Lovett Family Chiropractic & Wellness Center
Auto Accident Paperwork

Please provide the front desk with a photo ID & most current insurance card.

Name: ____________________________ **Nickname:** _____________ Today's Date:______________

Address: ___________________________ Apt#: _____ City: _____________ State: ____ Zip: _________

Social Security#:_____________________ Marital: M S W D Birth Date:______________ Age:_________

Occupation: _________________ Employer: _________________

Home #:____________________ Cell #:____________________ Ok to contact you via text: YES NO

E-Mail: ______________________________________ Ok to E-mail LFC Newsletter to you: YES NO

*Your information (including e-mail address & phone number will never be shared with anyone)

Spouse: _____________________________ Phone#:_______________

How many children? _____ Names and Ages of Children:____

Emergency Contact: _____________________ Phone #: _____________ Relationship: ______________

Who referred you to our office? ____

Family Medical Doctor: __________________________ Phone: _______________________________

May we update your medical doctor regarding your care at this office? YES NO

Who is ultimately responsible for this account? ______________________________

PAST MEDICAL HISTORY

Have you ever been diagnosed as having or have suffered from? (Place a check by those that apply to you)

___Broken or Fractured Bones	___Osteoarthritis	___Eating Disorder	___Tumors
___Circulatory Problems	___Epilepsy	___Alcoholism	___Skin Disorders
___Rheumatoid Arthritis	___Pacemaker/IED	___Drug Addiction	___Diabetes
___Seizures/Convulsions	___Strokes	___HIV Positive	___Vascular problems
___A Congenital Disease	___Cancer	___Gall Bladder	___Ulcers
___Excessive Bleeding	___Ruptures	___Depression	___Coughing Blood

Do you have a **history of stroke, hypertension or high blood pressure**? YES NO

Have you had any major illnesses, injuries, falls, auto accidents or surgeries? Women, please include information about childbirth (include dates): ____

Have you been treated for any health condition by a physician in the last year? YES NO

If yes, describe: ____

What **medications or drugs** are you taking? Date started/stopped and dosage. Prescribed by: Dr or Self

____

____

What **Vitamins or Supplements** are you taking? Date started/stopped and dosage. Prescribed by: Dr or Self

____

Do you have any allergies of any kind? YES NO If yes, describe: _______________________________

____

Please list any other health problems you have, no matter how insignificant they may be: ___________________

____

____

SOCIAL HISTORY

Do you drink alcoholic beverages? YES NO If yes, how much per week? _________________________

Do you use any tobacco products? YES NO Do you smoke? YES NO If yes, packs per day: __________

Do you consume caffeine? YES NO If so, how much per day: ___________________________

Do you exercise? YES NO If yes, what is the frequency and type of exercise? __________________

FAMILY HISTORY

Father: Living ___ Deceased ___ Current age if still living: _______ Cause of death and age at death if deceased:

____

Mother: Living ___ Deceased ___ Current age if still living: _______ Cause of death and age at death if deceased:

____

Do you have any family members who suffer from the same condition you do? If so, please list:

____

FAMILY DISEASES (check if applicable and indicate whether family member is **F**ather, **M**other, **S**ister, **B**rother):

______Tuberculosis ______Cancer ______Mental Illness ______Lung Disease

______Diabetes ______Asthma ______Heart Disease ______Kidney Disease

______Stroke ______Arthritis ______Liver Disease ______Other __________________

INSURANCE COVERAGE (Please check any and all insurance coverage that may be applicable in this case**)**

____Major Medical ____Medicare ____ Auto Accident ____Worker's Compensation

____Medical Savings Account & Flex Plans ____Other _____________________________

Name of Primary Insurance Company: ____

Name of Secondary Insurance Company (if any): ____

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.

Patient's Signature: ____ Date: _______________

Guardian's Signature Authorizing Care: ____________________________ Date: _______________

ACCIDENT/INJURY FORM

NAME_________________________________ DATE______________________

Date of Accident___________ Time: ___am ___pm Location of Accident: _____________

AUTO INJURY

Were You: ( ) Driver ( ) Passenger ( ) Pedestrian

Were you struck from: ( ) Behind ( ) Right Side ( ) Left Side ( ) Front ( ) Parked

Did your car strike the others involved: ( ) Yes ( ) No ( ) Undetermined

Did the other car strike yours: ( ) Yes ( ) No ( ) Undetermined

As a result of the Accident, were traffic citations issued to you? ( ) Yes ( ) No

OTHER

Describe the circumstances of the accident (Be Specific)________________________________

____

CHECK SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT

( ) Headache
( ) Neck Pain
( ) Neck Stiff
( ) Dizziness
( ) Back Pain
( ) Nervousness
( ) Tension
( ) Irritability
( ) Chest Pain
( ) Sleeping Problems
( ) Head Too Heavy
( ) Pins & Needles in Arms
( ) Pins & Needles in Legs
( ) Numbness in Fingers
( ) Numbness in Toes
( ) Shortness of Breath
( ) Fatigue
( ) Depression
( ) Lights Bother Eyes
( ) Loss of Memory
( ) Ears Ringing
( ) Face Flushed
( ) Buzzing in Ears
( ) Loss of Balance
( ) Fainting
( ) Loss of Smell
( ) Loss of Taste
( ) Diarrhea
( ) Feet Cold
( ) Hands Cold
( ) Stomach Upset
( ) Constipation
( ) Cold Sweats
( ) Fever
( ) Other

How has this accident effected your day to day life? (ie: difficulty sleeping, difficulty working, difficulty doing things at home etc…)____

____

____

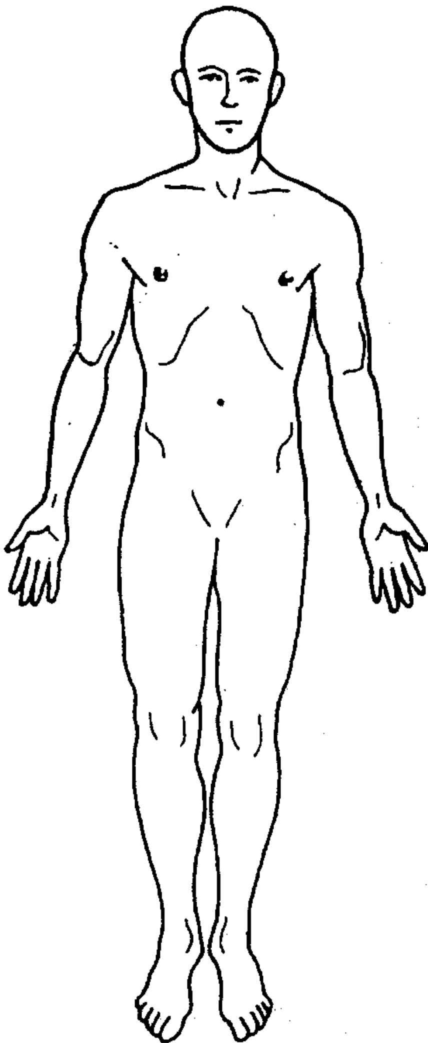
Did you require post-accident hospitalization? ( ) Yes ( ) No
Did you take an ambulance to the hospital? ( ) Yes ( ) No
Did you receive any x-rays or MRI's at the hospital or elsewhere? ( ) Yes ( ) No
Have you lost any days of work? ( ) Yes ( ) No If Yes, __________ through _________

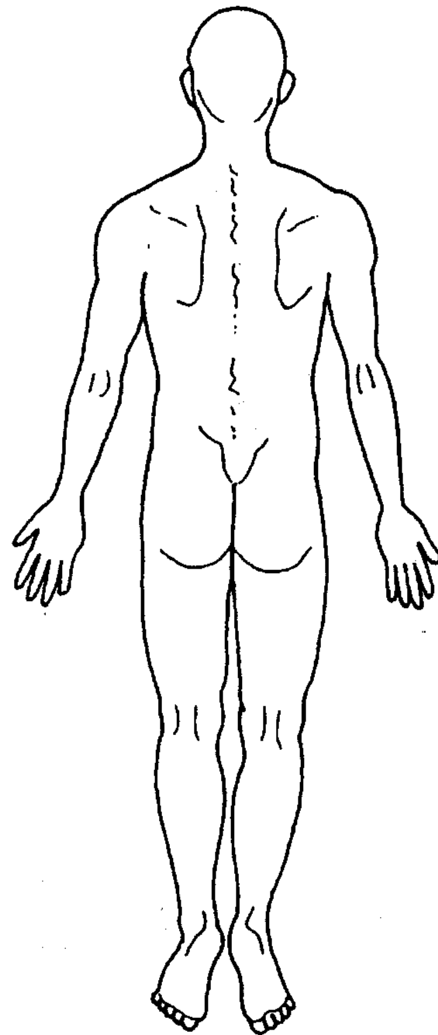
Pain Drawing

TELL US WHERE YOU HURT.

Please read carefully:
Mark the areas on your body where you feel your pain. Include all affected areas. Mark areas of radiation. If your pain radiates, draw an arrow from where it start to where it stops. Please extend the arrow as far as the pain travels. Use the appropriate symbol(s) listed below.

Ache = A	Numbness = N	Pins & Needles = P
Burning = B	Stabbing = S	Throbbing = T





Informed Consent For Chiropractic Care and Therapies

Chiropractic care, like ALL forms of health care, while offering considerable benefit may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care and therapies include stiffness, soreness, discomfort, skin irritation, sprain/strain injuries, irritation of a disc condition, and very rarely, fractures.

Prior to receiving chiropractic care this Chiropractic office, a thorough health history and physical examination will be completed. These procedures are performed to assess your specific condition, your overall health and, in particular, your spinal health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies are needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan prior to beginning care.

I understand that chiropractic adjustments involve the doctor placing his or her hands on me and delivering a very specific, quick thrust or impulse to the involved area(s). Alternatively, the doctor may use an instrument in place of his or her hands. I understand and accept that there are risks and benefits associated with chiropractic care and give my consent to the examinations that the doctor deems necessary, and to the chiropractic care including spinal adjustments and other therapies, as reported following my assessment.

________________________ _________________________ ________________

Printed Name Signature of Patient Date

Informed Consent to X-Rays (Pregnancy Release)

In order for Lovett Family Chiropractic to correctly evaluate, diagnose and treat my condition, x-rays may be needed. X-Rays expose the patient to radiation, similar to the amount of radiation on a Trans-Atlantic flight. Repeated exposure to radiation has been correlated to increase cancer risk. I grant LFC permission to perform x-rays, if needed, and assume all risks and responsibilities from an x-ray procedure.

The radiation in x-rays may be harmful to an unborn child/developing fetus. I understand that there are risks involved in exposing an unborn child to radiation and assume all responsibility for receiving an x-ray procedure. By my signature below, I certify that I am not pregnant at the time of this x-ray procedure.

________________________ _________________________ ________________

Printed Name Signature of Patient Date

Pacemaker Release

I hereby certify that I do not have a Pacemaker of Defibrilator of any kind in or on my body. I understand that if I do have one of these devices in or on my body, I will let the doctor know and my treatment may be slightly altered as a result. Pacemakers and Defibrilators are NOT contraindicated with chiropractic care but they ARE contraindicated with cold laser therapy.

________________________ _________________________ ________________

Printed Name Signature of Patient Date

Patient Health Information Consent Form

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is obligated to agree to those restrictions only to the extent they coincide with state and federal law.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. Our office may contact you periodically regarding appointments, treatments, products, services, or charitable work performed by our office. You may choose to opt-out of any marketing or fundraising communications at any time.
6. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
7. Patients have the right to file a formal complaint with our privacy official and the Secretary of HHS about any possible violations of these policies and procedures without retaliation by this office.
8. Our office reserves the right to make changes to this notice and to make the new notice provisions effective for all protected health information that it maintains. You will be provided with a new notice at your next visit following any change.
9. This notice is effective on the date stated below.
10. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Printed Patient Name　　Patient/Guardian Signature　　Date

For further information regarding this notice, please contact our office at (720) 747-1500.

ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO DOCTOR
PRIVATE AND GROUP ACCIDENT AND HEALTH INSURANCE

Patient:____

Insurance Company: ____

Claim/Group #: ____

Insured SS#/ID: ____

I hereby instruct and direct the payment of all professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy to:

Lovett Family Chiropractic
12201 E Arapahoe Rd, #B10
Centennial, CO 80112

as payment for professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above mentioned assignee, I agree to pay, in a current manner, any balance of professional service charges over and above this insurance payment.

I hereby grant Lovett Family Chiropractic (the "Practice")a lien against any proceeds resulting from any claim I have or may have against any proceeds resulting from any claim I have or may have against any third party whose negligence may have caused my injuries or illnesses. I hereby grant a lien against the proceeds of any insurance policy or healthcare plan to which I may be entitled as a result of services rendered to me by the Practice. I hereby instruct and direct any attorney representing me for said claim to honor the above lien directly to the Practice.

If my current policy prohibits direct payment to doctor, then I hereby agree to promptly pay any and all amounts due to the Practice, to:

Lovett Family Chiropractic
12201 E Arapahoe Rd, #B10
Centennial, CO 80112

A photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster or attorney involved in this case.

______________________________ ______________________________ ____________
Insured Witness Date

INSURANCE INFORMATION

Your Insurance Company ______________________________ Phone #: ______________________

Claim #: _____________________________

Other Party's Name: ___________________________________

Other Party's Ins. Co.________________________________ Phone #: ______________________

Claim #: _______________________________

Have you been contacted by an insurance adjustor regarding this claim ( ) Yes ( ) No

If yes, name of adjustor________________________________Company______________________

Do you have an attorney that has advised you in this case: ( ) Yes ( ) No

If yes, attorney's name______________________________ Phone #: _______________________