FALLS HEALING ARTS, S.C.
AUTO ACCIDENT FORM

1. PATIENT INFORMATION Today's Date _____

Patient Name (First, MI, Last) _____

Address _____ City, State, Zip _____

Phone Home# _____ Work#_____ ext. _____ Cell# _____

Sex ___ M ___F Age _____ Birthdate _____ SS#_____

___Single ___Married ___Widowed ___Divorced ___Other Height _____ Weight _____

Your Employer _____ ___Full Time ___Part Time

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2. INSURANCE INFORMATION

___Cash/Credit ___Medicare ___Medicaid ___Health Insurance ___Worker's compensation ___Personal Injury/Auto

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3. ACCIDENT INFORMATION

Is this condition due to an accident? ___Yes ___No Date & Time: _____

Type of accident ___Auto ___Work ___Home ___Other _____

Attorney Name (if applicable) _____

Were you the: ___Driver ___Front Passenger ___Rear Passenger

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

Were there any witnesses? ___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 base of skull

What did your vehicle impact? ___Another vehicle ___Other If other, explain: _____

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

If yes, please explain: _____

Make & model of the vehicle you were occupying: _____

Name of the location/street on which you were traveling?

_____

In which direction were you headed? ___North ___South ___East ___West

What was the approx. speed of your vehicle? _____

Did the impact to your vehicle come from the: ___Front ___Rear ___Right Side ___Left Side ___Other

During impact, were you facing: ___Right ___Left ___Forward

Were you ___aware or ___surprised by the impact?

If accident vehicle made impact with another vehicle…

Make and model of that other vehicle? _____

Direction other vehicle was headed? ___North ___South ___East ___West

Speed of the other vehicle? _____

In your words, please describe the accident:

_____

_____

4. PATIENT CONDITION

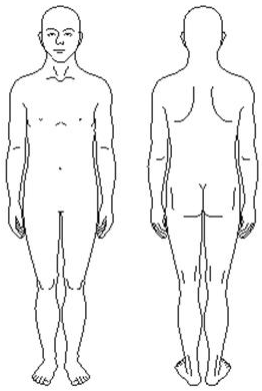
Reason for visit _____

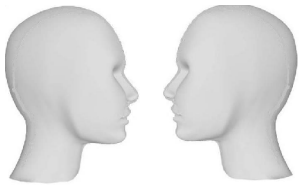
When did your symptoms appear? _____

What caused this problem? _____

What makes the symptoms worse? _____ What makes the symptoms better? _____

Shade and code areas to indicate location of pain or discomfort: (use codes below)





Right View Left View

Numbness	- - - - -
Pins and Needles	+++++
Burning	XXXX
Dull Ache	ooooo
Stabbing Pain	/ / / / /

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

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

Activities or movements that are painful to perform ___sitting ___standing ___walking ___bending

___lying down other_____

IN CASE OF EMERGENCY, CONTACT _____

Phone # _____ Relationship _____

5. HEALTH HISTORY

What treatment have you already received for your condition? ___medications ___surgery ___physical therapy ___chiropractic ___none other _____

Name and address of other doctor(s) who have treated you for your condition? _____

_____

Date of last:

Physical Exam _____ Spinal X-Ray_____ Spinal Exam _____ Chest x-ray _____

Dental x-ray _____ MRI, CT-scan, Bone scan _____ Blood Test _____ Urine test _____

Place an X next to "yes" or "no" to indicate if you have had any of the following:

Aids/HIV	___yes ___no	Glaucoma	___yes ___no	Pinched Nerve	___yes___no
Alcoholism	___yes ___no	Gonorrhea	___yes ___no	Pneumonia	___yes___no
Allergy shots	___yes ___no	Goiter	___yes ___no	Polio	___yes___no
Anemia	___yes ___no	Gout	___yes ___no	Prostate Problems	___yes___no
Anorexia	___yes ___no	Heart Disease	___yes ___no	Prosthesis	___yes___no
Appendicitis	___yes ___no	Hepatitis	___yes ___no	Psychiatric Care	___yes___no
Arthritis	___yes ___no	Hernia	___yes ___no	Rheumatoid Arthritis	___yes___no
Asthma	___yes ___no	Herniated Disc	___yes ___no	Rheumatic Fever	___yes___no
Bleeding Disorders	___yes ___no	Herpes	___yes ___no	Scarlet Fever	___yes___no
Breast Lump	___yes ___no	High Cholesterol	___yes ___no	STD's	___yes___no
Bronchitis	___yes ___no	Kidney Disease	___yes ___no	Stroke	___yes___no
Bulimia	___yes ___no	Liver Disease	___yes ___no	Suicide Attempt	___yes___no
Cancer	___yes ___no	Measles	___yes ___no	Thyroid Problems	___yes___no
Cataracts	___yes ___no	Migraine	___yes ___no	Tonsillitis	___yes___no
Chemical Dependency	___yes ___no	Miscarriage	___yes ___no	Tuberculosis	___yes___no
Chicken Pox	___yes ___no	Mononucleosis	___yes ___no	Tumors, Growths	___yes___no
Diabetes	___yes ___no	Multiple Sclerosis	___yes ___no	Typhoid Fever	___yes___no
Emphysema	___yes ___no	Mumps	___yes ___no	Ulcers	___yes___no
Epilepsy	___yes ___no	Osteoporosis	___yes ___no	Vaginal Infections	___yes___no
Fracture	___yes ___no	Pacemaker	___yes ___no	Whooping Cough	___yes___no
Hand Dominance	_____R____L	Parkinson's	___yes ___no	Other: _____	

EXERCISE	WORK ACTIVITY	HABITS
___None	___Sitting	___Smoking Packs/Day _____
___Moderate	___Standing	___Alcohol Drinks/Wk _____
___Daily	___Light Labor	___Coffee/Caffeine Cups/Day ____
___Heavy	___Heavy Labor	___High Stress Level Reason _____
Are You Pregnant? ___Yes ___No	Due Date: _____	

6. INJURIES/SURGERIES YOU HAVE HAD

Description **Date**

Falls: _____

Head Injuries: _____

Broken Bones: _____

Dislocations: _____

Surgeries: _____

7. MEDICATIONS / ALLERGIES / VITAMINS / HERBS / MINERALS

_____

_____

_____

FALLS HEALING ARTS AUTO POLICY

FALLS HEALING ARTS
275 N. Main Street
Sheboygan Falls, WI 53085
(920) 467-8690

If you have been in an auto accident, please use the following as a guide to help you through the process:

Contact your auto insurance and file a claim under your medical payments. We will need a copy of your auto insurance card. Please provide us with your medical payment limit. Your medical pay limit can be found in your auto policy information. The medical payments option within your policy generally covers medical expenses no matter who's found to be at fault. It covers you, your passengers, and any family members driving the insured vehicle at the time of the accident.

If you have retained a lawyer we will need the lawyer's name and phone number so we have it for our records.

Falls Healing Arts Policy is not to bill "at fault" or health insurance.

You may be encouraged by your auto insurance or your lawyer to have us bill the at fault auto party or bill your health insurance. Our policy at Falls Healing Arts is to bill your medical portion of your auto policy. We do not bill health insurance unless their auto policy is set up to be secondary to the health insurance or at times at our discretion we will bill health insurance if there is no auto medical pay on the patient's policy. We bill your medical payments on your auto policy and when it comes to settlement the "at fault" insurance will pay your auto policy back (subrogation).

If you have exhausted your medical pay and still have outstanding charges after you have been discharged from treatment, you will be responsible for the remaining balance.

We encourage you not to sign off on a settlement until you are completely discharged from your auto injury. If you sign any agreement or accept any payout before you are discharged from treatment in this office, you will be responsible for any charges after the date you have accepted as settlement.

It is important that you follow the prescribed treatment schedule to ensure maximum medical improvement in the shortest amount of time possible.

Please feel free to contact our office to discuss any further questions you may have.

Falls Healing Arts S.C.

Consent to Treat:

The primary treatment used by Doctors of Chiropractic is the spinal adjustment. We will primarily use that procedure to treat you. The doctor may use his or her hands or a mechanical device upon your body in such a way as to move, or adjust, your joints. Additionally, other treatments may be used to help you, and will be explained to you at the time the Doctor decides to utilize these techniques or treatments.

The side effects associated with a chiropractic adjustment are extremely rare. Initially, a small amount of soreness may be expected in certain cases, but this can be discussed with the Doctor. Any other concerns or questions may also be discussed with the Doctor.

By signing below you state that you are wiling to undergo a chiropractic examination, x-rays of the spine or the area(s) involved (if indicated), and chiropractic treatment as may be outlined by the Doctor after the examination has been done.

In addition, it is important to understand that health and accident insurance policies are arrangements between you and your insurance carrier. As a courtesy to you, our office will bill your insurance company under normal circumstances and will complete any necessary forms to assist you in collection of payment from your insurance company assuming you have assigned benefits to be paid directly to our office. However, please understand that you are personally responsible for any and all charges regardless if your insurance company pays or not.

Signature: _____ Date: _____

Consent to treat minor child: _____

Relation: _____

Consent for Use and Disclosure of Health Information

This notice describes how chiropractic and medical information about you may be used and disclosed, your rights as a patient, and ways for you to get additional information on our policies.

Our clinic has always been very protective and respectful of your personal information. Under new federal regulations (the HIPPA Privacy Act), we have adopted additional guidelines to ensure the proper use, confidentiality and disclosure of your health information.

We May Release or Disclose Your Health Information:

- For treatment purposes to another health care provider or clinic if we refer you, or to providers or staff within our clinic that are taking part in your care.
- For billing and collection purposes, we may release records of your health care and information that you have provided to your insurance carrier or other financially responsible parties.
- For operational purposes within our clinic for quality control, office administration, record keeping, staff or provider training.

Specifically, you authorize the release of any information pertinent to your case to any insurance company, adjuster, or attorney involved in this case for the purpose of obtaining payment on your health claims.

We may also use your personal health information to contact you regarding your appointments, to send you information about our clinic or office events, or to share treatment options. We will not disclose information about you to anyone outside our office without your written approval.

You have the right to inspect or obtain a copy of the information we will use for these purposes. You have the right to amend your records at this office. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization, it will not affect the care provided to you or the reimbursement avenues associated with your care. Requests to inspect, copy or amend your health related information should be provided to the front desk in writing.

We normally provide information about your health to you in person at the time you receive care from us. We may also mail information to you regarding your health care or about the status of your account. If you would like to receive this information at an address other than your home, or if you would like the information in a different form, please advise us in writing as to your preferences.

Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities, you should direct your complaint in writing to the Clinic Director.

If you would like further information about our privacy policies and practices, please see the "NOTICE OR PRIVACY PRACTICES" binder in reception or ask for a copy at the front desk.

By supplying my home phone number, mobile phone number, email address, and any other personal contact information, I authorize my health care provider to employ a third-party automated outreach and messaging system to use my personal information, the name of my care provider, the time and place of my scheduled appointment(s), and other limited information, for the purpose of notifying me of a pending appointment, a missed appointment, courtesy call, balances due, or other communications. I also authorize my healthcare provider to disclose to third parties, who may intercept these messages, limited protected health information (PHI) regarding my healthcare events. I consent to receiving messages from the automated outreach and messaging system, when necessary.

_____	_____	_____
Name (Printed Please)	Signature	Date

If you are a minor, or if you are being represented by another party:

_____	_____	_____
Name (Printed Please)	Signature	Date

AUTO INJURY VERIFICATION FORM

1. PATIENT NAME: _____

2. DATE OF INJURY/ACCIDENT: _____

IT IS OUR OFFICE POLICY TO BILL YOUR MEDICAL PAYMENTS COVERAGE ON YOUR AUTO POLICY.
(Medical payments coverage-sometimes referred to as medical expense coverage-can help cover the medical expenses associated with auto accidents. It generally covers medical expenses for you, your passengers and any family members driving the insured vehicle at the time of the accident-no matter who's found to be at fault. It can also help cover you if you or your family member is injured in another car or injured as a pedestrian.)

3. HAS PATIENT NOTIFIED INS. CO. OF ACCIDENT AND FILED A CLAIM UNDER THEIR AUTO MEDICAL PAY
YES OR NO

If No, patient needs to contact Auto insurance immediately.

4. PATIENT'S AUTOMOBILE INSURANCE INFORMATION: (**Please give copy of auto insurance card)**

INSURANCE COMPANY NAME, ADDRESS AND PHONE NUMBER:

_____

_____

_____

NAME OF INSURED: _____ POLICY # INSURED: _____

5. WHAT ARE THE MAXIMUM MEDICAL PAYMENT LIMITATIONS ON AUTO POLICY: _____

IF YOU DO NOT KNOW YOUR MEDICAL PAYMENTS LIMITATIONS PLEASE CONTACT YOUR AUTO INSURANCE CO. OR YOU MAY FIND IT ON YOUR AUTO INSURANCE DECLARATION PAGE AND LET US KNOW ON YOUR NEXT APPOINTMENT.

6. DOES PATIENT HAVE AN ATTY? YES OR NO

ATTY NAME, ADDRESS, AND PHONE NUMBER

_____

_____

_____

FOR OFFICE USE ONLY:

CALL PATIENTS AUTO POLICY AND ASK THE FOLLOWING QUESTIONS:

ADJUSTER'S NAME: _____ ADJUSTER'S PHONE NUMBER: _____

CLAIM NUMBER: _____

ADDRESS TO SEND CLAIMS TO: _____

_____

NAME OF PERSON GIVING INFO: _____ NAME OF PERSON VERIFYING: _____
Once information is received and entered into computer you need to go into patient records and use the auto verification merged form and have patient sign.