ChiroWerx
Chiropractic and Bodywork

Confidential Patient Information

Full Name: _____ Nickname: _____ SS#: _____

Address _____
Street Apt# City State Zip Code

Marital Status: S M D W Age: _____ DOB: _____ Gender M F

Home Phone: _____ Cell Phone: _____ Email address: _____

Occupation: _____ Employer: _____ Work Phone: _____

Emergency Contact: _____ Phone Number: _____

Who may we thank for your referral? ○Family ○Friend ○Neighborhood Mailer ○Office Mailer ○Provider ○ Other

Please Specify_____

YOUR PRESENT COMPLAINT _____

Have you been treated by a physician for this condition in the last year? Yes No

Which word describes the frequency of your symptom? (Select one)

❑ Constant (76% - 100% of awake time)
❑ Intermittent (26% - 50% of awake time)
❑ Frequent (51% - 75% of awake time)
❑ Occasional (0% - 25% of awake time)

Which phrases best describe *changes* in your symptoms during the day? (select all that apply)

❑ It is worse in the morning
❑ It is worse at night
❑ It does not change
❑ It is worse in the afternoon
❑ It changes with the weather

What helps *relieve* your symptoms? (select all that apply)

❑ Ice ❑ Heat ❑ Medication ❑ Nothing helps ❑ Other _____

What activities are limited by your discomfort? (select all that apply)

❑ Bending ❑ Lifting ❑ Reading ❑ Turning Head ❑ Other
❑ Coughing/ Sneezing ❑ Lying Down ❑ Sitting ❑ Twisting at waist
❑ Driving ❑ Pulling ❑ Sleeping ❑ Walking
❑ Getting up ❑ Pushing ❑ Standing ❑ Working

List all over-the-counter medications being taken. _____

List all vitamins or other dietary supplements being taken. _____

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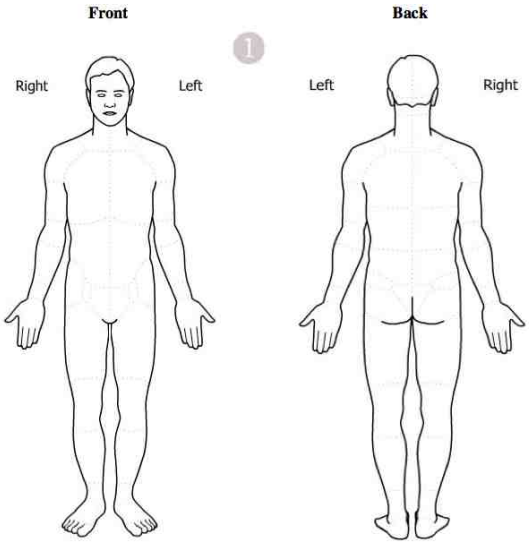
Identify your areas of discomfort by marking the affected body parts in the illustration.



Smoking status: ❑ Every Day ❑ Some Day ❑ Former ❑ Never

How many alcoholic beverages do you consume per week? _____

How many days do you exercise each week? _____

Have you ever been diagnosed with any allergies? No Yes

If yes, please explain _____

Are you pregnant? No Yes Date of last cycle: _____

List all prescription medications being taken. _____

_____

Describe any operations you have had and the dates: _____

_____

Have you ever been diagnosed with cancer? No Yes

If yes, please explain: _____

Has anyone in your family ever been diagnosed with cancer? No Yes

If yes, please explain _____

Accident Information

What type of accident were you involved in? (Mark all that apply)

- Automobile
- Work-related
- Other, please explain _____

What was the date that the accident occurred? _____ **Were the police contacted?** Yes No

Do you have a police report or a report number, if so please provide the information below?

_____

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Please describe what happened in the accident.

_____

_____

Did you sense the accident coming? Yes No **Were you wearing your seatbelt?** Yes No

Did the airbags deploy? Yes No **Have you gone to the hospital or seen a doctor?** Yes No

When did you go? o Immediately o Next Day o_____ **Were X-Rays Taken?** Yes No

How did you get there? o Ambulance o Private Transportation **Was Medication Prescribed?** Yes No

Name of Hospital and/or Doctor? _____

Immediately following the accident how did you feel? (Please check all that apply)

o Disoriented or Dizzy o Scared o Unconscious
o Nauseous o Tightness in your chest o Other

Which best describes your involvement in the accident? (Please Circle)

o Driver o Rear Passenger
o Front Seat Passenger o By-Stander

Have you missed any time from work due to the accident? Yes No **If Yes, how many days?** _____

Are you currently still out of work? Yes No **Are you being compensated for time lost from work?** Yes No

Will an attorney be handling your case? Yes No

If yes, please provide our office with the name and phone number below.

_____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse co-issued remittances for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. It is my understanding that my credit may be checked if ChiroWerx, PLLC extends credit to me and I understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable unless prior arrangements are made. I hereby authorize the doctors at ChiroWerx, PLLC and whomever they may designate as assistants, to administer treatment as they so deem necessary and I also authorize the release of any information acquired in the course of my examination and treatment. I certify that the above information is true and correct.

Patient's (Parent or Guardian's) Signature _____ **Date:** _____

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INFORMED CONSENT

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended integrative and complementary procedure to be used so that you make an informed decision whether or not to undergo the procedure after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or withhold your consent to the procedure.

NOTICE: Refusal to consent to the integrative and complementary procedure should not affect your right to future care or treatment.

I (We) voluntarily request Dr. Dunning as my physician, and such associates, technical assistants, and other health care providers as they may deem necessary, to treat my condition, which has been explained to me as: spinal/extremity muscle injury or condition, ligamentous or vertebral disc injury, "pinched nerve", vertebral or pelvic subluxation and/or extremity subluxation.

I (We) understand that the following integrative and complementary procedure(s) is planned for me and I (We) voluntarily consent and authorize these procedures: spinal and/or extremity manipulation, manual muscle therapies, physical therapy modalities also known as ultrasound, electrical muscle stimulation, heat/ice, and spinal intersegmental traction.

I (We) understand that no warranty or guarantee has been made to me as to the result of care.

I (We) realize that just as there may be risks and hazards in continuing my present condition without conventional medical treatment, there are also risks and hazards related to the performance of the integrative and complementary treatment, alternative forms of treatment, risks of treatment, risks of non-treatment, procedures to be used, and the risks and hazards involved, and I (We) believe that I (We) have sufficient information to give this informed consent.

I (We) certify this form has been fully explained to me, that I (We) have read it or have had it read to me and that I (We) understand its contents.

_____ _____

Signature Date

_____ _____

Witness Date

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ASSIGNMENT OF PROCEEDS, LIEN, AND AUTHORIZATION

I hereby authorize and direct any and all insurance carriers, attorneys, agencies, governmental departments, companies, individuals, and/or other legal entities ("payers"), which may elect or be obligated to pay, provide, or distribute benefits to me for any medical conditions, accidents, injuries, or illnesses, past, present, or future ("condition") to pay directly and exclusively in the name of **ChiroWerx, PLLC** ("**Office**") such sums as may be owing to **Office** for charges incurred by me at the **Office** relating to my condition ("charges"), with such payments to be made exclusively in the name of **ChiroWerx, PLLC** ("assignment"). I further grant a lien to **Office** with respect to my charges and authorize, grant and direct **Office** to file a UCC lien with the appropriate office at **Office**'s discretion. This lien shall apply to all payers and to the full extent permitted by law. For the purposes of this document (herein, "Assignment and Lien"), "benefits" shall include, but not be limited to, proceeds from any settlement, judgement or verdict, as well as any proceeds relating to commercial health or group insurance, attorney retainer agreements, medical payments benefits, personal injury protection, no-fault coverage, uninsured and underinsured motorist coverage, third party liability distributions, disability benefits, worker's compensation benefits, and any other benefits or proceeds payable to me for the purposes stated herein.

Further, I hereby authorize **ChiroWerx, PLLC** to file my claim with my health insurance. I understand, however, that in the event that my charges are submitted in their full amount to any other form of insurance (e.g., liability, medpay, etc), I hereby authorize and direct **ChiroWerx, PLLC** to collect any and all write-offs or discounts, issued by my health insurance, out of the proceeds from the other insurance. This authorization cannot be revoked with the express written consent of **ChiroWerx, PLLC** Consistent with these terms, I hereby direct any and all Payers, to pay the Proceeds directly to, immediately to, and exclusively in the name of, the **Office** to the full extent of my charges. To the extent that any law, including without limit a lien statute, purports to limit, reduce, or modify the distribution of proceeds in any manner inconsistent with this Assignment & Lien including without limit through the reservation of a portion of the proceeds exclusively to me, I hereby waive such limits, reductions, or modifications. I further agree to and hereby irrevocably waive any present or future right I may have, whether arising under a "Common Fund Doctrine" or other legal basis, to require the office to reduce its charges or balance by a proportionate or weighted share of my attorney's fees, costs, and other expenses of pursuing collection of my claims, including the office's charges.

In the event that I retain one or more attorneys to represent me in this matter, regardless of location (inside or outside of North Carolina), I will direct each attorney to issue an unrestricted letter of protection to this office regarding my charges. Upon issuance, I hereby agree that such letter(s) of protection cannot be revoked or modified without the express written consent of the office.

I authorize this office to release any information regarding my treatment or pertinent to my case(s) to all payers as defined above to facilitate collection under this Assignment and Lien. I further authorize and direct all payers to release to **Office** any information regarding any coverage or benefits which I may have including, but not limited to, the amount of the coverage, the amount paid thus far, and the amount of any outstanding claims. I hereby direct this office to file a copy of this Assignment and Lien, together with any applicable charges, with any or all payers, regardless of whether a claim has been established with said payers, including but not limited to, group health insurance, medpay, liability and/or worker's compensation. I hereby authorize **Office** to sign/endorse my name on any and all checks listing me as payee which are presented to this office for payment of an account relating to me, my spouse, or any of my dependents. I further authorize **Office** to apply any credit balances on charges incurred by me to any other charges still owed by me, my spouse, or my dependents, regardless of these other charges are related to my condition.

I understand that I remain personally responsible for the total amount due **Office** for their services. This Assignment and Lien does not constitute consideration for this office to wait payment and it may demand payments from me immediately upon rendering services at its option. If this office must take any action to collect an outstanding balance on my account, I will be responsible for payment and will reimburse office for all costs of such collection efforts, including, but not limited to, all court costs and all attorney's fees.

This Assignment and Lien shall not be modified or revoked without the mutual written consent of **Office** and myself. I hereby revoke any previously signed authorizations, whether executed in this office or any other office to the extent that the terms of those authorizations conflict with the terms of this Assignment and Lien.

Patient Name (please print):_____ Date _____

Patient Signature: _____ Date _____

Name of Custodial Parent of Legal Guardian (please print): _____ Date _____

Parent/Guardian' Signature: _____Date _____

Election Not to File Health Insurance Claims
(Personal Injury/Accident)

Dr. Kyle Dunning | 8307 University Exec Park Dr #251 | Charlotte, NC 28262 | Ph: 980-201-9484

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The chiropractor(s) at this clinic are participating ("in-network") providers for your health benefit plan. As participating providers, we are obligated to file claims for reimbursement with your plan for all covered services provided to you UNLESS you instruct us in writing not to file.

You have indicated that rather than using your own health insurance, you wish to consider seeking payment from other third-party payors such as the at-fault driver's liability insurance. To help you make an informed decision, please carefully review the following information.

If you elect NOT to file claims on your health insurance:

1. The clinic will rely on your decision and extend credit to you for the cost of care based on the assumption that your bill will be paid by sources other than your health insurance. You will be required to assign to the clinic the right to receive monies paid by liability insurers, medical payments insurers or other third-party payors to the extent necessary to satisfy your bill.
2. You will not be required to pay co-payments/co-insurance and/or deductibles that would normally be required by your health benefit plan.
3. The cost of your treatment will be billed at the clinic's usual rates rather than the discounted rates that routinely apply to services covered by your health benefit plan.
4. If the combined payments received from other sources do not fully satisfy your bill, you may be personally liable for any unpaid balance.
5. None of the charges for your treatment will be applied towards satisfying the annual deductibles associated with your health benefit plan.

If you elect TO file claims on your health insurance:

1. Your health insurance should pay the cost of *covered* services associated with this accident/injury EXCEPT FOR copayments, co-insurance and/or deductibles, which you will be expected to pay directly to the clinic at the time services are rendered.
2. You will be responsible for paying to the clinic the cost of any *non-covered* services you elect to receive, and your payment will be due at the time services are rendered.
3. If your health benefit plan initially pays the clinic for your treatment and later determines that it is not legally responsible for payment, the plan administrator may require the clinic to refund to the plan all or part of the payments received. If that happens, you will become responsible for reimbursing the clinic the amount it was required to refund.
4. Your health benefit plan requires the clinic to submit claims in a timely fashion and while timely filing requirements vary, most plans require claims to be filed within 3-6 months from date of service. If your action or inaction causes a claim to be submitted late, the claim could be denied, and you would be responsible for paying this clinic for those services which were denied.

Election not to file health insurance claims:

1. By my signature below, I attest that I have read and understand the above information regarding the options available to me and have been given an opportunity to ask questions and to have those questions answered.
2. I hereby instruct the clinic not to file claims on my health insurance for services associated with this accident/injury, and I authorize the clinic to seek payment from, and send my treatment records to, other third-party payors who are potential sources of payment.
3. I understand that the clinic is relying on my decision not to file health insurance claims, and that with regards to claims related to this accident/injury, this decision is irrevocable.
4. I understand that no subsequent action on my part shall impair the clinic's right to bill and receive payments from third-party payors; subject only to any contractual obligation the clinic may have to my health benefit plan.

_____	_____
Printed Name of Patient	**Printed** Clinic Representative
_____	_____
Signature of Patient (or parent/legal guardian, as applicable)	Signature of Clinic Representative
_____	_____
Date:	Date:

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AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I authorize the use and disclosure of my individually identifiable health information as described below. I understand that this is voluntary.

Patient Information
Name: _____ DOB: _____/_____/_____

SS#: _____-_____-_____ Patient Address: _____

Person/ Organization Providing Information:
Name: _____ Fax: _____

Person/ Organization Receiving Information:
Name: **ChiroWerx, PLLC** **Phone: 980-201-9484** Fax: **980-201-9126**

Address: **8307 University Exec Park Dr #251 Charlotte, NC 28262**

Information Needed:
Specific description of information covering health care from _____ to_____

_____ Complete Health Records
_____ Lab
_____ Imaging (Please Specify) _____ X-Ray _____ MRI _____CT

Unless otherwise revoked, this authorization will expire on the following date, event or condition _____. If I fail to specify an expiration date, event or condition, this authorization will expire in six months. I may revoke this authorization at any time in writing to the concerned parties. The revocation will not be effective to the extent that others or we have acted in reliance upon this authorization. Information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer be protected by this rule.

_____ _____
Signature of Patient or Legal Representative Date

_____
If Signed by Legal Representative, Relationship to Patient