# VEHICLE ACCIDENT INFORMATION

## PATIENT INFORMATION

Date_____

Patient Name_____

Date of Accident_____ Time of Accident_____ ☐ a.m. ☐ p.m.

Please describe the accident in your own words:_____

_____

_____

_____

Were you the: ☐ Driver ☐ Front Passenger ☐ Rear Passenger ☐ Pedestrian

How many people were in the accident vehicle?_____

## ACCIDENT SITE

Road/Street Name_____

City/State_____

Nearest intersection with road/street_____

Driving conditions ☐ Dry ☐ Wet ☐ Icy ☐ Other _____

Which direction were you headed?_____

Speed you were traveling?_____

## VEHICLE

Make and model of vehicle you were in:

_____

Were you wearing a seatbelt? ☐ Yes ☐ No

If yes, what type? ☐ Lap ☐ Shoulder

Was vehicle equipped with airbags? ☐ Yes ☐ No

If yes, did it/they inflate properly? ☐ Yes ☐ No

Did your seat have a headrest? ☐ Yes ☐ No

If yes, what was the position of the headrest?

☐ Low ☐ Midposition ☐ High

## IMPACT

Did your car impact another vehicle? ☐ Yes ☐ No

Did your car impact a structure? ☐ Yes ☐ No

If yes, explain_____

_____

Did any part of your body strike anything in the vehicle?

☐ Yes ☐ No If yes, explain_____

Was impact from :

☐ Front ☐ Rear ☐ Left ☐ Right ☐ Other_____

At the time of impact were you:

☐ Looking straight ahead ☐ Looking to the right

☐ Looking to the left ☐ Looking down

☐ Looking up

Were both hands on the steering wheel? ☐ Yes ☐ No

If no, which hand was on the wheel? ☐ Right ☐ Left

Was your foot on the brake? ☐ Yes ☐ No

If yes, which foot was on the brake? ☐ Right ☐ Left

Were you: ☐ Surprised by impact ☐ Braced for impact

## OTHER VEHICLE (if applicable)

Make and model of other vehicle_____

Which direction was other vehicle headed?_____

Speed other vehicle was traveling_____

## POLICE

Did the police come to the accident site? ☐ Yes ☐ No

Were there any witnesses? ☐ Yes ☐ No

Was a police report filed? ☐ Yes ☐ No

Was a traffic violation issued? ☐ Yes ☐ No

If yes, to whom?_____

## PATIENT CONDITION

Were you unconscious immediately after the accident? ☐ Yes ☐ No If yes, for how long?_____

Please describe how you felt immediately after the accident:

_____

_____

## TREATMENT

Did you go to the hospital? ☐ Yes ☐ No

When did you go? ☐ Immediately after accident ☐ Next day ☐ 2 days or more after the accident

How did you get to the hospital? ☐ ☐ Ambulance ☐ Private transportation

Name of hospital_____ Name of doctor_____

Diagnosis_____

_____

Treatment received_____

X-rays taken_____

## SYMPTOMS/INJURIES

Have you been able to work since this injury? ☐ Yes ☐ No How many work days have you missed?_____

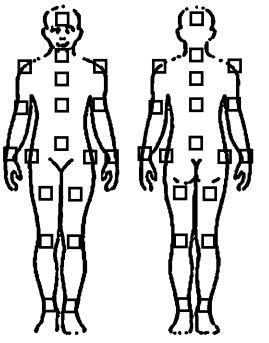
Prior to the injury were you able to work on an equal basis with others your age? ☐ Yes ☐ No

If you have had any of the following symptoms since your injury, please ☑ check:

| | | |
|---|---|---|
| ☐ Arm/shoulder pain | ☐ Feet/toe numbness | ☐ Neck pain |
| ☐ Back pain | ☐ Hand/finger numbness | ☐ Neck stiff |
| ☐ Back stiffness | ☐ Headaches | ☐ Shortness of breath |
| ☐ Chest pain | ☐ Irritability | ☐ Sleep difficulty |
| ☐ Dizziness | ☐ Jaw problems | ☐ Stomach upset |
| ☐ Ear buzzing | ☐ Leg pain | ☐ Tension |
| ☐ Ear ringing | ☐ Memory loss | ☐ Vision blurred |
| ☐ Fatigue | ☐ Nausea | |

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.



Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain)____

Type of pain:

| | | | |
|---|---|---|---|
| ☐ Sharp | ☐ Dull | ☐ Throbbing | ☐ Numbness |
| ☐ Aching | ☐ Shooting | ☐ Burning | ☐ Tingling |
| ☐ Cramps | ☐ Stiffness | ☐ Swelling | ☐ Other_____ |

How often do you have this pain?_____

Is it constant or does it come and go?_____

Does it interfere with your: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Movements that are painful to perform: ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____

Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

Patient Name:_____ Date:_____

## CURRENT SYMPTOMS:

Review The PAIN SCALE On The Bottom Of This Page And List Your Complaints In Order Of Severity:

COMPLAINT #1: _____

What Percentage Of The Time Do You Experience/Feel This Symptom? _____%
Pain Scale _____ 0 (no pain) – 10 (severe pain).
What Makes This Symptom Better? _____
What Makes This Symptom Worse? _____
Which Side is Worse? Right_____ Left_____ Both_____

COMPLAINT #2: _____

What Percentage Of The Time Do You Experience/Feel This Symptom? _____%
Pain Scale _____ 0 – 10.
What Makes This Symptom Better? _____
What Makes This Symptom Worse?_____
Which Side is Worse? Right_____ Left_____ Both_____

COMPLAINT #3: _____

What Percentage Of The Time Do You Experience/Feel This Symptom? _____%
Pain Scale _____ 0 – 10.
What Makes This Symptom Better? _____
What Makes This Symptom Worse?_____
Which Side is Worse? Right_____ Left_____ Both_____

COMPLAINT #4:_____

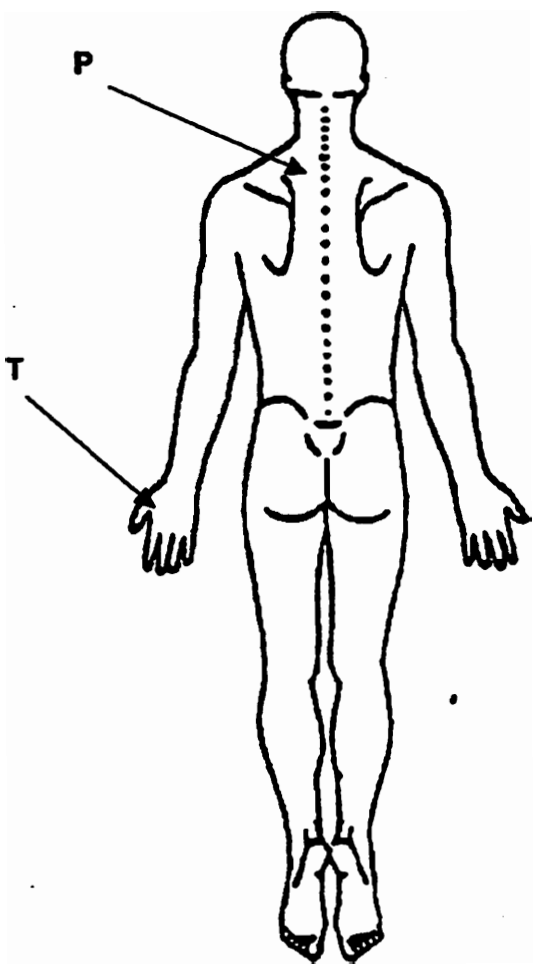
What Percentage Of The Time Do You Experience/Feel This Symptom? _____%
Pain Scale _____ 0 – 10.
What Makes This Symptom Better? _____
What Makes This Symptom Worse?_____
Which Side is Worse? Right_____ Left_____ Both_____

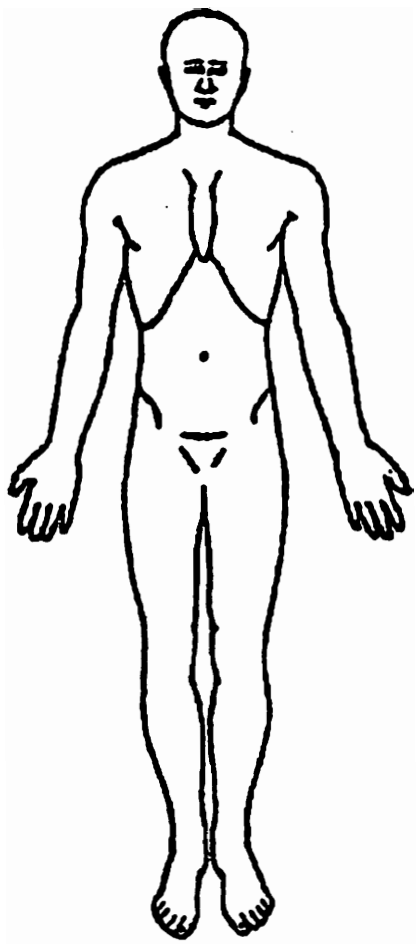
**PAIN SCALE**

| | | | | |
|---|---|---|---|---|
| 0-1 | = | Minimal | = | The pain is an annoyance but does not stop me from working. |
| 2-3 | = | Slight | = | I can tolerate the pain but it causes some difficulty in doing my work. However, it does not stop me from working. |
| 5 | = | Moderate | = | The pain causes a marked handicap in my ability to work, but I can continue. |
| 7-8 | = | Moderate To Severe | = | The pain is approaching the worst I have ever experienced or could imagine. It causes a significant problem with working and most of the time I can't. |
| 10 | = | Severe | = | The pain is the worst I have ever experienced or could imagine and causes me to stop all work and activity. |

Mark The Areas On Your Body Where You Are Having Symptoms.

P = Pain N = Numbness/Tingling T = Tenderness B = Burning R = Radiating



Time of day that pain is worse? _____

Does Pain increase with activity? _____

Any difficulty doing household duties(outside)?_____

Any difficulty doing work duties? _____

Any difficulties doing domestic duties (indoor)? _____

# NECK DISABILITY INDEX QUESTIONNAIRE

**NAME**_____ **AGE**_____ **DATE**_____ **SCORE**_____

***PLEASE READ:*** This questionnaire is designed to enable us to understand how much your neck pain has affected your ability to manage your everyday activities. Please answer each section by circling the ONE CHOICE that most applies to you. We realize that you may feel that more than one statement may relate to you, but ***PLEASE JUST CIRCLE THE ONE CHOICE THAT MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.***

*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 (Washing, Dressing, etc.)*

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 weights without extra pain.
B. I can lift heavy weights, but it gives extra pain.
C. Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example, on a table.
D. Pain prevents me from lifting heavy weights, but I can manage light to 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 to with no pain in my neck.
B. I can read as much as I want to with slight pain in my neck.
C. I can read as much as I want to with moderate pain in my neck.
D. I cannot read as much as I want because of moderate pain in my neck.
E. I cannot read as much as I want 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 the time.

*SECTION 6 - Concentration/*

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

*SECTION 7 - Work*

A. I can do as much work as I want to.
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 cannot do my usual work.
E. I can hardly do any work at all.
F. I cannot 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 in my neck.
D. I cannot drive my car as long as I want because of moderate pain in my neck.
E. I can hardly drive at all because of severe pain in my neck.
F. I cannot drive my car at all.

*SECTION 9 – Sleeping*

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

*SECTION 10 – Recreation*

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

**COMMENTS:** _____

_____

_____

*Vernon H, Mior S. The Neck Disability Index: A study of reliability and validity. J Manipulative Physiol Ther 1991;14:409-415.*

# OSWESTRY DISABILITY INDEX 2.0

**NAME**_____ **DATE**_____ **SCORE**_____

***PLEASE READ:*** Could you please complete this questionnaire. It is designed to give us information as to how your back (or leg) trouble has affected your ability to manage in everyday life.

Please answer ***every section***. Mark ***one box only*** in each section that most closely describes you ***today***.

*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 (washing, dressing, etc.)*
- A ☐ I can look after myself normally without causing extra pain.
- B ☐ I can look after myself normally but it is very painful.
- 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, wash with difficulty☐ and stay in bed.

*SECTION 3 - Lifting*
- A ☐ I can lift heavy weights without extra pain.
- B ☐ I can lift heavy weights, but it causes extra pain.
- C ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g. on a table.
- D ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- E ☐ I can only lift very light weights, at the most.
- F ☐ I cannot lift or carry anything at all.

*SECTION 4 - Walking*
- A ☐ Pain does not prevent me from walking any distance.
- B ☐ Pain prevents me from walking more than one mile.
- C ☐ Pain prevents me from walking more than 1/4 mile.
- D ☐ Pain prevents me from walking more than 100 yards.
- E ☐ I can only walk while using a stick or crutches.
- F ☐ I am in bed most of the time and have to crawl to the toilet.

*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 1 hour.
- D ☐ Pain prevents me from sitting more than 1/2 hour.
- E ☐ Pain prevents me from sitting more than ten minutes.
- F ☐ Pain prevents me from sitting at all.

*SECTION 6 - Standing*
- A ☐ I can stand as long as I want without extra pain.
- B ☐ I can stand as long as I want but it gives me extra pain.
- C ☐ Pain prevents me from standing for more than 1 hour.
- D ☐ Pain prevents me from standing for more than 1/2 hour.
- E ☐ Pain prevents me from standing for more than 10 minutes.
- F ☐ Pain prevents me from standing at all.

*SECTION 7 - Sleeping*
- A ☐ My sleep is never disturbed by pain.
- B ☐ My sleep is occasionally disturbed by pain.
- C ☐ Because of pain I have less than 6 hours' sleep.
- D ☐ Because of pain I have less than 4 hours' sleep.
- E ☐ Because of pain I have less than 2 hours' sleep.
- F ☐ Pain prevents me from sleeping at all.

*SECTION 8 - Sex Life (if applicable)*
- A ☐ My sex life is normal and causes me no extra pain.
- B ☐ My sex life is normal, but causes some extra pain.
- C ☐ My sex life is nearly normal but is very painful.
- D ☐ My sex life is severely restricted by pain.
- E ☐ My sex life is nearly absent because of pain.
- F ☐ Pain prevents any sex life at all.

*SECTION 9 - Social Life*
- A ☐ My social life is normal and causes me no extra pain.
- B ☐ My social life is normal, but increases the degree of pain.
- C ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., sport, etc.
- D ☐ Pain has restricted my social life and I do not go out as often.
- E ☐ Pain has restricted my social life to my home.
- F ☐ I have no social life because of the pain.

*SECTION 10 - Traveling*
- A ☐ I can travel anywhere without pain.
- B ☐ I can travel anywhere but I gives extra pain.
- C ☐ Pain is bad but I manage journeys over 2 hours.
- D ☐ Pain restricts me to journeys of less than 1 hour.
- E ☐ Pain restricts me to short necessary journeys under 30 minutes.
- F ☐ Pain prevents me from traveling except to receive treatment.

**COMMENTS:** _____

_____

_____

_____

_____

*Roland, M. and J. Fairbank (2000). "The Roland-Morris Disability Questionnaire and the Oswestry Disability Questionnaire." Spine 25(24): 3115-24.*

# DEWALD CHIROPRACTIC INC.

1037 W. Avenue N, Suite 101 – Palmdale, California 93551 (661) 266-3500 Fax (661) 266-3591

## DOCTOR'S ASSIGNMENT AND LIEN

PATIENT:_____

DATE OF INJURY:_____

I hereby authorize Dewald Chiropractic Inc. to furnish my attorney. Or other Third Party Insurance Company, with a full report of my history and examination findings in regards to the above referenced accident.

Pursuant to California Civil Code section 2881 (1), I hereby authorize and direct you to pay ***directly*** to Dewald Chiropractic, Inc. such as sums as may due and owing them for medical services rendered to me by reason of this accident, and by reason of any other bills that are due to his office; and, to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect said doctor. I hereby further give a lien on my case to Dewald Chiropractic, Inc. against any and all proceeds of any settlement, judgment or verdict which my be paid to me, my attorney, or any other third party as the result of the injuries for which I have been treated, or injuries in connection therewith. ***This is a direct assignment of my rights and benefits under this claim.***

I fully understand that ***I am directly and fully responsible*** to said doctor for all medical benefits, including major medical, submitted by him for services rendered to me, and that this agreement is made solely for said doctors additional protection and consideration of his awaiting payment. I further understand that such payment is not contingent on any settlement, judgment, or verdict by which I may eventually recover said fee. If I do not wish to cooperate in protecting the doctor's interest, he may not await payment, and declare the entire balance due and payable by me. If this account is assigned for collection and/or suit, collection cots, interest, and/or attorney/court costs will be added to the total amount due.

Dated:_____ Patient's Signature:_____

Acknowledgement of Third Party:

I,_____, the undersigned (Attorney/Insurance Company Representative) agrees to observe all the terms of the above, and agrees to withhold such sums form any settlement, judgment or verdict as may be necessary to adequately protect Dewald Chiropractic, Inc.

Dated:_____ Authorized Signature:_____

Please date, sign and return one copy to above doctor's address at your earliest convenience.

This office holds an assignment / lien on this case for services rendered. Any settlement of this claim without honoring said assignment / lien will cause you to be responsible to this office for payment.
(California State Insurance Code #101.33)

# Cancellation Policy/ Missed Appointment

As stated in our Missed Appointment Policy you signed as part of your New Patient Packet, our policy is to take a credit card as security upon your first appointment.

We kindly ask for the courtesy of a **24-hour notification of cancellation** in the event you are unable to show for your appointment. If we do not receive the timely notice, please understand that a non-waivable fee of $30 per half-hour missed will be charged to your account. If you purchased any packages or are subscribed to our wellness program, please understand that failure to give proper 24-hour notice will result in the forfeiture of that session.

This policy ensures that all of our patients have the best opportunity for appointment choice, and that times are not held for patients who will not be showing up. We do our best to consider each individual case, and rest assured **YOUR CARD WILL NOT BE CHARGED** unless the above occurs without reasonable cause.

By signing below, you agree and accept the above-stated policy.

Name:_____

Signature:_____ Date:_____

Parent/Guardian (if Minor):_____

DC Employee Signature:_____

Credit Card Type: V/MC

Credit Card Number:_____

Expiration Date:_____

Name on Card:_____

**NOTE: This form will be destroyed by shredding once processed by Dewald Chiropractic.**

# NOTICE OF PRIVACY PRACTICES

**Dewald Chiropractic Inc.**
**1037 West Ave N**
**Suite 101**
**Palmdale, CA 93551**
**(661)266-3500**

**Privacy Officer: Thomas E. Dewald**
**Effective Date: 4/1/2003**

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

We understand that your medical information is private and we strive to protect the confidentiality of your medical records. The new federal regulations require that we issue this official notice of our privacy practices. You have the right to the confidentiality of your medical information, and this practice is required by law to maintain the privacy of that information. The practice is required to abide by the terms of the Notice of Privacy Practices currently in effect and to provide notice of its legal duties and privacy practices with respect to the protected health information.
Prior to making important changes to our privacy practices, we will make available on request a revised Notice of Privacy Practices.
This notice will be followed by any health care professional authorized to enter information in your medical record. All employees, staff, and other personnel at this practice who may need access to your information must abide by this Notice. All subsidiaries, business associates, sites and locations of this practice may share medical information with each other for treatment, payment purposes or health care operations described in this notice. Except where treatment is involved, only the minimum necessary information needed to accomplish the task will be used.

## HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU

The following categories describe different ways that we may use and disclose medical information without your specific consent or authorization. Examples are provided for each category of uses or disclosures. Not all possible uses or disclosures are listed.

**For Treatment:** We may use and disclose medical information about you to provide you with medical treatment or services. Example: In treating you for a specific condition, we may need to know if you are allergic to specific drugs that could influence which medication we prescribe for treatment purpose.

**For Payment:** We may use and disclose medical information about you so that treatment and services you receive from us may be billed and payment may be collected from you insurance, third party or you. Example: We may need to send your protected health information, such as your name, address, office visit date and codes identifying your diagnosis and treatment to your health insurance company for payment.

**Health Care Operations:** We may use and disclose medical information about you for health care operations to assure that you receive quality care. Example: We may use medical information to review our treatment and services and evaluate the performance of our staff in caring for you.

**Other Uses or Disclosures That Can Be Made Without Consent or Authorization**
-As required during an investigation by Law enforcement agencies.
-To avert a serious threat to public health and safety
-As required by military command authorities for their medical records
-To workers' compensation or similar programs for processing of claims
-In response to legal proceeding
-To a coroner or medical examiner for identification of body
-If an inmate, to the correctional institution or law enforcement official
-As required by the US Food and Drug Administration (FDA)
-Other healthcare providers' treatment activities
-Other covered entities' healthcare operations activities (to the extent permitted under HIPPA)
-Uses and disclosures required by law
-Uses and disclosures in domestic violence or neglect situations
-Health Oversight activities
-We may contact you to provide appointment reminders of information about treatment alternatives or other health related benefits and services that may be of interest to you.

**(over)**

**Uses and Disclosures of Protected Health Informational Requiring Your Written Authorization:**
Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written authorization. If you give us authorization to use or disclose medical information about you, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will thereafter no longer use or disclose medical information about you about you for the reasons covered by your written authorization. You understand that we're unable to take back any disclosures we have already made with your authorization, and that we are required to retain our records of the care we have provided you.

## YOUR INDIVIDUAL RIGHT REGARDING YOUR MEDICAL INFORMATION

**Complaints:** If you believe your privacy rights have been violated, you may file a complaint with the Privacy Officer at this practice or with the Secretary of the Department of Health and Human Services.
All complaints must be submitted in writing. You will not be penalized or discriminated against for filing a complaint.

**Right to request Restrictions:** You have the right to request a restriction or limitation on the medical information we use or disclose about you for your treatment, payment or health care operations or to someone who is involved with or in your care or the payment for your care. We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment. To request restriction you must submit your request in writing to the Privacy Officer at the practice. In your request, you must tell us what information you want limited.

**Right to request Confidential Communications:** You have the right to request how we should send communications to you about medical matters, and where you would like those communications sent. To request confidential communications, you must make your request in writing to the Privacy Officer at this practice. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted. We reserve the right to deny a request if it imposes an unreasonable burden on the practice.

**Right to Inspect and Copy:** You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually this includes medical and billing records but does not include psychotherapy notes, information compiled for use in a civil, criminal or administrative action or proceeding and protected health information to which access is prohibited by law. To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to the Privacy Officer at this practice. If you request a copy of the information, we reserve the right to charge a fee for he costs of copying, mailing or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that denial be reviewed. Another licensed healthcare professional chosen by this practice will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

**Right to a Paper Copy of This Notice:** You have the right to a paper copy of this Notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy. To obtain a paper copy of the current Notice, please request on in writing from the Privacy Officer at this practice.

**Right to Amend:** If you feel the medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept. To request an amendment, your request must be made in writing and submitted to the Privacy Officer at this practice. In addition you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if the information was not created by us, is not part of the medical information kept at this practice, is not part of the information which you would be permitted to inspect and copy, or which we deem to be accurate and complete. If we deny your request for an amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttals to your statement and will provide you a copy of any such rebuttal. Statements of disagreement and any corresponding rebuttals will be kept on file and sent out with any future authorized requests for information pertaining to the appropriate portion of your record.

**Changes to This Notice:** We reserve the right to change this Notice. We reserve the right to make the revised or changed Notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current notice, with the effective date in the upper right corner of the first page.

I have read the Privacy Notice and understand my rights contained in the above Notice. By way of my signature, I provide Dewald Chiropractic with my authorization and consent to use and disclose my protected health care information as described above.

| _____ | _____ | _____ |
|---|---|---|
| Patients Name (**Print**) | Patients/Guardian Signature | Date |

# Dewald Chiropractic
# Office Policies & Consent

Thank you for choosing Dewald Chiropractic, Inc. as your healthcare provider. We are committed to your successful treatment and for your experience with us to be second to none. Please thoroughly review the following office policies and areas of consent prior to your first appointment. For us to provide the best treatment possible for all of our patients, we do require that all policies are agreed to prior to your first visit.

## INFORMED CONSENT FOR TREATMENT

I understand that, as with any medical treatment, there are possible side effects associated with chiropractic treatment. These may include, but are not limited to: pain, stiffness, headaches, dizziness, or fatigue. I also understand that although the doctor will examine me to rule out any high-risk situations, there is still a remote chance of paralysis, stroke or even death. To help the doctor with his treatment, I certify that I have filled out the "Patient Information/Questionnaire" truthfully and to the best of my ability, and furthermore I am fully responsible for any errors or omissions.

(Initials) _____

## MISSED APPOINTMENTS

When you schedule an appointment with Dewald Chiropractic, we will (as a courtesy to you) send you a reminder text message or email; but it is your responsibility to remember when you schedule your appointments regardless of whether you received said reminder. If for any reason you are unable to make your appointment it is your responsibility to cancel or reschedule at least 24 hours in advance. If you fail to do so you will be charged $30 per every 30 minutes you were scheduled for. Upon your first appointment, we will require a credit card to be kept on file to ensure future payment of missed appointments or appointments that are cancelled/rescheduled without 24 hours prior notice.

(Initials) _____

## ASSIGNMENT OF BENEFITS

I, the undersigned verify that I, (or my dependent) have insurance coverage, and hereby assign any benefits paid on my behalf for services rendered, to be paid directly to Dewald Chiropractic, Inc. I hereby authorize Dewald Chiropractic to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. However, I clearly understand and agree that although insurance billing services are provided as a courtesy, all services rendered to me (or my dependent) are my personal and direct responsibility, as well as any and all co-pays or deductibles which may apply.

(Initials) _____

**PATIENT CO-INSURANCE/CO-PAY**

I understand that Dewald Chiropractic has agreed to accept the discounted rates from my insurance company, and as such copayments, coinsurances, and deductibles are not negotiable and fully my responsibility to be paid to Dewald Chiropractic. I understand that copayments, coinsurances, and deductibles are agreed upon amounts between myself and my insurance company and that Dewald Chiropractic does not have the authority to increase or decrease the patient responsibility assigned by my agreement with my insurance company.

(Initials) _____

**THERAPIST REQUESTS**

Often, patients may find that they prefer to be seen by specific therapist for their appointments. Our office does allow requests while scheduling, however due to the increased difficulty in scheduling such appointments there is an additional $5 fee for all requests. This fee will be provided to your therapist as gratuity for your visit. You are welcome to tip your therapist in addition to this $5 fee if you would like, however please do not feel as though you are pressured to do so. Due to this policy, please understand that therapist requests are not available to those who are visiting our office under a Personal Injury or Worker's Compensation claim.

(Initials) _____

**COLLECTIONS POLICY**

I understand that I am responsible for payment of all deductibles, copayments, and upgrade costs related to my care. I understand that if I have a balance for medical services not paid and am unable to pay the balance “in full”, I will agree to a payment plan specified by Dewald Chiropractic. If my balance is not paid "in full" 60 days after I receive my first bill, and I have not set up an auto-debit, then a $20 late fee will be assessed to my account monthly.

After 3 consecutive months of late fees and non-payments I understand that my account will be sent to collections. I acknowledge that I am responsible for paying any and all collection, court, and attorney fees involved in the collection of my account. I further understand that if my treatment is associated with a personal injury or accident claim, all medical bills will be paid at 100% regardless of the outcome of my case (at the sole discretion of Dewald Chiropractic). I understand that if a check or debit is returned for insufficient funds, I will be charged a $25.00 service charge.

(Initials) _____

I have read & fully understand the above policies.

**Patient Name (Print) _____**

**Patient Signature _____ Date_____**

**Guardian Signature _____ Date_____**

**DC Staff Signature _____**

DEWALD CHIROPRACTIC
EFFECTIVE HEALTH CARE SOLUTIONS

**Patient Informed Consent**

Patient Name:_____

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

**The Nature of the Chiropractic Adjustment**

The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click", much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

**Analysis / Examination / Treatment**

As a part of the analysis, examination, and treatment, you are consenting to the following procedures:

| | | | |
|---|---|---|---|
| Spinal Manipulative Therapy | Palpation | Vital Signs | Myofascial Release |
| Range of Motion Testing | Orthopedic Testing | Basic Neuro. Testing | Ultrasound |
| Muscle Strength Testing | Postural Analysis | EMS | |
| Hot/Cold Therapy | | | |

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**The Material Risks Inherent in Chiropractic Adjustment**

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains, and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries of the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

**The Probability of Those Risks Occurring**

Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the taking of your history and during examination and X-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

**The Availability and Nature of Other Treatment Options**

Other treatment options for your condition include:

- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers
- Hospitalization
- Surgery

If you chose one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

**The Risks and Dangers Attendant to Remaining Untreated**

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

**DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE. PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW**

**I have read [ ] or have read to me [ ] the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Dr. Dewald and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that Treatment.**

**Patient's Name** _____ **Signature** _____ **Dated:** _____

**Parent or Guardian Name** _____

**Signature of parent or Guardian** _____

**Dr. Thomas E. Dewald** _____ **Dated:** _____