DAKOTA RIDGE CHIROPRACTIC, P.C.
PERSONAL INJURY QUESTIONNAIRE

PATIENT INFORMATION (please print) DATE ____________

NAME ________________________________ SS# ______________ DL# ____________

ADDRESS ________________________________ CITY ___________ STATE ___ ZIP _____

HOME PHONE ____________________ BIRTH DATE _________ AGE _____ SEX (M)___ (F)___
MARITAL STATUS ______________ SPOUSES NAME ______________________________
EMPLOYER __________________________________ WORK PHONE _______________ X _____
EMPLOYER'S ADDRESS ____
IF YOU ARE A MINOR: MOTHER / FATHER'S NAME? ________________ PHONE #__________

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

☐ **AUTOMOBILE INSURANCE:** NAME OF INSURANCE CO. ____________________________
NAME OF INSURED ______________________ POLICY # ____________________________
ARE YOU RELATED TO THE INSURED? ☐ Yes ☐ No WHAT RELATION? ________________
DO YOU LIVE AT THE SAME ADDRESS? .... ☐ Yes ☐ No
HAVE YOU REPORTED THIS ACCIDENT TO YOUR INSURANCE COMPANY? .. ☐ Yes ☐ No
DID YOU REPORT THAT YOU SUFFERED INJURIES? .... ☐ Yes ☐ No
HAVE YOU FILLED OUT THE INSURANCE CO.'S PIP APPLICATION FORM? .... ☐ Yes ☐ No
DATE & TIME OF ACCIDENT: ______________________ ☐ a.m. ☐ p.m. STATE _____
NAME OF OWNER OF CAR YOU WERE IN DURING ACCIDENT ______________________
DO YOU HAVE AUTO INSURANCE? ☐ Yes ☐ No WITH WHOM? __________________

☐ **HEALTH INSURANCE:** NAME OF INSURANCE CO. ______________________________
NAME OF INSURED ______________________ POLICY # _______________ ID ______

☐ **WORKERS COMPENSATION INSURANCE:** (WORK RELATED INJURY)
DATE OF ACCIDENT ______________
DID YOU REPORT THE INJURY TO YOUR EMPLOYER? ☐ Yes ☐ No

☐ **CASH** ☐ **PAYMENT AT TIME OF SERVICE** ☐ **I NEED TO DISCUSS PAYMENT**

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

PATIENT/RESPONSIBLE PARTY SIGNATURE X__________________________ DATE ___________

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

PARENT/GUARDIAN'S SIGNATURE ______________________________ DATE ___________

ATTORNEY INFORMATION:
HAVE YOU RETAINED AN ATTORNEY BECAUSE OF THIS ACCIDENT? ☐ Yes ☐ No
IF YES, WHO? ______________________ WHEN? __________________________

The above information is accurate SIGNED X______________________________ DATE__________

PT. NAME ______________________ DATE __________ FILE # __________

AUTO RELATED ACCIDENT INFORMATION

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

AFTER INJURY

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

The above information is accurate SIGNED X ______________________ DATE __________

PT. NAME ______________________ DATE __________ FILE # __________

PRIOR HISTORY

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

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

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

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

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

WORK HISTORY

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

The above information is accurate SIGNED X______________________ DATE __________

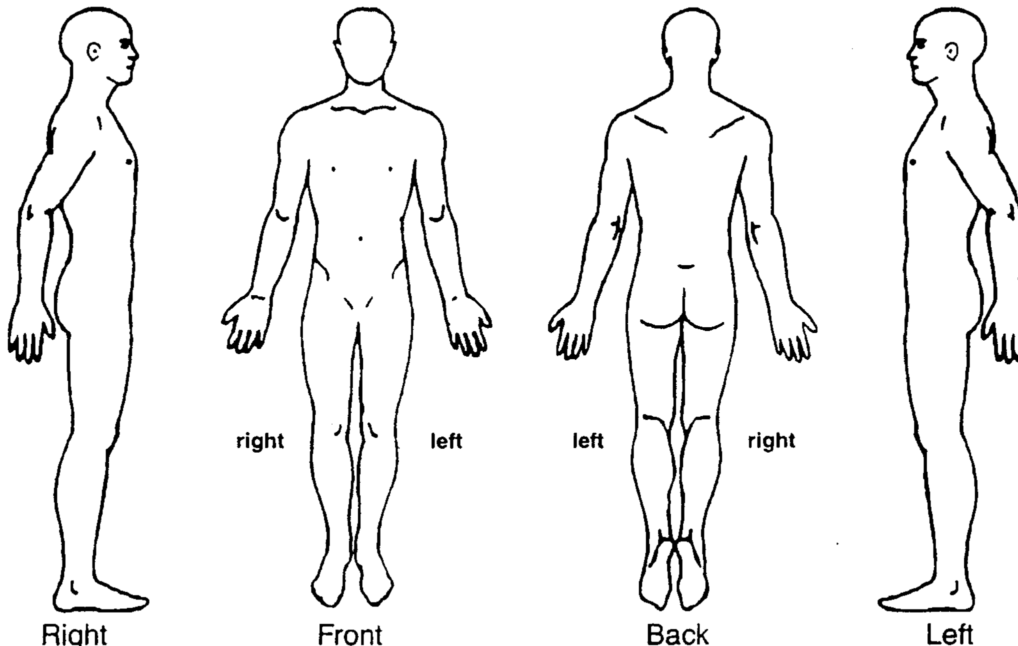
PT. NAME ______________________ DATE ____________ FILE # ____________

PAIN CHART

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

- ☐ HEADACHE ____________
- ☐ NECK PAIN ____________
- ☐ SHOULDER PAIN ____________
- ☐ UPPER BACK PAIN ____________
- ☐ MID BACK PAIN ____________
- ☐ LOW BACK PAIN ____________
- ☐ CHEST PAIN ____________
- ☐ ARM/WRIST/HAND PAIN ____________
- ☐ ARM/WRIST/HAND NUMBNESS ____________
- ☐ LEG PAIN ____________
- ☐ LEG NUMBNESS ____________
- ☐ KNEE PAIN ____________
- ☐ JAW PAIN ____________
- ☐ VISUAL PROBLEMS ____________
- ☐ DIZZINESS ____________
- ☐ MEMORY PROBLEMS ____________
- ☐ DIFFICULTY CONCENTRATING ____________
- ☐ DEPRESSION ____________
- ☐ SLEEPLESSNESS ____________
- ☐ CHANGE IN PERSONALITY ____________
- ☐ CHANGE IN BOWEL/BLADDER HABITS ___
- ☐ LIST OTHER SYMPTOMS ____________

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



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

____

____

____

WERE YOU RECEIVING TREATMENT FOR ANY OF THESE COMPLAINTS BEFORE THE ACCIDENT? ☐ Yes ☐No
IF YES, NAME OF DOCTOR__________________ DATE OF LAST TREATMENT__________
I FEEL MY PAIN IS DUE TO INJURIES I SUFFERED IN THE RECENT AUTOMOBILE ACCIDENT ☐ Yes ☐No

The above information is accurate SIGNED X______________________________ DATE_______

PATIENT NAME: ______________________________ DATE________ I.D.#_______

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

HOUSEWORK

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

PERSONAL GROOMING

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

TRAVEL

_____ Driving
_____ Riding (Passenger)

YARD WORK

_____ Mowing lawn
_____ Shoveling Snow
_____ Raking leaves
_____ Gardening

GENERAL

_____ Running
_____ Sitting
_____ Lifting
_____ Bending
_____ Climbing stairs
_____ Reading
_____ Chewing
_____ Walking
_____ Standing
_____ Sports: List

_____ Sleeping
_____ Using telephone
_____ Getting in and out of auto
_____ Sexual intercourse
_____ Using typewriter/computer

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

____

____

Signed X______________________________ Date ____________________________

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

PATIENT:____
EMPLOYER:_______________________________________
CLAIM/GROUP:____________________________________
SS#/ID:____

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

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

OR:

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

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

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

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

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

SIGNED AT 11550 W. MEADOWS DR. UNIT E , THIS__________ DAY OF__________ 20____.

__________________________ ________________________
SIGNATURE OF POLICY HOLDER WITNESS

____
SIGNATURE OF CLAIMANT, IF OTHER THAN POLICYHOLDER

Dakota Ridge Chiropractic

Responsibility for Payment of Fees

Payment to be made to Dakota Ridge Chiropractic

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

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

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

Patient/Guardian ______ Relationship to Patient ______ Date ______

Authorization and Release

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

Specific Risks Possibilities with Chiropractic Care:

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

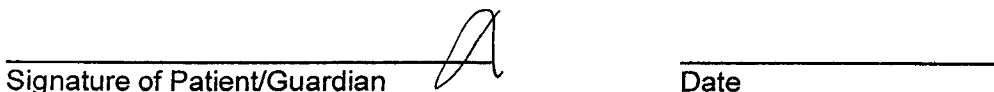
Soft Tissue Injury—Occasionally chiropractic treatment may aggravate a disc injury, or cause other minor joint, ligament, tendon or other soft tissue injury.

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

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

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

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



Signature of Patient/Guardian ______ Date ______

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

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

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

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

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

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

X______________________________
Signature of Patient or Personal Representative

____
Name of Patient or Personal Representative

____
Date

____
Description of Personal Representative's Authority

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Dakota Ridge Chiropractic, P.C.

HEALTH CARE PROVIDER LIEN

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

Patient's Name: ______________________________ Date of Injury: ______________________________

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

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

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

Dated: __________________ X____
Patient

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

Dated: __________________ By: ____
Health Care Provider

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

Dated: __________________ ____
Attorney

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