SOUTHEAST CHIROPRACTIC
THE MOTION CENTERS

Patient Personal/Confidential Data

Patient Name _____ Today's Date _____
(First) (Middle Initial) (Last)

Home Address _____ City_____ State ____ Zip _____

Home #_____ Cell # _____ Employer _____

Occupation _____ Work # _____ Date of Birth ____/____/____

Sex: Male / Female Marital Status _____ # of Children _____ Social Security # _____-_____-_____

How did you hear about our office? _____ **Email** _____

Name of Spouse _____ Spouse's Date of Birth _____/_____/_____

Spouse's Employer _____ Contact # _____

Nearest Relative Not Living With You _____ Phone # _____

What is the purpose of this appointment? _____

What makes your condition better? _____ Worse? _____

Have you ever been under chiropractic care before? ☐ Yes ☐ No Where _____

Name of your Primary Care Doctor _____ Practice Name _____

Informed Consent to Chiropractic Treatment

I hereby request and consent the performance of chiropractic adjustments and other chiropractic procedures. This includes various modes of physical therapy and diagnostic radiographs performed on me, or on the patient named below, for whom I am legally responsible. I further understand that this may be performed by the Doctor of Chiropractic, Dr. Michael Silver, Dr. Jodie Silver, Dr. Richard Snyder, Dr. Crown Hoffman, Dr. Kate Hoffman, and/or other licensed Physicians of Chiropractic who may treat me now or in the future at this office. This will include those employed by, working for, or associated with **SouthEast Chiropractic: The Motion Centers**.

I have had the opportunity to discuss with the attending physician and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments or other procedures. I understand that the results are not guaranteed. I understand and am informed that, as in the practice of medicine, the practice of chiropractic carries some risks to treatment, including, but not limited to, fractures, disc injuries, strokes (CVA), dislocations, and sprains. I do not expect the physician to anticipate and explain all risk and complications. Further, I wish to rely on the physician to exercise judgment during the course of the procedures which the physician feels are in my best interest, at the time, based upon the facts then known.

I have read, or have had read to me, the above consent. I have also had the opportunity to ask questions about its contents, and by signing below, I agree to the treatment recommended by my physician. I intend this consent form to cover the entire course of treatment for my present condition(s) and for any conditions(s) for which I seek treatment at this facility.

Patient Signature (or Guardian) _____ **Date** _____

Patient Health Questionnaire

Patient Name _____ ***Date*** _____

1. When did your symptoms start: _____ ***Describe your symptoms and how they began:***

_____

_____

2. How often do you experience your symptoms?

① Constantly (76-100% of the day)
② Frequently (51-75% of the day)
③ Occasionally (26-50% of the day)
④ Intermittently (0-25% of the day)

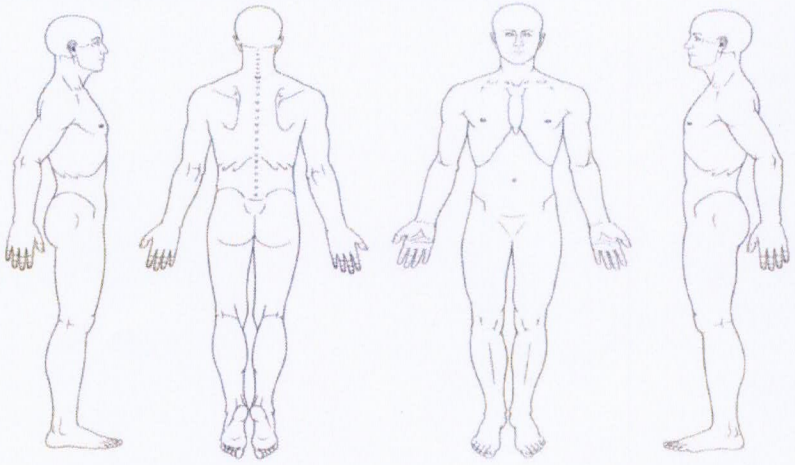
3. What describes the nature of your symptoms?

① Sharp ④ Shooting
② Dull ache ⑤ Burning
③ Numb ⑥ Tingling

4. How are your symptoms changing?

① Getting Better
② Not Changing
③ Getting Worse

Indicate where you have pain or other symptoms



5. How bad are your symptoms at their:

	None										*Unbearable*
a. worst:	⓪	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
b. best:	⓪	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩

6. How do your symptoms affect your ability to perform daily activities?

⓪	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
No complaints		*Mild, forgotten with activity*		*Moderate, interferes with activity*		*Limiting, prevents full activity*		*Intense, preoccupied with seeking relief*		*Severe, no activity possible*

7. What activities make your symptoms worse: _____

8. What activities make your symptoms better: _____

9. Who have you seen for your symptoms?

① No One
② Other Chiropractor
③ Medical Doctor
④ Physical Therapist
⑤ Other

a. When and what treatment? _____

b. What tests have you had for your symptoms and when were they performed?

① Xrays *date:* _____ ③ CT Scan *date:* _____
② MRI *date:* _____ ④ Other *date:* _____

10. Have you had similar symptoms in the past? ① Yes ② No

a. If you have received treatment in the past for the same or similar symptoms, who did you see?

① This Office
② Other Chiropractor
③ Medical Doctor
④ Physical Therapist
⑤ Other

11. What is your occupation?

_____

① Professional/Executive
② White Collar/Secretarial
③ Tradesperson
④ Laborer
⑤ Homemaker
⑥ FT Student
⑦ Retired
⑧ Other

a. If you are not retired, a homemaker, or a student, what is your current work status?

① Full-time
② Part-time
③ Self-employed
④ Unemployed
⑤ Off work
⑥ Other

12. What do you hope to get from your visit/treatment *(select all that apply):*

① Reduce symptoms
② Resume/increase activity
③ Explanation of condition/treatment
④ Learn how to take care of this on my own
⑤ How to prevent this from occurring again
⑥

Patient Signature _____ ***Date*** _____

Patient Health Questionnaire - page 2

ACN Group, Inc PHQ-102

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name _____ ***Date*** _____

What type of regular exercise do you perform? ① None ② Light ③ Moderate ④ Strenuous

What is your height and weight? Height [ ][ ][ ] Weight [ ][ ][ ] lbs.

Feet *Inches*

For each of the conditions listed below, place a check in the Past column if you have had the condition in the past. If you presently have a condition listed below, place a check in the Present column.

Past	Present		Past	Present		Past	Present	
○	○	Headaches	○	○	High Blood Pressure	○	○	Diabetes
○	○	Neck Pain	○	○	Heart Attack	○	○	Excessive Thirst
○	○	Upper Back Pain	○	○	Chest Pains	○	○	Frequent Urination
○	○	Mid Back Pain	○	○	Stroke			
○	○	Low Back Pain	○	○	Angina	○	○	Smoking/Use Tobacco Products
						○	○	Drug/Alcohol Dependence
○	○	Shoulder Pain	○	○	Kidney Stones			
○	○	Elbow/Upper Arm Pain	○	○	Kidney Disorders	○	○	Allergies
○	○	Wrist Pain	○	○	Bladder Infection	○	○	Depression
○	○	Hand Pain	○	○	Painful Urination	○	○	Systemic Lupus
			○	○	Loss of Bladder Control	○	○	Epilepsy
○	○	Hip/Upper Leg Pain	○	○	Prostate Problems	○	○	Dermatitis/Eczema/Rash
○	○	Knee/Lower Leg Pain				○	○	HIV/AIDS
○	○	Ankle/Foot Pain	○	○	Abnormal Weight Gain/Loss			
			○	○	Loss of Appetite	***Females Only***		
○	○	Jaw Pain	○	○	Abdominal Pain	○	○	Birth Control Pills
○	○	Joint Swelling/Stiffness	○	○	Ulcer	○	○	Hormonal Replacement
○	○	Arthritis	○	○	Hepatitis	○	○	Pregnancy
○	○	Rheumatoid Arthritis	○	○	Liver/Gall Bladder Disorder	○	○	
○	○	General Fatigue	○	○	Cancer	***Other Health Problems/Issues***		
○	○	Muscular Incoordination	○	○	Tumor	○	○	
○	○	Visual Disturbances	○	○	Asthma	○	○	
○	○	Dizziness	○	○	Chronic Sinusitis	○	○	

Indicate if an immediate family member has had any of the following:

○ Rheumatoid Arthritis ○ Heart Problems ○ Diabetes ○ Cancer ○ Lupus ○ _____

List all prescription and over-the-counter medications, and nutritional/herbal supplements you are taking:

_____ _____ _____

_____ _____ _____

List all the surgical procedures you have had and times you have been hospitalized:

_____ _____ _____

_____ _____ _____

Patient Signature _____ ***Date*** _____

Doctor's Additional Comments

_____

_____

_____

Doctors Signature _____ ***Date*** _____

SOUTHEAST CHIROPRACTIC
THE MOTION CENTERS

Insurance Information

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that this Chiropractic Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this Chiropractic Office will be credited to my account upon receipt. I also give this office power of attorney to endorse checks made out to me, to be credited to my account. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

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

Consent of Professional Services and Release of Information

I hereby authorize and release the doctor and whomever he/she may designate as his/her assistants to administer treatment, physical examination, X-Ray studies, laboratory procedures, chiropractic care or any other services that he/she deems necessary in my case: and I further authorize him/her to disclose all or any part of my patient record to any person or corporation which is or may be liable under a contract to the clinic or to the patient or to a family member or employer of the patient for all or part of the services rendered to me including and not limited to hospital or medical service companies, insurance companies, worker's compensation carriers, welfare funds or employers.

Patients Signature:_____ **Date:**_____

Signature of Parent or Guardian:_____ Date:_____

HIPPA POLICY ACKNOWLEDGMENT

I acknowledge that I have read and have been given a copy of the HIPPA POLICY at SouthEast Chiropractic:The Motion Centers.

Patient Signature_____ **Date**_____

Witness _____ Date_____

SOUTHEAST CHIROPRACTIC
THE MOTION CENTERS

Payment Policy

Our Primary goal is to provide chiropractic care to all of our patients and we wish to spend our time and energy toward that end. It is necessary to establish payment policies to avoid any misunderstandings. Therefore, we wish to clarify the following policies of our practice.

1. Payments for office visits are expected at the time services are rendered. Any co-payments and unpaid deductibles due to our office are expected at the time of your visit.
2. Even though you may have an insurance claim pending, you will receive a statement each month for the outstanding balance of your account. We cannot accept responsibility for collecting an insurance claim or for negotiating a disputed claim. Insurance reimbursement is a contract between you and your carrier. You are responsible for your bills regardless of what your insurance pays.
3. Bills which remain unpaid for over 60 days will be charged 1 ½ % per month or part thereof which they are overdue.

I HAVE READ THIS PAYMENT POLICY AND UNDERSTAND THAT REGARDLESS OF MY INSURANCE COVERAGE I MAY HAVE, I AM RESPONSIBLE FOR PAYMENT OF MY ACCOUNT WITHIN THE USUAL LIMITS OF THIS POLICY.

_____ _____

Patient Signature Date

Automobile Accidents or Workman's Comp ONLY

It has been our experience that it is wise for our patients to have a complete understanding of our office policy, fees, and insurance filing. If you were involved in an auto accident, or a related injury we will gladly accept your case with the following regulations:

1. If you have an attorney, notify us as soon as possible and ask him/her to send us a letter of representation. All bills will be sent to your attorney for you.
2. If you do not have an attorney, you will need to provide us with a police report and all information for billing the insurance company. No bills or copies of bills, will be given to you or to the insurance company until we have spoken to the adjuster and they have indicated that they will do everything to protect the doctor's interest.
3. If you do not have an attorney and do not give us the information needed to bill the insurance company by your second visit at our office, you will be expected to make a payment at that time. Once your case has been settled and all medical bills paid, if an overpayment exists on your account (due to having more than one insurance) we will forward the overpayment to you. By signing below I am agreeing that I have read and do understand I will not be presented with copies of bills until the proper procedures have been followed.

_____ _____

Patient Signature Date

Witness: _____

SOUTHEAST CHIROPRACTIC
THE *MOTION* CENTERS

Automobile Accident Questionnaire

Patient Name: _____ Date of Birth: _____

Insurance carrier for <u>your</u> vehicle
Ins Co: _____
Phone #: _____
Claim #: _____
Adjuster: _____

Insurance carrier for <u>other</u> vehicle
Ins Co: _____
Phone #: _____
Claim #: _____
Adjuster: _____

Attorney Information

Have you retained an attorney? ☐ Yes ☐ No

Name of Attorney: _____ Attorney's phone #: _____

Accident Information

Date of accident: _____ Time of day accident happened: _____
Please explain in detail how your accident happened: _____

_____

Name of driver in **your** vehicle: _____
Name of driver in **other** vehicle: _____
How many passengers were in your vehicle? _____ Other vehicle? _____
Were police notified? ☐ Yes ☐ No Did your head strike windshield or object? ☐ Yes ☐ No
Were you knocked unconscious? ☐ Yes ☐ No If yes, for how long? _____
Were you struck from: ☐ Behind ☐ Front ☐ Passenger side ☐ Driver side
You were: ☐ Driver ☐ Passenger ☐ Front seat ☐ Back seat ☐ Wearing seat belt ☐ other protective device
When did you feel pain? ☐ Immediately after accident ☐ later that day ☐ next day ☐ _____
Where did you feel pain? _____
Where were you taken after the accident? _____
What treatment was given? _____
Did you consult any doctor after the accident? ☐ Yes ☐ No If yes, who? _____
What was diagnosis? _____
What treatment was given? _____
Have you ever had any complaints in the same area before? ☐ Yes ☐ No If yes, when? _____
What were the complaints? _____
Before this 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 this injury, are your symptoms: ☐ Improving ☐ getting worse ☐ the same

Patient Signature (or Guardian) _____ **Date** _____

SOUTHEAST CHIROPRACTIC
THE *MOTION* CENTERS

Assignment of Benefits

In consideration of the willingness of **SouthEast Chiropractic** to treat me on credit without demand for payment at the time services are rendered, I hereby agree and stipulate as follows:

I irrevocably assign to **SouthEast Chiropractic** any proceeds or compensation that I am or may become entitled to receive as a result of injuries that occurred on _____ to the extent of the chiropractic services rendered.

I make this agreement without prejudice to any rights I may have to prosecute legal claims against any party who may be liable for my injuries, but I hereby authorize and instruct you to pay directly to **SouthEast Chiropractic**, from any disability benefits, medical payments benefits, liability benefits, health and accident benefits, workers compensation benefits, judgments, settlements, or proceeds of any kind that would otherwise be payable to me, such sums as are due or may become due to **SouthEast Chiropractic** for its services rendered.

I appoint **SouthEast Chiropractic** as my attorney, in fact, to affix my name as an endorsement upon the reverse of any check or draft upon which I am a named payee, and to deposit said check or draft and apply the proceeds to any unpaid balance I may have with **SouthEast Chiropractic**.

I authorize **SouthEast Chiropractic** to release to any insurer with applicable coverage or to my attorney or successor attorney any information regarding my injuries, prior medical history, or treatment as may be necessary to facilitate collection of proceeds under this assignment.

I acknowledge that I remain personally liable for the total amount due to **SouthEast Chiropractic** for services rendered, including any balance remaining after the application of insurance payments and settlement or judgment proceeds. If **SouthEast Chiropractic** is required to take legal action against me to recover any unpaid balance on my account, I agree to reimburse **SouthEast Chiropractic** for its costs of recovery, including reasonable attorney's fees.

Patient Signature (or Guardian) _____ **Date** _____

Witness Signature _____

Notice of Lien

Pursuant to N.C.G.S. 44-49 and 44-50, **SouthEast Chiropractic** hereby asserts and gives notice of a lien upon any sums recovered in damages for personal injury in any civil action and also upon all funds paid to the above-named patient in compensation for or settlement of injuries sustained, whether in litigation or otherwise.

SouthEast Chiropractic hereby requests that if its claim is not pain in full from the foregoing proceeds, a full disclosure and accounting of proceeds be provided in conformity with N.C.G.S. 44-50.1. **SouthEast Chiropractic** agrees to be bound by any confidentiality agreements regarding the contents of the accounting.

SouthEast Chiropractic _____ **Date** _____

SOUTHEAST CHIROPRACTIC
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MEDPAY

A lot of people have medical benefits (Medpay) included on their insurance policies, and don't even realize it. Our office highly recommends that you use your Medpay coverage, if you have it, in the event that you have been injured in an automobile accident, regardless of who was at fault.

Here are 3 major reasons that we file your Medpay.

1) **MEDPAY IS EXACTLY LIKE HEALTH INSURANCE...USING IT DOESN'T CAUSE YOUR RATES TO INCREASE**. If your rates increase, it's not because you filed your Medpay, its most likely because: (a) It was determined that you were at fault; (b) you received a police citation or ticket; or (c) you've been involved in numerous reported auto accidents within a brief period of time, and therefore, are now considered to be "high risk."

2) **FILING YOUR MEDPAY DOES NOT RELIEVE THE OTHER PARTY FROM HAVING TO PAY IN FULL FOR YOUR LOSS**. On the contrary, by filing your Medpay, when you collect from the other driver's liability insurance, a greater amount of the settlement will go directly to you because your bill at our office will be less or even paid in full. If the other driver's liability insurance refuses to make payment for whatever reason, filing your Medpay will help to ensure that you are not stuck with all of the medical bills.

3) **IF YOU HAVE MEDPAY COVERAGE AND CHOOSE NOT TO FILE IT, THEN YOU ARE PAYING FOR AN OPTION, BUT NOT RECEIVING ANY BENEFIT.** For the very same reasons, our office may recommend that you file your commercial health insurance. The important thing to remember is that you are not guaranteed of receiving full payment from the liable party's insurance.

Our Office Financial Policy

As long as our office is filing your Medpay and/or health insurance, and these companies are continuing to cover your charges, we will defer collection of payment at the time of service. **If we receive overpayment on your account, we will be happy to refund you the difference.** Any balance owed will become immediately due and payable should your case not settle within a reasonable time from your release from care.

SouthEast Chiropractic reserves the right to deduct $150.00 for filing your Medpay claim. Applicable only if collected.

I am filing Medpay for treatment received by **SouthEast Chiropractic** and I understand that if the liable party does not pay my bill in full, I will be responsible for the balance in full.

This agreement is made solely for **SouthEast Chiropractic's** protection and in consideration of their awaiting payment.

Patient Signature (or Guardian) _____ **Date** _____

Witness (Name & Signature) _____ **Date**_____