remedy will be to resolve it with a separate action from My Claim.
6. **NOTICE: I DIRECT ANY INSURANCE COMPANY, ATTORNEY, OR OTHER PERSON WHO HOLDS OR LATER HOLDS ANY PROCEEDS FROM MY CLAIM TO APPLY ANY PROCEEDS FROM MY CLAIM TO MY ACCOUNT BALANCE OUT OF THE TOTAL PROCEEDS HELD IN MY BEHALF, UNLESS THE CLINIC CONFIRMS PRIOR PAYMENT OF IT IN WRITING. PAYMENT IS TO BE MADE BY CHECK MADE OUT AND MAILED DIRECTLY TO HEALTHY SOLUTIONS 77 CHARLESTON SQUARE ST. CHARLES, MO 63304. "TOTAL PROCEEDS" HELD BY AN ATTORNEY FOR MY CLAIM SHALL MEAN PROCEEDS AFTER DEDUCTION OF ATTORNEY FEES.**
7. I authorize the Clinic to provide you with a report of his examination, diagnosis, treatment, prognosis, etc. of myself in regard to the accident that occurred on or around the above date.
8. **I REALIZE THAT I HAVE NOW GIVEN AWAY A PART OF ANY PROCEEDS FROM MY CLAIM. IF I RECEIVE ANY PROCEEDS FROM MY CLAIM,, I AGREEE TO IMMEDIATELY DETERMINE IF THIS CLINIC HAS BEEN SEPERATELY PAID IN FULL. UNLESS THE CLINIC CONFIRMS FULL PAYMENT IN WRITING, I REALIZE THAT ANY USE BY ME OF THESE PROCEEDS IS TAKING OR CONVERTING MONEY THAT IS PROPERTY OF THIS CLINIC.**
9. I HAVE READ THIS DOCUMENT AND I FULLY UNDERSTAND IT.

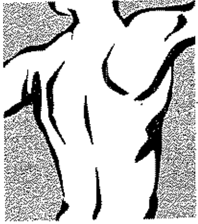
____________________________________ __________________________________
[signature of patient] *[date]*

____
[Print or type patient name]

THIS ASSIGNMENT HAS BEEN SIGNED ON THE CLINIC PREMISES

____
[Patient's Street Address, City, State and Zip Code]

____________________________________ __________________________________
[signature of parent or legal guardian] *[Staff Witness]*



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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 this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. 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.*
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 effect 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 privacy official 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.*

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

____

Name of Patient Date