ATKINSON FAMILY CHIROPRACTIC, P.C.

BRYAN C. ATKINSON, D.C.
2830 E. Brown Rd. Suite C-11 Mesa, AZ 85213 (480) 324-1000

APPLICATION FOR EXAMINATION/TREATMENT

I. Patient Care

Please check the type of care desired; Relief Care ___, Corrective Care ___ or
Dr. Recommended Level of Care ___
Referred To Our Office By? : _____

II. Patient Information **(Please write legibly for us)**

A. Personal

Name: Mr./Ms. _____ DOB: ___/___/___
(first) (middle) (last)
Social Security Number: _____-_____-_____
Home Address: _____ City:_____ State: _____ ZIP:_____
Home Phone. (_____) _____-_____ Cell Phone: (____) _____-_____
E-MAIL Address: _____@_____
Best method to contact you (circle one) Phone- Hm. Cell; Txt.; E-mail; Other _____
Marital Status: MARRIED, SINGLE, DIVORCED or SEPARATED?
IF YOU HAVE CHILDREN PLEASE LIST THEIR NAMES AND AGES?
_____(___), _____(___), _____(___),
_____(___), _____(___), _____(___).

B. EMPLOYMENT

Company Name: _____ Occupation (describe):_____
Address:_____ City:_____ State: _____ ZIP:_____
Ph.: (____) _____-_____ Ext. _____ Full time/ Part time

C. INSURANCE

Health Insurance Co. (Name): _____
Phone: (_____) _____-_____ Policy #: _____
Employee #: _____ Group #: _____

III. SPOUSE INFORMATION

Name of Spouse:_____DOB: ___/___/___
Social Security Number: _____-_____-_____ Cell Phone/Pager: (____) _____-_____
Is home address and Phone same as above? YES / NO _____

_____

Company Name: _____ Occupation: _____
Address:_____ City:_____ State: _____ ZIP:_____
Ph.: (____) _____-_____ Ext. _____ Full time/ Part time
Health Insurance Co. (Name): _____
Phone: (_____) _____-_____ Policy #: _____
Employee #: _____ Group #: _____

Patient Name:_____

IV. EMERGENCY NOTIFICATION

Your closest friend or relative to contact in case of an emergency

Name: _____ Relationship:_____

(first) (middle) (last)

HOME ADDRESS: _____ CITY:_____

STATE: ____ ZIP: _____ Hm. Ph. (___)____-_____ Cell Ph. # (___) _____-_____

Place of Employment: _____Bus. Ph.: (____)____-_____

V. FINANCE

Fees Are Payable At Time Of Consultation, Examination, Laboratory, Diagnostic Imaging (X-RAY), Treatment Or When Other Services Are Performed. Exceptions Must Be Made In Advance. X-RAY Films Remain The Property Of Your Medical File And Need To Remain At This Clinic. Films Will Be Made Available For Loan To Other Healthcare Facilities Or Copies Will Be Made Available Upon Request And Advance Payment Of The Copy Fee.

Who Will Assist You In Paying For Your Care?
Self ___ Spouse ___ Employer ___ Insurance ___Other _____

How Will Payment Be Made? Cash ___ Check ___ Health Ins. ___ Auto Ins. ___
Other: _____

PATIENT'S SIGNATURE: _____ DATE: ____/____/_____
(Self/Legal Guardian)

VI. AUTHORIZATIONS

I Authorize Communications Between _____ Insurance Company And/Or Attorney's Office And Atkinson Family Chiropractic, PC. I Also Authorize Said Insurance Company and/or Attorney's Office To Make Benefit Payments Directly To Atkinson Family Chiropractic, PC For Services Relating To My Medical Claim/File.

I Understand, As With Any Medical Examination Or Procedure, There Are Inherent Risks To Examination And Care With Chiropractic Medicine. The Doctor Has Explained These Risks To My Satisfaction. With This Understanding, I Accept These Risks. Initials: _____

Claims Past 90 Days Due Will Be Charged 1.5% Or $5 Per Month Late Fee, Which Ever Is Greater. Claims Past 120 Days Due Can Be Sent To Collections. The Patient/Responsible Party Will Incur All Fees And Expenses Associated With This Process.

PATIENT'S SIGNATURE: _____ DATE: ____/____/_____
(Self/Legal Guardian)

Information Taken By: _____
(Office Staff)

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Patient Financial Agreement

(Equitable Lien/Benefit Assignment Contract and Indemnification Agreement)

Please read the following very carefully as it concerns your financial responsibility to the Health Care or Service Provider from whom you are about to receive services.

I the undersigned Patient hereby agree to establish a lien/assignment of benefits or claim in favor of Atkinson Family Chiropractic, PC by this contract and pursuant to any state statutes that apply in the state of Arizona. I give my permission for Atkinson Family Chiropractic, PC and/or their agent, to file, record and serve notice of this agreement (lien/assignment) upon myself and all other parties who may be liable to me for damages arising from the accident which occurred on (mm/dd/yy) _____ and any subsequent claims arising from this accident for which I am about to receive health care. I understand that by doing so, I have entered into a contract with the above named health care or service provider. **This agreement authorizes direct payment to said provider from any and all proceeds from any insurance policy** (including but not limited to 3rd party claim, uninsured/underinsured motorist and medical payment coverage), settlement, compromise, judgment verdict or damages to which I may be entitled and paid in connection with the settlement of claims or litigation arising from this accident, in sums necessary to fully compensate the health care or service provider from whom I have received care. The lien/assignment created by this Equitable Lien Contract and Indemnification Agreement shall have priority from the time and date on which said documents are actually filed, or recorded or served on the liable parties, over any subsequent liens or assignments of my interests in claims arising from this accident.

In exchange for providing necessary medical care without requiring payment in full at the time service is received, I agree to be responsible for all charges associated with my care, regardless of the insurance companies' reimbursement, settlement or compromise. Charges for which I agree to be responsible include any administrative expenses associated with processing my claim such as charges incurred by the provider for recording and or serving notice of this lien/assignment upon any liable parties and their insurance companies. Also included are any collection charges or legal cost and fees incurred by the provider while attempting to collect the medical bills related to this claim should such activity become necessary.

Should my health insurance not allow balance billing, I agree to forego submission to my health insurance, and allow my attorney to pay Atkinson Family Chiropractic, PC all medical expenses out of my settlement proceeds. If Atkinson Family Chiropractic, PC elects to bill an indemnification health insurance plan, I will not, nor will my attorney assert a claim for a pro rata of attorney fees for collection of settlement funds. I nor will my attorney make a claim for a reduction of my medical expenses to Atkinson Family Chiropractic, PC under Samaritan v LaBombard or the Common Fund doctrine.

_____
Initial

I further understand that as a part of the process of recording a lien/assignment, I will receive certified mail with a copy of the lien/assignment enclosed and that this copy is for my own records and does not require any response on my part.

_____ _____
Patient's Signature. If legal guardian, please indicate. Date

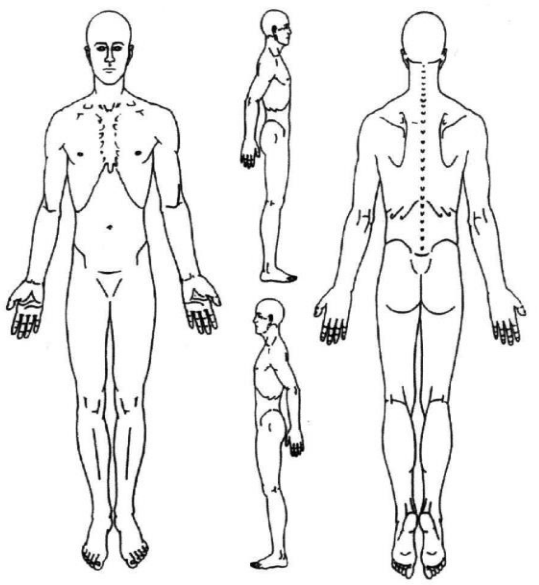
Patient Name:_____

Please list your symptoms below and the relative pain intensity (0 – 10) <u>for each</u> symptom. (*<u>Example: Low back pain – 4</u>*)

	No Pain			Mild			Moderate			Severe			Unbearable
1) _____	0	1	2	3	4	5	6	7	8	9	10		
2) _____	0	1	2	3	4	5	6	7	8	9	10		
3) _____	0	1	2	3	4	5	6	7	8	9	10		
4) _____	0	1	2	3	4	5	6	7	8	9	10		
5) _____	0	1	2	3	4	5	6	7	8	9	10		
6) _____	0	1	2	3	4	5	6	7	8	9	10		
7) _____	0	1	2	3	4	5	6	7	8	9	10		
8) _____	0	1	2	3	4	5	6	7	8	9	10		

Please mark on the diagram to the right with the following symbols as they relate to your symptoms location and description:

SS = spasms ST = stiffness DP = dull pain SP = sharp pain
SH = shooting pain TI = tingling NU = numbness O = Other



Over all, has this been getting ___worse? ___better? ___staying the same?

How has this affected your life?

Home: _____
Occupation: _____
Recreation: _____
Rest and Sleep: _____

Duties Under Duress: What activities are you required to perform that cause pain or discomfort that under normal circumstances would not be a problem? _____

_____

_____

_____

Loss Of Enjoyment: What activities have you missed or postponed due to pain or discomfort that under normal circumstances would not be a problem? _____

_____

_____

Have you ever received treatment for this condition before? ___Yes ___No
If yes, When, Where, and What were your results? _____

_____

Doctors you have consulted with in the past for this problem:
Name: _____ Ph. (___) _____
Name: _____ Ph. (___) _____

Do you have a family Dr.? Name: _____ Ph. (___) _____

Patient Name:_____

Have you had any surgeries? _____

_____

Are you currently taking medication? Heart, Birth Control, Diabetes, Pain, Anti-Inflammatory….?

Name of Rx: _____ For condition: _____
Name of Rx: _____ For condition: _____
Name of Rx: _____ For condition: _____
Name of Rx: _____ For condition: _____

Have you ever been involved in any other motor vehicle or personal injury accidents? **Y N**

When? 1) _____ Hit from: Front/Back, Right side/Left side? Any injuries? _____

_____

2) _____ Hit from: Front/Back Right side/Left side? Any injuries? _____

_____

3) _____ Hit from: Front/Back Right side/Left side? Any injuries? _____

_____

Check any of the following symptoms you have experienced as a result of or since your injury:

___Pregnancy (months ____)	___Low Back Pain	___Tension
___Headache	___Head Seems Heavy	___Fever
___ Muscle Spasms	___Stiff Neck	___ Sleep Disturbances
___Decreased Range of Motion	___Feet Hot/Cold	___Bruising Anywhere
___Dizziness	___Hands Hot/Cold	___Cuts &/or Stitches
___Visual Disturbances	___Pins/Needles in Hands/Arms	___Arm Pain (upper/lower)
___Radiating Pain	___Pins/Needles in Feet/Legs	___Leg Pain (upper/lower)
___Anxiety/Depression	___Numbness in Hands	___ Loss of Smell
___TMJ dysfunction (Jaw)	___Numbness in Feet	___ Loss of Taste
___Hearing Changes	___Chest Pain or Bruising	___ Mid Back Stiffness
___Loss of Balance	___Upset Stomach	___ Lower Back Stiffness
___Neck Pain	___Constipation/Diarrhea	___Mental focusing problems
___Mid Back Pain	___Fatigue	___ Any Burns

Symptoms other than listed above? _____

_____

_____

What is your most comfortable position (D=Day, N=Night)? ___Sitting ___Standing
___On Back ___On Stomach ___On Right Side ___On Left Side Other: _____

Difficult to move around in bed? __Yes/__No

Difficult to Stretch or Twist? __Yes/__No

Do you feel better moving around? __Yes/__No

Do you feel better Resting? __Yes/__No

Have you tried a brace? __Yes/__No

Heel height change your pain? __Yes/__No

Knee Problems? __Yes/__No __Right __Left

Cramps? __Yes/__N Where? _____

Any Recent Change In __Bowels? __Bladder? and/or __Reproductive System(s)? None

Are you able to take care of your own personal needs? Eating, Bathing, Dressing: __Yes/__No

Patient's Signature: _____ Date: _____ Phys: _____

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PATIENT'S AFFIRMATION OF RECEIPT OF PATIENT'S NOTICE OF PRIVACY RIGHTS

I hereby acknowledge receipt of this office's Patient's Notice of Privacy Rights, provided on my behalf and in accordance with law, and have read and understand my rights to privacy and security of Personal Health Information, as a patient of this practice.
This document can be reviewed online at www.afcmesa.com, under the "New Patient Center" tab, "Online Forms" page.

Affirmed,

_____
Patient Name (or legal guardian)

_____
Date

Personal Injury Information Review

Patient Name:_____ Date of Injury: _____/_____/_____ Time: _____am/pm

Location/Address: _____

Describe in your own words how the injury occurred: _____

_____

_____

If a motor vehicle accident, were you the ___ Driver? ___ Passenger? ___ Pedestrian? ___ Other? _____

If passenger, were you sitting ____ Front? ____ Middle Front? ____ Right Rear? ____ Left Rear? ____ Middle Rear?

Was your vehicle struck by another? ____ Yes/No Did your vehicle strike another? ____ Yes / No / Do not remember

Was a traffic citation issued to you or the driver of your vehicle? ____ Yes/No To the other vehicle driver? ____ Yes/No

At the time of impact, were you looking : ____ Straight ahead? ____ Right? ____ Left? ___ In the Rear View Mirror?

I was looking somewhere else: _____ Were you braced for the impact? _____ Yes/No

Were your hands on the steering wheel? ___ One, ___ Both ___ Neither Were you wearing a seatbelt? ___ Lap Belt? ___ Shoulder Belt? Did you strike anything inside the vehicle at the time of impact? ___ Yes / No / Do not remember

If so, please state what body part struck what part of the vehicle: (Chest, Head, Chin, Shoulder, Knee, Hand…), (Head Restraint, Air Bag, Steering Wheel, Dashboard, Arm Rest, Side Window, Windshield, Side of Door…): _____

_____

Did your body shift or move during impact, if so where? _____

If you had a hat or glasses on at the time of impact, did they stay on or did you find them else where after the accident?

_____

Immediately after the accident, how did you feel? _____

_____

Did you loose consciousness? ___ Yes / No / Do not remember Did Paramedics Provide Care? ___ Yes/No If so, what care did they provide? _____

Did you go to the hospital? ___ Yes/No By ambulance? ___ Yes/No Personal Vehicle? ___ Yes/No Did you drive yourself, or did someone drive you? _____

Did you go immediately after accident? ___Yes/No Next Day? ___ Yes/No Later? ___ Yes/No, Date: _____

Which hospital did you go to? _____ What exams and or care was performed? (X-Rays, Blood Work, Medications, bracing) _____

_____

What recommendations were given before leaving the hospital? _____

_____

Date and time of release: _____ ____:____ am/pm

(continued next page)

Patient Name: _____ Date of Injury:_____/_____/_____

Have you seen any other physician for this injury? ___ Yes/No If so whom? _____

What exams and or care was performed? _____

Did they give you any recommendations? ___ Yes/No If so, What were they? _____

_____

Please list your injuries, related to this accident, as you understand them? _____

_____

Have you lost time at work/school as a result of this injury? ___ Yes/No If so please give dates of time lost:

From: _____ to _____

Totally Disabled from: _____ to _____

Partially disabled from: _____ to _____

Your Vehicle Information:

Vehicle information: Make: _____ Model: _____ Year: _____

Please list your auto insurance company and name of agent: _____

Contact phone number: (_____) _____-_____ Name of the insured listed for your vehicle: _____

Policy #: _____ Claim ID # for this injury: _____

Do you have Med Pay Coverage with this policy? ___ Yes/No Uninsured / Underinsured Coverage? ___ Yes/No

Do you have other insurance coverage that may help you cover your medical expenses? ___ Yes/No If so please provide the following: Insurance Company: _____ Provider Contact Phone #: (_____) _____-_____

Policy #: _____ Group #: _____ Primary Policy Holder: _____

Other Vehicle Information:

Vehicle information: Make: _____ Model: _____ Year: _____

Please list their auto insurance company and name of agent: _____

Contact phone number: (_____) _____-_____ Ext: _____

Name of the insured listed for their vehicle: _____ Policy #: _____

Claim Adjuster: _____ Claim #: _____

Have you retain legal counsel for this injury? ___ Yes/No If so, please provide their name and contact information:

_____

The above information is accurate and correct to the best of my knowledge. I authorize Atkinson Family Chiropractic, PC and its agent(s) to discuss information regarding this injury to the above named legal counsel or agents of my personal insurance company if no legal counsel has been retain. I also authorize my legal counsel to provide in writing the settlement balance sheet prior to final settlement agreements.

_____ _____

(Patient Signature) (Date)