Gateway
Chiropractic

10320 W. McDowell Rd., Ste. A-1002
Avondale, AZ 85392
Ph. 602-566-7676

Date_____ Whom may we thank for referring you to us?_____

Patient Name_____ Date of Birth_____ Age____ Gender M F

Address_____

City_____ State_____ Zip_____

Cell Phone_____ Home_____ Preferred Phone Home / Cell

E-mail Address_____

Would you like a reminder via TEXT or EMAIL? TEXT / EMAIL (circle one)

Emergency Contact_____ Relationship_____ Phone#_____

Primary Insurance Company_____ Insurance ID #_____

Group #_____ Insured's Name (If not self)_____

Secondary Insurance Company_____ Insurance ID #_____

Group #_____ Insured's Name (If not self)_____

Assignment and Release

I, the undersigned, assign directly to Gateway Chiropractic all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. Patient/ Responsible party agrees that in the event of non-payment, all costs of collections(not to exceed 50% of the outstanding balance) if necessary including attorney and court costs, plus interest, shall be the full responsibility of the patient.

_____

Patient signature / Responsible party signature Date

Vehicle Accident Information

Patient Information			
Patient Name:		**Date:**	
Date of Accident:		**Time of Accident:**	AM/PM
Please describe the accident in your own words:			
How many people were in the accident vehicle?			
Were you the:	□Driver	□Rear Passenger	□Front Passenger □Pedestrian

Accident Site			
Road/Street Name:			
City/State:			
Nearest intersection with road/street:			
Which direction were you headed?			
What speed were you traveling?			
Driving conditions:			
□Dry	□Icy	□Wet	□Other:

Vehicle			
Make and model of vehicle you were in:			
Were you wearing a seatbelt?	□Yes	□No	
If yes, what type?	□Lap	□Shoulder	
Was the 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 head rest?			
	□Low	□Mid	□High

Other Vehicle (if applicable)
Make and model of other vehicle:
Which direction was the other vehicle headed?
Speed other vehicle was traveling?

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 the impact were you:		
□Looking straight ahead	□Looking right	
□Looking left	□Looking down	
□Looking up		
Were both hands on the steering wheel?	□Yes	□No
If not, which hand was on the wheel?	□Right	□Left
Was your foot on the brake?	□Yes	□No
If so, which foot was on the pedal?	□Right	□Left
Were you:		
□Surprised by impact	□Braced for impact	

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?		

Vehicle Accident Information

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 or more days after accident

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

Name of hospital: **Name of doctor:**

Diagnosis:

Treatment/medications received:

Medical imaging taken (X-ray, MRI, CT Scan):

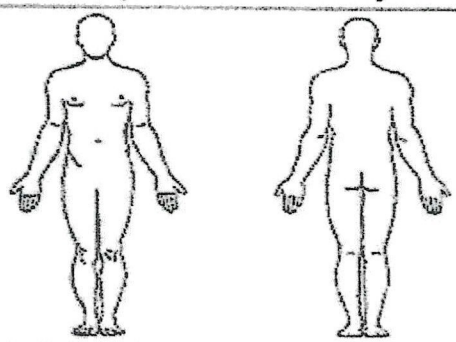
Symptoms/Injuries

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

Please indicate any other symptoms you have experienced since the accident and mark painful areas on the picture:

☐Arm/shoulder pain	☐Feet/toe numbness	☐Neck pain
☐Back pain	☐Hand/finger numbness	☐Neck stiffness
☐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	☐Blurred vision
☐Fatigue	☐Nausea	



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

Rate the severity of your pain on a scale of 0 (no pain) to 10 (severe pain):

Type of pain: ☐Sharp ☐Dull ☐Throbbing ☐Numbness ☐Aching ☐Shooting ☐Burning ☐Tingling ☐Cramping ☐Stiffness ☐Swelling ☐Other:

How frequent is your pain? ☐Morning ☐Afternoon ☐Evening ☐Night ☐Constant

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

Activities or movements that are painful to perform:

☐Bending ☐Sitting ☐Standing ☐Walking ☐Lying down

I certify that the above information is complete and correct to the best of my knowledge.

Patient Signature **Date**

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Patient's Name:_____ Date:_____

PLEASE MARK AS MANY OF THE FOLLOWING THAT APPLY TO YOUR CASE:

- ☐ I have Medical Payment (Med-Pay) benefits, either personally or through the driver of the vehicle.
- ☐ I have group health insurance benefits either directly or through my spouse or parents.
- ☐ I have retained an attorney
- ☐ I have not retained an attorney
- ☐ I have the adverse or third party information available. (Insurance company of the other driver)

PLEASE PROVIDE THE APPROPRIATE INSURANCE INFORMATION:

1) Your automobile insurance carrier:_____

   Address:_____ Insured:_____

   Claim #:_____ Policy #:_____

   Telephone:_____ Fax:_____

2) Adverse or 3rd party automobile insurance carrier:_____

   Address:_____ Insured:_____

   Claim #:_____ Policy #:_____

   Telephone:_____ Fax:_____ Claim Rep:_____

3) Your group health insurance company:_____

   Address:_____ Insured:_____

   Date of Birth_____ Policy #:_____ SS#_____

   Telephone:_____ Fax:_____

4) Attorney:_____ Legal Assistant:_____

   Address:_____

   Telephone:_____ Fax:_____

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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 healthcare 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 PHI, 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 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 required by the insurance companies 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 not obligated to agree to those restrictions.
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 affect 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. 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.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of the policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payments, and healthcare 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.

Name of Patient (Print) Date

Patient Signature Date