

**DAKOTA RIDGE CHIROPRACTIC, P.C.
PERSONAL INJURY QUESTIONNAIRE**

PATIENT INFORMATION (please print)

DATE _____

NAME _____ SS# _____ DL# _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE _____ BIRTH DATE _____ AGE _____ SEX (M) (F) _____

MARITAL STATUS _____ SPOUSES NAME _____

EMPLOYER _____ WORK PHONE _____ X _____

EMPLOYER'S ADDRESS _____

IF YOU ARE A MINOR: MOTHER / FATHER'S NAME? _____ PHONE # _____

INSURANCE/FINANCIAL INFORMATION (HOW YOU CHOOSE TO PAY FOR TREATMENT)

AUTOMOBILE INSURANCE: NAME OF INSURANCE CO. _____

NAME OF INSURED _____ POLICY # _____

ARE YOU RELATED TO THE INSURED? Yes No WHAT RELATION? _____

DO YOU LIVE AT THE SAME ADDRESS? Yes No

HAVE YOU REPORTED THIS ACCIDENT TO YOUR INSURANCE COMPANY? .. Yes No

DID YOU REPORT THAT YOU SUFFERED INJURIES? Yes No

HAVE YOU FILLED OUT THE INSURANCE CO.'S PIP APPLICATION FORM? Yes No

DATE & TIME OF ACCIDENT: _____ a.m. p.m. STATE _____

NAME OF OWNER OF CAR YOU WERE IN DURING ACCIDENT _____

DO YOU HAVE AUTO INSURANCE? Yes No WITH WHOM? _____

HEALTH INSURANCE: NAME OF INSURANCE CO. _____

NAME OF INSURED _____ POLICY # _____ ID _____

WORKERS COMPENSATION INSURANCE: (WORK RELATED INJURY)

DATE OF ACCIDENT _____

DID YOU REPORT THE INJURY TO YOUR EMPLOYER? Yes No

CASH PAYMENT AT TIME OF SERVICE I NEED TO DISCUSS PAYMENT

SHOULD MY INSURANCE COMPANY SEND ME A CHECK/DRAFT (FOR SERVICES RENDERED ME), I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO IMMEDIATELY GIVE THIS TO YOU. I WILL NOT CASH OR DEPOSIT SAID CHECK/DRAFT TO A BANK ACCOUNT.

PATIENT/RESPONSIBLE PARTY SIGNATURE X _____ DATE _____

AUTHORIZATION TO TREAT A MINOR:

I HEREBY GIVE MY PERMISSION TO THE DOCTORS AT THIS CLINIC TO RENDER CHIROPRACTIC/ACUPUNCTURE AND/OR MASSAGE TREATMENT TO MY SON/DAUGHTER

PARENT/GUARDIAN'S SIGNATURE _____ DATE _____

ATTORNEY INFORMATION:

HAVE YOU RETAINED AN ATTORNEY BECAUSE OF THIS ACCIDENT? Yes No

IF YES, WHO? _____ WHEN? _____

The above information is accurate SIGNED X _____ DATE _____

PT. NAME _____ DATE _____ FILE # _____

AUTO RELATED ACCIDENT INFORMATION

Date & Time of Accident: _____ a.m. p.m.
 Were you the: Driver Front Passenger Rear Passenger Motorcycle Pedestrian
 If a traffic violation was issued, to whom was it issued? _____
 Number of people in accident vehicle? _____
 Did the police come to the accident site?..... Yes No
 Was a police report filed?..... Yes No
 Have you filed an accident report?..... Yes No
 Has your insurance company sent you papers to fill out?..... Yes No
 If yes, have you filled them out and returned them?..... Yes No
 Were you wearing your seat belt?..... Yes No
 Was this vehicle equipped with airbags?..... Yes No
 If yes, did it/they inflate?..... Yes No
 In relation to the base of your skull, where was the headrest? Above Below At the base of skull
 What did your vehicle impact? Another vehicle Other if other, explain _____
 Did any part of your body strike any part of the car, including the headrest? Yes No
 If yes, please describe _____
 Make and model of vehicle you were occupying? _____ Was your car towed? Yes No
 Describe the damage to your car _____
 What was the dollar amount of damage to your car? _____ Where did you get this amount? _____
 What was the approx. speed of your vehicle? _____
 Make and model of other vehicle _____
 What was the approx. speed of the other vehicle? _____
 Name of the location/street on which you were traveling? _____
 In which direction were you headed? North South East West
 In which direction was the other vehicle headed? North South East West
 Did the impact to your vehicle come from the: Front Rear Right Side Left Side
 During impact were you facing: Forward Right Left
 Were you aware, or surprised by the impact?
 The accident happened in: Daylight Night
 The road was: Wet Icy snowy Dry
 In your words, please describe the accident: _____

AFTER INJURY

Did accident render you unconscious? Yes No if yes, how long? _____ Were you dazed? Yes No
 Did you have any cuts or bruises? Yes No if yes, describe _____
 Did you have any broken bones? Yes No if yes, describe _____
 Did you go to the hospital? Yes No if yes, which hospital? _____
 Were you taken by ambulance? Yes No
 What did they do at hospital? _____
 Have you seen any other doctors for your injuries? Yes No if yes, who have you seen and what have they done? _____
 Are you on any medications? Yes No if yes, which _____

The above information is accurate SIGNED X _____ DATE _____

PT. NAME _____ DATE _____ FILE # _____

PRIOR HISTORY

Have you had prior automobile accidents? Yes No if yes, list dates _____
If yes, who gave you treatment? _____ What was the last date of treatment? _____
What areas of your body were injured? _____

Have you ever had a work related injury? Yes No If yes, were you treated? Yes No
If yes, who gave you treatment? _____ What was the last date of treatment? _____
What areas of your body were injured? _____

Have you had any other previous injuries to the areas of the body injured in this auto accident? Yes No
If yes, were you treated? Yes No If yes, who gave you treatment? _____
What was the last date of treatment? _____
What areas of your body were injured? _____

Are you pregnant, or is there any chance that you may be pregnant? Yes No
Have you had a recent pregnancy? Yes No If yes, when _____

Have you had any significant illnesses or injuries in the past five years? Yes No If yes, please list them _____

WORK HISTORY

Were you employed at the time of the accident? Yes No If yes, what is your occupation? _____
Who is your employer? _____
At your job do you bend frequently? Yes No Do you lift frequently? Yes No How much weight? _____
Does your work aggravate your injuries? Yes No
Have you missed work because of your injuries? Yes No If yes, what dates? _____
Were you on the job at the time of the accident? Yes No If yes, were you car pooling? Yes No

The above information is accurate SIGNED X _____ DATE _____

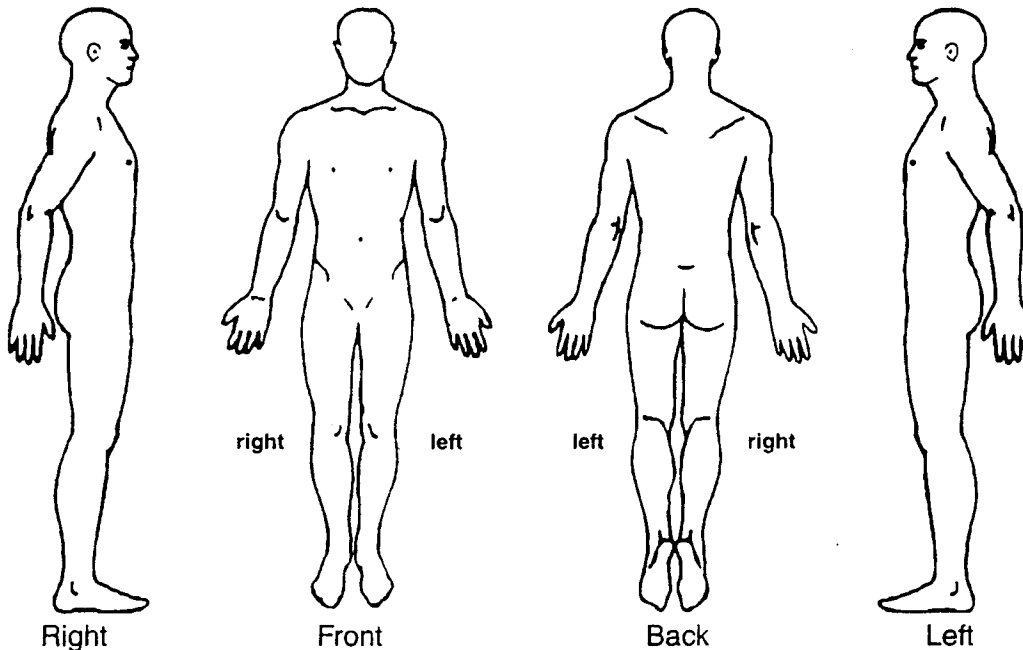
PT. NAME _____ DATE _____ FILE # _____

PAIN CHART

PLACE AN (X) NEXT TO THE SYMPTOMS YOU ARE EXPERIENCING, AND A NUMBER, FROM 1 (DISCOMFORT) TO 10 (EXTREME PAIN) BY EACH OF THE PAIN SYMPTOMS

- | | |
|--|---|
| <input type="checkbox"/> HEADACHE _____ | <input type="checkbox"/> KNEE PAIN _____ |
| <input type="checkbox"/> NECK PAIN _____ | <input type="checkbox"/> JAW PAIN _____ |
| <input type="checkbox"/> SHOULDER PAIN _____ | <input type="checkbox"/> VISUAL PROBLEMS _____ |
| <input type="checkbox"/> UPPER BACK PAIN _____ | <input type="checkbox"/> DIZZINESS _____ |
| <input type="checkbox"/> MID BACK PAIN _____ | <input type="checkbox"/> MEMORY PROBLEMS _____ |
| <input type="checkbox"/> LOW BACK PAIN _____ | <input type="checkbox"/> DIFFICULTY CONCENTRATING _____ |
| <input type="checkbox"/> CHEST PAIN _____ | <input type="checkbox"/> DEPRESSION _____ |
| <input type="checkbox"/> ARM/WRIST/HAND PAIN _____ | <input type="checkbox"/> SLEEPLESSNESS _____ |
| <input type="checkbox"/> ARM/WRIST/HAND NUMBNESS _____ | <input type="checkbox"/> CHANGE IN PERSONALITY _____ |
| <input type="checkbox"/> LEG PAIN _____ | <input type="checkbox"/> CHANGE IN BOWEL/BLADDER HABITS _____ |
| <input type="checkbox"/> LEG NUMBNESS _____ | <input type="checkbox"/> LIST OTHER SYMPTOMS _____ |

MARK THE AREAS ON YOUR BODY WHERE YOU FEEL THE FOLLOWING SYMPTOMS:
PAIN OR ACHE (USE "XXXXX") NUMBNESS OR TINGLING (USE "OOOO")



WERE YOU EXPERIENCING ANY OF THE PAIN PRIOR TO THIS ACCIDENT? Yes No
IF YES, LIST PAIN LOCATIONS AND INDICATE DEGREE OF PAIN BEFORE ACCIDENT (1-10)

WERE YOU RECEIVING TREATMENT FOR ANY OF THESE COMPLAINTS BEFORE THE ACCIDENT? Yes No

IF YES, NAME OF DOCTOR _____ DATE OF LAST TREATMENT _____

I FEEL MY PAIN IS DUE TO INJURIES I SUFFERED IN THE RECENT AUTOMOBILE ACCIDENT Yes No

The above information is accurate SIGNED X _____ DATE _____

PATIENT NAME: _____ DATE _____ I.D.# _____

Check each of the activities which you have difficulty performing and/or can perform only with pain. (There is no particular priority in the order presented.)

HOUSEWORK

- _____ Doing laundry
- _____ Making beds
- _____ Vacuuming
- _____ Washing dishes
- _____ Ironing
- _____ Carrying groceries
- _____ Caring for pets
- _____ Cooking
- _____ Other _____

PERSONAL GROOMING

- _____ Combing hair
- _____ Shaving
- _____ In/out bathtub
- _____ Brushing teeth
- _____ Other: _____

TRAVEL

- _____ Driving
- _____ Riding (Passenger)

YARD WORK

- _____ Mowing lawn
- _____ Shoveling Snow
- _____ Raking leaves
- _____ Gardening

GENERAL

- _____ Running
- _____ Sitting
- _____ Lifting
- _____ Bending
- _____ Climbing stairs
- _____ Reading
- _____ Chewing
- _____ Walking
- _____ Standing
- _____ Sports: List
- _____ Sleeping
- _____ Using telephone
- _____ Getting in and out of auto
- _____ Sexual intercourse
- _____ Using typewriter/computer

OTHER: Please list any other difficulties you are experiencing with activities you have engaged in since your condition arose: _____

Signed X _____ Date _____

ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO:
DAKOTA RIDGE CHIROPRACTIC, P.C.
PRIVATE, GROUP, ACCIDENT AND HEALTH INSURANCE

PATIENT: _____
EMPLOYER: _____
CLAIM/GROUP: _____
SS#/ID: _____

I HEREBY INSTRUCT AND DIRECT THAT _____
INSURANCE COMPANY PAY BY CHECK MADE OUT AND MAILED DIRECTLY
TO:

DAKOTA RIDGE CHIROPRACTIC, P.C.
*11550 W. MEADOWS DR. UNIT E.
LITTLETON, CO 80127*

OR:

IF MY CURRENT POLICY PROHIBITS DIRECT PAYMENT TO THE DOCTOR,
THEN I HEREBY ALSO INSTRUCT AND DIRECT YOU TO MAKE OUT THE
CHECK TO ME AND MAIL TO:

DAKOTA RIDGE CHIROPRACTIC, P.C.
*11550 W. MEADOWS DR. UNIT E
LITTLETON, CO 80127*

THE PROFESSIONAL OR MEDICAL EXPENSE BENEFITS ALLOWABLE, AND OTHERWISE
PAYABLE TO ME UNDER MY CURRENT INSURANCE POLICY AS PAYMENT TOWARD THE
TOTAL CHARGES FOR THE PROFESSIONAL SERVICES RENDERED. THIS A DIRECT
ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. THIS PAYMENT WILL
NOT EXCEED MY INDEBTEDNESS TO THE ABOVE-MENTIONED ASSIGNEE, AND I HAVE
AGREED TO PAY, IN A CURRENT MANNER, ANY BALANCE OF SAID PROFESSIONAL
SERVICE CHARGES OVER AND ABOVE THIS INSURANCE PAYMENT.

A PHOTOCOPY OF THIS ASSIGNMENT SHALL BE CONSIDERED AS EFFECTIVE AND VALID
AS THE ORIGINAL.

I ALSO AUTHORIZE THE RELEASE OF INFORMATION PERTINENT TO MY CASE TO ANY
INSURANCE COMPANY, ADJUSTER, OR ATTORNEY INVOLVED IN THIS CASE.

SIGNED AT *11550 W. MEADOWS DR. UNIT E*, THIS _____ DAY OF _____
20____.

SIGNATURE OF POLICY HOLDER

WITNESS

SIGNATURE OF CLAIMANT, IF OTHER THAN POLICYHOLDER

Dakota Ridge Chiropractic


Responsibility for Payment of Fees

Payment to be made to Dakota Ridge Chiropractic

I fully understand and agree that I am directly and fully responsible to pay in full for all professional services and/or products provided to me and/or my dependents at the time of service. I also understand and agree that such payment is not contingent upon any settlement, claim, judgment or verdict by which I may eventually recover said fee.

***** Health Insurance Patients.***** Dakota Ridge Chiropractic will make every effort to verify benefits and bill your health insurance. However, I fully understand that it is the patient's (+/or guardian's) responsibility to verify their individual coverage, and that Dakota Ridge Chiropractic will not be held liable for any misinformation given by the insurance company. It is strongly recommended that you refer to your policy brochure and/or contact your health insurer to determine your **coverage for chiropractic care.**

I also agree to pay all reasonable costs of collection, attorney fees and interest at the ANNUAL PERCENTAGE RATE of 21% (1.75% per month) on any PAST DUE BALANCE (over 60 days old).

Patient/Guardian  _____
Relationship to Patient Date _____

Authorization and Release

To the best of my knowledge, the questions on this form have been accurately answered. I understand providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the health staff to perform the necessary services I need.

Specific Risks Possibilities with Chiropractic Care:

Soreness—Chiropractic adjustments and procedures are sometimes accompanied by post-treatment soreness. This is a normal and acceptable accompanying response to chiropractic care. While it is generally not dangerous, please advise your doctor if you experience soreness or discomfort.

Soft Tissue Injury—Occasionally chiropractic treatment may aggravate a disc injury, or cause other minor joint, ligament, tendon or other soft tissue injury.

Rib Injury—Manual adjustments to the thoracic region, in rare cases, may cause rib injury or fracture. Treatment is performed carefully to minimize risk.

Stroke—Stroke is extremely rare, but is the most serious complication associated with chiropractic care. Studies estimate there is only a 1 in 5.85 million risk of stroke following an upper cervical adjustment and that the risk is no greater than a regular office visit to a family physician. (Canadian Medical Association Journal 2001) Chiropractic continues to be considered to be one of the safest forms of healthcare.

If you have any questions about this form, please ask your doctor.

I hereby give my informed consent to have chiropractic treatment administered.

Signature of Patient/Guardian  _____
Date _____

Dakota Ridge Chiropractic, P.C.
Consent for Purposes of Treatment, Payment and Healthcare Operations

I, _____ [Name of Individual] consent to Dakota Ridge Chiropractic's ("the Practice's") use and disclosure of my Protected Health Information for the purpose of providing treatment to me, for purposes relating to the payment of services rendered to me, and for the Practice's general healthcare operations purposes. Healthcare operations purposes shall include, but not be limited to, quality assessment activities, credentialing, business management and other general operation activities. I understand that the Practice's diagnosis or treatment of me may be conditioned upon my consent as evidenced by my signature on this document.

For purposes of this Consent, "Protected Health Information" means any information, including my demographic information, created or received by the Practice, that relates to my past, present, or future physical or mental health or condition; the provision of health care to me; or the past, present, or future payment for the provision of health care services to me; and that either identifies me or from which there is a reasonable basis to believe the information can be used to identify me.

I understand I have the right to request a restriction on the use and disclosure of my Protected Health Information for the purposes of treatment, payment or healthcare operations of the Practice, but the Practice is not required to agree to these restrictions. However, if the Practice agrees to a restriction that I request, the restriction is binding on the Practice.

I understand I have a right to review the Practice's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes my rights and the Practice's duties regarding the types of uses and disclosures of my Protected Health Information.

I have the right to revoke this consent, in writing, at any time, except to the extent that Physician or the Practice has acted in reliance on this consent.

X _____
Signature of Patient or Personal Representative

Name of Patient or Personal Representative

Date

Description of Personal Representative's Authority



Dakota Ridge Chiropractic, P.C.

HEALTH CARE PROVIDER LIEN

Health Care Provider: Dakota Ridge Chiropractic, P.C.

Patient's Name: _____ Date of Injury: _____

Upon receiving proceeds on my behalf, I hereby authorize and direct my attorney(s), _____, to pay directly to the above-referenced Health Care Provider such sums from any settlement, judgment, or verdict from my personal injury claim based on the accident referenced above, as may be necessary to pay in full said Health Care Provider for services rendered on my behalf.

This lien shall be irrevocable and shall be valid and enforceable out of the net proceeds of my settlement, judgment, or verdict. Net proceeds means the gross amount recovered, less any attorney fees and costs. This lien applies to sums currently owed, and to sums which may be incurred in the future. **I intend for receipt of this document by my attorney to constitute notice to the attorney of this lien and I intend for this lien to be valid and enforceable regardless of whether or not my attorney signs the lien below.**

I fully understand that I am directly and fully responsible to the above-referenced Provider for all professional bills submitted by the Provider for services rendered to me, regardless of the outcome of my personal injury claim. This agreement is made in consideration of my Health Care Provider awaiting payment for services rendered to me and to grant to the Provider security for the payment of the Provider's bills. I understand that such payment is not contingent on the outcome of any action against an insurer or any person or entity that may be responsible for the payment of such bills.

Dated: _____ Patient

The above-referenced Health Care Provider agrees that in exchange for execution of this lien by the patient, the Provider will refrain from referring any bills for professional services rendered to the patient to any third-party for collection or take any legal action to collect these bills until the personal injury claim is resolved.

Dated: _____ By: _____
Health Care Provider

The undersigned attorney for the above patient hereby agrees to withhold such sums from any settlement, judgment, or verdict and to pay such sums directly to the Health Care Provider as required by the terms of this lien.

Dated: _____ Attorney

Notice: Please date, sign, and return to Provider's office at once. Also, please keep a copy for your records.