## AUTO ACCIDENT(CHIRO OR PT):

**Describe your situation:**

**Date of Accident: _____** **Where did the collision happen?**

**Time of Accident: _____ am/pm** **City/County/State/General Area: _____**

**Type of vehicle driven by you (car, truck, etc.): _____** **Size of your vehicle (compact, full size, etc.): _____**

**Your position in vehicle (driver, passenger, etc.): _____** **Describe the other vehicle (car, truck, etc.): _____**

**Approx speed of your vehicle at impact (mph): _____** **Approx. speed of other vehicle at impact (mph):_____**

**Driving conditions: Weather (clear, cloudy, sunny, rainy, etc.): _____**

**Road (wet, dry, icy patches, snow, etc.): _____**

**Visibility (fair, good, or poor): _____**

**Action of patient's vehicle:**

- □ crossing intersection
- □ stopped at intersection
- □ stopped for a pedestrian
- □ stopped in traffic
- □ traveling slower than speed limit
- □ traveling faster than speed limit
- □ turning left
- □ traveling at posted speed limit
- □ turning right
- □ heading north
- □ heading northeast
- □ heading east
- □ heading southeast
- □ heading south
- □ heading southwest
- □ heading west
- □ heading northwest

**What happed to your car?**

- □ hit head-on
- □ hit on the left front
- □ hit on right front
- □ hit on left rear
- □ hit on right rear
- □ was rear-ended
- □ was side-swiped on left
- □ was side-swiped on right
- □ hit the car head-on
- □ hit the car on the left front
- □ hit the car on the right front
- □ hit the car on the left rear
- □ hit the car on the right rear
- □ rear-ended the car
- □ side-swiped the car on left
- □ side-swiped the car on right

**Damage to your vehicle:**

- □ complete
- □ extensive
- □ minimal
- □ moderate
- □ extensive outside, moderate inside
- □ moderate outside, minimal inside
- □ minimal outside, moderate inside

**Damage to the other vehicle:**

- □ complete
- □ extensive
- □ minimal
- □ moderate
- □ extensive outside, moderate inside
- □ moderate outside, minimal inside
- □ minimal outside, moderate inside

**Body position at impact:**

- □ leaning forward
- □ slouched down in the seat
- □ sitting straight
- □ turned to the left
- □ turned to the right
- □ holding onto the steering wheel
- □ bracing your arms on dash
- □ bracing your legs against floor
- □ not bracing arms on dash
- □ not bracing legs against floor

**Type of restraint:**

- □ lap belt
- □ shoulder belt
- □ shoulder-lap belt

**Your vehicle was pushed:**

- □ forward
- □ backward
- □ sideways

**Direction body thrown:**

- □ backward then forward
- □ forward then backward
- □ to the left
- □ to the right
- □ about the car
- □ outside the car
- □ under the car

**Head position at impact:**

- □ straight
- □ tilted forward
- □ turned to left
- □ turned to right

**Direction head thrown:**

- □ Backward then forward
- □ shoulder belt
- □ shoulder-lap belt

**Did your vehicle spin or roll after impact? (circle): Yes No**

**Were the brakes being applied? (circle): Yes No**

**Did the airbags deploy? (circle): Yes No**

**Was your ankle turnd? (circle): Yes No**

**Did your head go over the headrest? (circle): Yes No**

**Did you hit anything inside the vehicle? (circle): Yes No**

**If yes, check what object you hit and list which body part(s) (head, right or left arm, etc.):**

- □ Dashboard: _____
- □ Windshield: _____
- □ Door: _____
- □ Seat: _____
- □ Steering wheel: _____
- □ Ceiling: _____
- □ Loose objects: _____
- □ Side window: _____

PATIENT'S INITIALS_____DATE_____

**FOR OFFICE USE ONLY:**
**Patient Number: _____**
**Doctor: _____**
**Insurance: _____**
**Emp. Initials: _____**

## PATIENT INFORMATION:

****Please give your Driver's License and insurance card to the front desk to copy for your records.****
**Patient Name: Last _____ First _____ Date _____ / _____ / _____**
**Address: _____ City _____ State _____ Zip _____**
**Cell Phone: (_____) _____ - _____ Home Phone (_____) ____ - _____ Birth date ____ / ____ / ____ Age ____**
**Sex: ____M ____F Driver's License: _____ Patient Soc. Sec. # _____ - _____ - _____**
**Marital Status: S M D W Spouse's Name: _____ Referred by: _____**
**Person responsible for payment: _____ Patient Employed by: _____**
**Occupation: _____ Work Phone: (____) ____ - _____**
**Email: _____**
**Preferred method of contact for appointment reminders (circle one): Phone (home or cell) / text / email**
**Have you ever been to a Chiropractor before?: YES NO**
**Have you filed a legal claim at this time (circle if yes): Auto accident / Personal injury / Workman's Compensation**

## CAUSATION:

**The cause for your visit today was from (Select one):**

- □ Unknown factors
- □ auto accident
- □ work injury
- □ other accident
- □ trauma
- □ illness
- □ aggravation of a congenital problem

**Date of onset (if known): ____ /____ / ____**

**OR (Select one):**

- □ few days ago
- □ week ago
- □ couple of weeks ago
- □ month ago
- □ several months ago
- □ more than a year ago

**Have you ever had this complaint before this onset? (circle one): Y N**
**If you circled yes, select the number of times:**

- □ one
- □ two
- □ three
- □ four
- □ more than four times
- □ multiple times

**Since the onset of this complaint, it has been (circle one):**

- □ improving
- □ getting worse
- □ staying the same
- □ intermittent

**Please add any other information about the primary complaint that may be helpful:**

_____

PATIENT'S INITIALS_____DATE_____

## CHIEF COMPLAINT:

**Please select the answers that best describe your primary complaint for today's visit. Choose MORE than one answer if appropriate.**

**WHERE is your WORST pain?**

- □ back of the head
- □ forehead
- □ area behind the eye
- □ face
- □ neck
- □ shoulder
- □ arm
- □ hand
- □ fingers
- □ upper back
- □ chest
- □ low back and buttock region
- □ abdomen
- □ groin
- □ "tailbone"
- □ hip
- □ knee
- □ leg
- □ foot

**What word(s) BEST describe(s) you pain?**

- □ constant
- □ intermittent
- □ mostly on the right side
- □ mostly on the left side
- □ about equal on both sides
- □ radiating from the neck into the back of the head
- □ radiating from the neck into the shoulder
- □ radiating from the neck into the arm and hand
- □ radiating into the chest
- □ radiating into the abdomen
- □ radiating into the groin
- □ radiating into the buttock and thigh
- □ radiating into the entire leg and foot
- □ "shooting"
- □ "burning"
- □ "stinging"
- □ "crawling"
- □ "aching"
- □ "throbbing"

## PAIN PROFILE:

**For the following questions, please rate your pain from 1 to 10. With zero(0) being NO pain to ten(10) being maximal pain.**

**My pain today is: _____**

**The best my pain has been in last 30 days: _____**

**The worst my pain has been in the last 30 days: _____**

**Since I started coming here, my pain is (circle one):** resolved much improved less severe the same more severe

## FAMILY HISTORY:

**Please select the conditions that pertain to your IMMEDIATE family. Put "M" for mother, "F" for father and "S" for siblings.**

| | | | | |
|---|---|---|---|---|
| □ Abdominal Pain | □ Bulimia | □ Hay Fever | □ Kidney Disease | □ PMS |
| □ Acid Reflux (GERD) | □ Colon Cancer | □ Headaches | □ Kidney Stones | □ Polio |
| □ Allergies | □ Depression | □ Heart Attacks | □ Knee Pain | □ Prostate Cancer |
| □ Angina/Chest Pain | □ Diabetes Type 1 | □ Heart Disease | □ Leg Pain | □ Prostate Problems |
| □ Anorexia | □ Diabetes Type 2 | □ Hepatitis A | □ Liver Disease | □ Rapid Heart Rate |
| □ Anxiety | □ Dislocated Joints | □ Hepatitis B | □ Low Blood Pressure | □ Rectum Cancer |
| □ Aortic Aneurysm | □ Dizziness | □ Hepatitis C | □ Lower Back Pain | □ Scoliosis |
| □ Arm Pain | □ Duodenum Ulcer | □ Hernias | □ Lung Cancer | □ Shoulder Pain |
| □ Arthritis | □ Emphysema | □ High Blood Pressure | □ Mid-Back Pain | □ Sinus Trouble |
| □ Asthma | □ Epilepsy | □ High Cholesterol | □ Migraine | □ Spinal Disc Disorder |
| □ Blood Disorder | □ Esophageal Cancer | □ HIV/AIDS | □ Multiple Sclerosis | □ Stomach Cancer |
| □ Bone Cancer | □ Fainting | □ Hyperthyroidism | □ Neck Pain | □ Stroke |
| □ Brain Cancer | □ Fatigue | □ Hypothyroidism | □ Osteoporosis | □ Stroke |
| □ Breast Soreness | □ Fibromyalgia | □ Irregular Bowel Habits | □ Overweight | □ Upper Back Pain |
| □ Breast Cancer | □ Gouty Arthritis | □ Irregular Menstruation | □ Painful Urination | □ Vision Problems |

PATIENT'S INITIALS_____DATE_____

## REVIEW OF SYSTEMS:

**If you have an issue in a section below, select your issue from the list. If you have no problems for a particular question, select the "No symptoms" box.**

**Do you have any ill feelings?**
- □ No symptoms
- □ Decreased activity level
- □ Fever
- □ Chills
- □ Fatigue
- □ Night sweats
- □ Loss of appetite
- □ Weight loss
- □ Weight gain
- □ Loss of energy
- □ Uncontrolled sweating

**Do you have any mental health problems?**
- □ No symptoms
- □ Irritability
- □ Depression
- □ Disturbed sleep
- □ Suicidal thoughts
- □ Anxiety
- □ Nervousness

**Do you have any trouble urinating?**
- □ No symptoms
- □ Frequent urination
- □ Urgency
- □ Trouble stopping or starting stream
- □ Erectile dysfunction
- □ Nocturia
- □ Burning with urination
- □ Losing control/incontinence
- □ Bowel dysfunction
- □ Sexual dysfunction
- □ Hesitancy

**Do you have trouble with your vision?**
- □ No symptoms
- □ Blurred vision
- □ Double vision
- □ Vision loss
- □ Work glasses/contacts

**Do you have any symptoms of heart trouble?**
- □ No symptoms
- □ Chest pain
- □ Palpitations
- □ Fainting
- □ Shortness of breath
- □ Ankle swelling

**Do you have any breathing problems?**
- □ No symptoms
- □ Coughing
- □ Wheezing
- □ Shortness of breath

**Do you have stomach problems?**
- □ No symptoms
- □ Nausea
- □ Vomiting
- □ Diarrhea
- □ Constipation
- □ Loss of bowel control

**Do you have muscle or joint problems?**
- □ No symptoms
- □ Joint pain
- □ Joint weakness
- □ Muscle weakness

**Do you have any skin problems?**
- □ No symptoms
- □ Rash
- □ Itching
- □ Dryness
- □ Lesions
- □ Open wounds/infection
- □ Hair/nail changes

**Do you have any immunity problems?**
- □ No symptoms
- □ Enlarged lymph nodes
- □ Hives
- □ Hay fever
- □ Persistent infections

**Do you have any endocrine problems?**
- □ No symptoms
- □ Diabetes
- □ Thyroid disorder

**Do you have any neurological problems?**
- □ No symptoms
- □ Seizures
- □ Abnormal sensory feelings in extremity
- □ Loss of memory

**Do you have any bruising or bleeding problems?**
- □ No symptoms
- □ History of anemia
- □ Abnormal bleeding
- □ Bruising
- □ Heat intolerance
- □ Cold intolerance

PATIENT'S INITIALS_____DATE_____

**SOCIAL HISTORY:**

**Marital Status:** ☐ single ☐ married ☐ divorced ☐ separated ☐ widowed

**# of Children:** ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10+

**Highest level of education:**

☐ not completed high school
☐ GED diploma or equivalent
☐ completed trade school
☐ high school graduate
☐ an associates degree
☐ a bachelor's degree
☐ a Masters degree
☐ a PH.D.
☐ completed law school
☐ completed medical school
☐ completed a doctorate program (other than medica

**Do you eat a well balanced diet?**

☐ never
☐ rarely
☐ occasionally
☐ usually
☐ regularly

**Do you exercise?**

☐ never
☐ rarely
☐ occasionally
☐ usually
☐ regularly

**Types of exercises:**

| | |
|---|---|
| running/jogging | baseball |
| walking | basketball |
| weightlifting | football |
| yoga/Pilates | golf |
| group exercises | soccer |
| swimming | tennis |

**Do you drink alcohol?** ☐ never ☐ occasionally ☐ frequently (more than 3 days per week) ☐ daily

**Do you use tobacco products?** ☐ never ☐ occasionally ☐ frequently (more than 3 days per week) ☐ daily

**Have you ever used illegal drugs?** ☐ yes ☐ no

**If yes, which ones?**

acid
angel dust
cocaine
crack
crystal meth
ecstasy
heroin
LSD
marijuana
opium
phencyclidines

**Have you ever had a substance abuse problem?** ☐ yes ☐ no

**If yes, which substance(s)?**

**General:**

alcohol
amphetamines
anti-depressants
cannabis
crack/cocaine
diet pills
hallucinogens
inhalants
methamphetamine
muscle relaxants
nicotine
opiates
pain medications
phencyclidines
sleeping pills
steroids

**Specific:**

| | |
|---|---|
| adderall | marijuana |
| ambien | methodone |
| beer | naproxen |
| celebrex | paxil |
| celexa | prozac |
| cigarettes | ritalin |
| cigars | skelaxin |
| cocaine | soma |
| crack | tramadol |
| crystal meth | ultracet |
| ecstasy | ultram |
| effexor | vicodin |
| flexeril | vicoprofen |
| hard liquor | vioxx |
| hydrocodone | zanaflex |
| ibuprofen | xanax |
| lorcet | zoloft |
| lortab | |

**Have you ever had treatment for substance abuse?** ☐ yes ☐ no

PATIENT'S INITIALS_____DATE_____

## PAST SURGICAL HISTORY:

**Please list any surgeries that you have had in the past and the date if known. Also include RIGHT or LEFT side of body where applicable.**

- □ **I have never had any previous surgery**

**PROCEDURE:** **DATE:**

_____

_____

_____

_____

_____

_____

_____

## CURRENT MEDICATIONS:

**Current Medications and Vitamin Supplements: (Please use reverse side if more space is required.)**

| NAME: | STRENGTH: | FREQUENCY: | NAME: | STRENGTH: | FREQUENCY: |
|---|---|---|---|---|---|
| _____ | _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ | _____ |

## ALLERGIES:

**Please list any allergies as well as your reaction to the allergen if known.**

**Environmental Allergies:** _____

**Food Allergies:** _____

**Medication/Drug Allergies:** _____

PATIENT'S INITIALS_____DATE_____

# Neck Pain and Disability Index

**Please Read Instructions:**

This questionnaire has been designed to give the doctor information as to how your **neck pain** has affected your ability to manage in everyday life. In each section, please fill in **ONE** box only which **most closely** describes your problem.

## Section 1 Pain Intensity

- **A**. I have no pain at the moment.
- **B**. The pain is very mild at the moment.
- **C**. The pain is moderate at the moment.
- **D**. The pain is fairly severe at the moment.
- **E**. The pain is very severe at the moment.
- **F**. The pain is the worst imaginable at the moment.

## Section 2 Personal Care

- **A**. I can look after myself normally without causing extra pain.
- **B**. I can look after myself normally but it causes extra pain.
- **C**. It is painful to look after myself and I am slow and careful.
- **D**. I need some help but manage most of my personal care.
- **E**. I need help every day in most aspects of self care.
- **F**. I do not get dressed, I wash with difficulty and stay in bed.

## Section 3 Lifting

- **A**. I can lift heavy weight without extra pain.
- **B**. I can lift heavy weight but it gives extra pain.
- **C**. Pain prevents me from lifting heavy weights off the floor, but I can manage it they are conveniently positioned.
- **D**. Pain prevents me from lifting heavy weights, but I can manage light-medium weights if they are conveniently positioned.
- **E**. I can lift very light weights.
- **F**. I cannot lift or carry anything at all.

## Section 4 Reading

- **A**. I can read as much as I want with no pain in my neck
- **B**. I can read as much as I want with slight pain in my neck.
- **C**. I can read as much as I want with moderate pain in my neck.
- **D**. I can't read as much because of moderate pain in my neck.
- **E**. I can hardly read at all because of severe pain in my neck.
- **F**. I cannot read at all.

## Section 5 Headaches

- **A**. I have no headaches at all.
- **B**. I have slight headaches which come infrequently.
- **C**. I have moderate headaches which come infrequently.
- **D**. I have moderate headaches which come frequently.
- **E**. I have severe headaches which come frequently.
- **F**. I have headaches almost all of the time.

## Section 6 Concentration

- **A**. I can concentrate fully when I want with no difficulty.
- **B**. I can concentrate fully when I want with slight difficulty.
- **C**. I have a fair degree of difficulty in concentrating when I want.
- **D**. I have a lot of difficulty in concentrating when I want.
- **E**. I have a great degree of difficulty in concentrating when I want.
- **F**. I cannot concentrate at all.

## Section 7 Work

- **A**. I can do as much work as I want.
- **B**. I can only do my usual work, but no more.
- **C**. I can do most of my usual work, but no more.
- **D**. I can hardly do any work at all.
- **E**. I cannot do my usual work.
- **F**. I can't do any work at all.

## Section 8 Driving

- **A**. I can drive my car without any neck pain.
- **B**. I can drive my car as long as I want with slight pain in my neck.
- **C**. I can drive my car as long as I want with moderate pain.
- **D**. I can't drive my car as long as I want because of moderate pain.
- **E**. I can hardly drive at all because of severe pain in my neck.
- **F**. I can't drive my car at all.

## Section 9 Sleeping

- **A**. I have no trouble sleeping.
- **B**. My sleep is slightly disturbed (less then 1hr. sleepless).
- **C**. My sleep is mildly disturbed (1-2 hrs. sleepless).
- **D**. My sleep is moderately disturbed (2-3 hrs. sleepless).
- **E**. My sleep is greatly disturbed (3-5 hrs. sleepless).
- **F**. My sleep is completely disturbed (5-7 hrs. sleepless).

## Section 10 Recreation

- **A**. I am able to engage in all recreational activities with no neck pain.
- **B**. I am able to engage in all my recreational activities, with some pain in my neck.
- **C**. I am able to engage in most, but not all of my usual recreational activities because of my neck pain.
- **D**. I am able to engage in a few of my usual recreational activities because of my neck pain.
- **E**. I can hardly do any recreational activities because of pain.
- **F**. I can't do any recreational activities at all.

**Office Use Only** **Score:_____**

PATIENT'S INITIALS_____DATE_____

# Low Back Pain and Disability Index

**Please Read Instructions:**

This questionnaire has been designed to give the doctor information as to how your **low back pain** has affected your ability to manage in everyday life. In each section, please fill in **ONE** box only which **most closely** describes your problem.

## Section 1 Pain Intensity

- **A**. The pain comes and goes and is very mild.
- **B**. The pain is mild and does not vary much.
- **C**. The pain comes and goes and is moderate.
- **D**. The pain is moderate and does not vary much.
- **E**. The pain comes and goes and is very severe.
- **F**. The pain is very severe and doesn't vary much.

## Section 2 Personal Care

- **A**. I can look after myself normally without causing extra pain.
- **B**. I can look after myself normally but it causes extra pain.
- **C**. It is painful to look after myself and I am slow and careful.
- **D**. I need some help but manage most of my personal care.
- **E**. I need help every day in most aspects of self care.
- **F**. I can't dress myself. I wash with difficulty and stay in bed.

## Section 3 Lifting

- **A**. I can lift heavy weight without extra pain.
- **B**. I can lift heavy weight but it gives extra pain.
- **C**. Pain prevents me from lifting heavy weights off the floor.
- **D**. Pain prevents me from lifting heavy weights, but I can manage if they are conveniently positioned.
- **E**. Pain prevents me from lifting heavy weights, but I can manage light-medium weights if they are conveniently positioned.
- **F**. I can only lift very light weights at the most.

## Section 4 Walking

- **A**. I have no pain while walking.
- **B**. I cannot walk more than one mile without increasing pain.
- **C**. I cannot walk more than ½ mile without increasing pain.
- **D**. I cannot walk more than ¼ mile without increasing pain.
- **E**. I can walk with crutches.
- **F**. I cannot walk at all without increasing pain.

## Section 5 Sitting

- **A**. I can sit in any chair as long as I like.
- **B**. I can only sit in my favorite chair as long as I like.
- **C**. Pain prevents me from sitting more than one hour.
- **D**. Pain prevents me from sitting more than a half hour.
- **E**. Pain prevents me from sitting more than 10 minutes.
- **F**. I avoid sitting because it increases pain straight away.

## Section 6 Standing

- **A**. I can stand as long as I want without pain.
- **B**. I have some pain on standing but it does not increase with time.
- **C**. I cannot stand for longer than one hour without increasing pain.
- **D**. I cannot stand for longer than a ½ hour without increasing pain.
- **E**. I can't stand for longer than 10 minutes without increasing pain.
- **F**. I avoid standing because it increases the pain straight away.

## Section 7 Sleeping

- **A**. I get no pain in bed.
- **B**. I get pain in bed but it doesn't prevent me from sleeping well.
- **C**. Because of pain my normal night's sleep is reduced by < 1/4.
- **D**. Because of pain my normal night's sleep is reduced by < 1/2.
- **E**. Because of pain my normal night's sleep is reduced by < 3/4.
- **F**. Pain prevents me from sleeping at all.

## Section 8 Traveling

- **A**. I get no pain while traveling.
- **B**. I get some pain while traveling but none of my usual forms of travel make it any worse.
- **C**. I get extra pain while traveling but it does not compel me to seek alternative forms of travel.
- **D**. I get extra pain while traveling which compels me to seek alternative forms of travel.
- **E**. Pain restricts all forms of travel.
- **F**. Pain prevents all forms of travel except that done lying down.

## Section 9 Social life

- **A**. My social life is normal and gives me no pain.
- **B**. My social life is normal but increases the degree of pain.
- **C**. Pain limits my more energetic interests, e.g. dancing, etc.
- **D**. Pain has restricted my social life and I do not go out very often.
- **E**. Pain has restricted my social life to my home.
- **F**. I have hardly any social life because of the pain.

## Section 10 Changing Degree of Pain

- **A**. My pain is rapidly getting better.
- **B**. My pain fluctuates but overall is definitely getting better.
- **C**. My pain seems to be getting better but improvement is slow.
- **D**. My pain is neither getting better nor worse.
- **E**. My pain is gradually worsening.
- **F**. My pain is rapidly worsening.

**Office Use Only** **Score:_____**

PATIENT'S INITIALS_____DATE_____

# HIPAA Acknowledgement and Consent

I, the undersigned, acknowledge that I have had access to a copy of the **NOTICE OF PRIVACY PRACTICES**. I consent to your disclosure, which you deem necessary in connection with my or my child's condition. This information will only be distributed to your third party payer for purposes of reimbursement for services provided, and only upon direct request of your third party payer.

**Patient signature**_____ **Date**_____

# Authorization and Assignment

**AUTHORIZATION TO BILL INSURANCE:** I understand my insurance will be billed for services rendered at Total Health Systems, PC.

**AUTHORIZATION TO RELEASE INFORMATION**: You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney, or adjuster, in order to process any claim for reimbursement of charges incurred by me as a result of professional services rendered by you of any consequence thereof.

**ASSIGNMENT OF PAYMENT**: My attorney and/or insurance company are hereby requested to pay direct to the doctor listed below, any moneys due him/her on account, the same to be deducted from any settlement made on my behalf. Further, I agree to pay the difference if any, between the total amounts of his/her charges and the amount paid him/her by the attorney and/or insurance company. It is further understood that I, the undersigned, agree to pay the full amount of his/her charges, should my condition be such that it is not covered by my policy or if for any reason the insurance company and/or attorney refuses to pay my claim. Accepting assignment does not release the patient from the responsibility for their yearly deductible or for their co-payment on services provided by the clinic. If you receive payment from your insurance carrier during the period which the clinic has accepted assignment of benefits, you are to bring the check into this office within one week of receipt and endorse it over to the clinic. Failure to do so will result in collection action.

**MEDICARE ASSIGNMENT *(if applicable)***: I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration to its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment below.

**ACKNOWLEGMENT AND UNDERSTANDING**: I hereby acknowledge;

That if there is no insurance company obligated to pay for the services, or if the insurance company involved refuses to acknowledge an assignment to the doctor, or make other provisions for the protection of the interest of the doctor; or if a liability claim exists and my attorney refuses to agree to protect the interest of the doctor, or if I have not engaged the services of an attorney; then payment of services rendered by Total Health Systems PC, will be made on a current basis and my bill paid in full as soon as my liability claim is settled or the passage of three months from my last statement, whichever comes first.

**SPECIAL CONSIDERATION**: I understand that should I have a financial hardship and am unable to completely satisfy my deductible/copay/or coinsurance I will notify Total Health Systems, PC and a separate written contract will be created and signed.

**Patient signature**_____ **Date**_____

# Consent to Treat

**THIS CONSTITUTES INFORMED CONSENT FOR MEDICAL, PHYSICAL THERAPY, AND/OR CHIROPRACTIC CARE.** I hereby request and consent to the performance of specific testing and procedures on me (or the patient named below for which I am legally responsible) as deemed necessary by the providing physicians at Total Health Systems, P.C. I understand, and am informed that, while extremely rare, there are some risks to treatment including, but not limited to: fractures, disc injuries, strokes, dislocations, sprains, and strains. I wish to rely on the doctor and treating provider to exercise judgment during the course of the procedure, based on the facts then known is in my best interest. I have read, or have had read to me, the above consent. I have the opportunity to discuss the nature and purpose of the chiropractic adjustments and other procedures with the doctor and/or office personnel. I agree to these procedures and intend this consent form to cover the entire course of treatment and for any future condition(s) for which I seek treatment.

**Patient signature**_____ **Date**_____

**Parent/Legal guardian name** (please print)_____

**Guardian Signature**_____ **Date**_____

TOTAL HEALTH SYSTEMS
Multi-Specialty Clinic
Chiropractic • Medical • Physical Therapy • Massage Therapy • Nutrition

## *(Consent to use PHI) Notice of Privacy Practices - Acknowledgement & Consent*

**Acknowledgement for Consent to Use and Disclosure of Protected Health Information**

**Use and Disclosure of your Protected Health Information**

Your Protected Health Information will be used by Total Health Systems, P.C. or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

**Notice of Privacy Practices**

You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. You may review the Notice prior to signing this consent. You may request a copy of the Notice at the Front Desk.

**Requesting a Restriction on the Use or Disclosure of Your Information**

- You may request a restriction on the use or disclosure of your Protected Health Information.
- This office may or may not agree to restrict the use or disclosure of your Protected Health Information.
- If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

**Revocation of Consent**

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

***By my signature below I give my permission to use and disclose my health information.***

| | |
|---|---|
| Patient or Legally Authorized Individual Signature | Date |
| Print Patient's Full Name | Time |
| Witness Signature | Date |

26672 Van Dyke ● Centerline ● Michigan 48015 ● (586) 756-7670
43740 Garfield ● Clinton Township Michigan 48038 ● (586) 228-0270
28098 23 Mile Rd ● Chesterfield Township ● Michigan 48051 ● (586) 949-0123
30045 Harper Ave ● St Clair Shores ● Michigan 48082 ● (586) 772-8560
57911 Van Dyke Rd ● Washington Township ● Michigan 48094 ● (586) 781-0800
Fax (586) 228-9019
www.totalhealthsystems.com

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## *Patient Authorization*

**Standard Authorization of Use and Disclosure of Protected Health Information**

**Information to Be Used or Disclosed**

The information covered by this authorization includes:

☐ X-Rays ☐ History ☐ Diagnosis ☐ Treatment ☐ Reports
☐ Other: _____

**Purpose of Release**

☐ For the purpose of treatment at the above health care facility.
☐ Other: _____

**Persons Authorized to Use or Disclose Information**

Information listed above will be used or disclosed by:

_____
Name of Person Organization

_____
Name of Person Organization

**Expiration Date of Authorization**

This authorization is effective through _____ unless revoked or terminated by the patient or patient's personal representative.

## *Patient Rights*

**Right to Terminate or Revoke Authorization**

You may revoke or terminate this authorization by submitting a written revocation to this office and contacting the Privacy Officer.

**Potential for Re-disclosure**

Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulations.

I understand this office will not condition my treatment or payment on whether I provide authorization for the requested use or disclosure. ***If you understand and agree with all of the above policies, please sign your name below.***

_____ _____
Patient or Legally Authorized Individual Signature Date & Time

_____ _____
Print Patient's Full Name Date of Birth ( XX/XX/XXXX )

_____ _____
Witness Signature Date

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