ASPEN
CHIROPRACTIC & WELLNESS

PATIENT INFORMATION ACCIDENT

Thank you for choosing Aspen Chiropractic and Wellness. Please place a line through any area that does not apply. Please don't hesitate to ask if you need assistance.

GENERAL INFORMATION

Name: _____ Date: _____ S.S. # _____
First M.I. Last

Address: _____ City: _____ State: _____ Zip: _____

Birth date: _____/_____/_____ Gender: ☐ Female ☐ Male Email: _____

Hm Ph: (_____) _____ Cell Ph: (_____) _____

How did you hear about us? _____

Patient Employer/School: _____ Spouse/Parent's Name: _____

Emergency Contact / Relationship: _____ Ph: (_____) _____

Primary Care Provider: _____ Phone number: _____

Personal Injury Insurance Information

Your Auto Insurance Company:
Driver's Name:_____
Policy Holder's Name:_____
Insurance Name:_____ Insurance Ph. #_____
Policy #_____ Claim #_____
Adjuster's Name_____ Ph. #_____

Third Party Liability: This is the insurance information for the person who was in the "other car".
Driver's Name:_____
Policy Holder's Name:_____
Insurance Name:_____ Insurance Ph. #_____
Policy #_____ Claim #_____
Adjuster's Name_____ Ph. #_____

Attorney Information:
Name:_____
Firm:_____
Contact Person:_____
Phone #:_____

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Accident Information

Please be as detailed as possible about your auto accident

Date of Accident: _____ Time of Accident: _____am / pm

Please describe to the best of your knowledge what happened during the accident:

_____

_____

_____

What type of vehicle were you driving? SUV ☐ Truck ☐ Sedan ☐ Coupe ☐ Motorcycle ☐
Was your car stopped at the time of impact? Yes ☐ No ☐
If no, approximately how fast was the vehicle moving? _____mph
If the vehicle was moving, was it: gaining speed ☐ slowing down ☐
What type of vehicle was the other vehicle involved? SUV ☐ Truck ☐ Sedan ☐ Coupe ☐ Motorcycle ☐
Was the other car stopped at the time of impact? Yes ☐ No ☐ If no, approximately how fast was the vehicle moving? _____mph
If the vehicle was moving, was it: gaining speed slowing down
Road conditions at time of accident: Wet ☐ Dry ☐ Other_____
Where were you seated in the vehicle? Driver ☐ Passenger ☐ Rear ☐ Other_____
Did you lose consciousness upon impact or prior to? Upon Impact ☐ Prior to Impact ☐ No ☐
Were you wearing a seatbelt? Yes ☐ No ☐ Was the seat broken by the accident? Yes ☐ No ☐
Did police come to the accident scene? Yes ☐ No ☐ Police report taken? Yes ☐ No ☐
Did the airbag deploy? Yes No If yes, did it strike you? Yes ☐ No ☐ Where?_____
At the time of the accident, did you become or experience any of the following?
Confused ☐ Disoriented ☐ Light Headed ☐ Dizzy ☐ Nauseated ☐ Blurred Vision ☐
Ringing/Buzzing in ears ☐ Loss of balance ☐ Other:_____

Did you go to the hospital? Yes ☐ No ☐ When? Immediately ☐ __hours later ☐ ___days later ☐
-If yes, what hospital? _____How long was your stay? _____
-What treatment did you receive? (medications, x-rays, splints, CAT scan, surgery, etc.)_____
-What x-rays were taken? _____Diagnosis?_____
-Any follow up care recommended? _____
-Was any other doctor consulted after the accident? Yes ☐ No ☐ If yes, fill out below:
-Dr:_____Specialty?_____Date seen:_____
-Type of treatment:_____Frequency:_____Duration:_____

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Occupation:

Job involves: Sitting ☐ Standing ☐ Lifting ☐ Bending ☐ Twisting ☐ Turning ☐ Stooping ☐
If standing, how long? _____ If lifting, how much? _____
Physical activity: Deskbound ☐ Light manual labor ☐ Manual labor ☐ Heavy manual labor ☐
Have you missed any time from work due to the accident? Yes ☐ No ☐ If yes, how many days? _____
Are work duties restricted as a result of this accident? Yes ☐ No ☐ If yes please explain:

_____

Current Complaints: List current symptoms separately in order of severity.

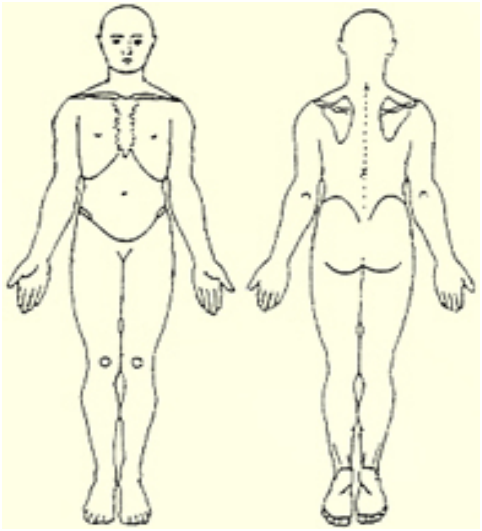
Use the body diagram to mark your symptom(s):

1st Area of Symptoms:

Date symptom(s) first appeared: _____
How often do you experience these symptoms? Constant ☐ Frequent ☐ Intermittent ☐ Occasional ☐
What makes symptoms increase? _____ decrease?_____
Type of pain? Sharp ☐ Dull ☐ Aching ☐ Burn ☐ Throb ☐ Numb ☐ Other_____
Please rate the intensity of your symptoms:
(0 being no symptoms, 10 being extreme) 0--- 1--- 2--- 3--- 4--- 5--- 6--- 7--- 8---9--- 10

2nd Area of Symptoms:

Date symptom(s) first appeared: _____
How often do you experience these symptoms?
Constant ☐ Frequent ☐ Intermittent ☐
Occasional ☐
What makes symptoms increase?
_____
What makes symptoms decrease?
_____
Type of pain? Sharp ☐ Dull ☐ Aching ☐ Burn ☐
☐ Throb ☐ Numb ☐ Other_____
Please rate the intensity of your symptoms:
(0 being no symptoms, 10 being extreme)
0--- 1--- 2--- 3--- 4--- 5--- 6--- 7--- 8---9--- 10



Is there anything else pertaining to your accident that we need to know?

_____
_____

_____ _____
Patient Signature Date

21681 NORTH 77TH AVENUE, SUITE 1415, PEORIA, ARIZONA 85382
623-572-9200 ASPENCHIROAZ.COM

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CHIROPRACTIC & WELLNESS

WELCOME TO OUR OFFICE

We are committed to providing you the best care and are pleased to discuss our professional fees with you at any time. Please ask any questions you may have regarding our fees or your responsibility in complying with our financial policy and/or procedures.

Insurance Patients: Professional services are rendered and charged to your insurance on your behalf. Any services not covered by your insurance are ultimately your responsibility and may have to be paid by you at the time of service. ***Deductibles are the patients' full responsibility.*** If you fail to keep your appointments or you discontinue care for any reason other than discharge by the Provider, the bill is due and payable by you in full immediately, regardless of any insurance claims submitted. Our office accepts billing for Individual or Group insurance policies, Personal Injury Claims, and authorized Worker's Compensation. If the provider, as part of a treatment plan prescribes manual therapy for you, you must see the provider on the same day of service. If you do not, you are responsible for the full amount of the service.

Collection/Attorney Fees: I agree to pay all costs of a collection agency if necessary, not to exceed 25% of the principle, to obtain payment in the event that legal action should become necessary to collect an unpaid balance due for medical services. I agree to pay reasonable attorney's fees or other such costs as the court determines proper.

Limited Release of Medical Information: I authorize Aspen Chiropractic to make inquiries and to release any pertinent information to any insurance company, adjuster or attorney to facilitate collection under these circumstances.

Assignment of Cause of Action: In the event that any insurance company or other third party obligated to make payment to me or to Aspen Chiropractic for the charges made for these services refuses to make such payment on demand, I hereby assign, transfer, and convey to Aspen Chiropractic any and all cause of action that might exist in my favor against any such company or person. I authorize Aspen Chiropractic to prosecute said action in my name or their name to collect fees due for care rendered and legal expenses, and to resolve said claims as they see fit.

By signing this statement, I am agreeing to all above notices. I have reviewed a copy of the Notice of Privacy Practices and may request a copy at any time.

_____ _____

Patient Signature / Guardian Signature Date

21681 NORTH 77TH AVENUE, SUITE 1415, PEORIA, ARIZONA 85382
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Dr. Shane McCall, D.C. Carli Walter, P.A.-C Dr. Joseph Vigneau, D.C. Dr. Brian Glick, D.O.
21681 N. 77th Ave. · Suite 1415 · Peoria, AZ · 85382

Others Involved in My Healthcare

Patient Name:_____ ID Number:_____

Aspen Chiropractic and Wellness, ***MAY*** discuss all aspects of my healthcare with:

_____ _____
Print Name Relationship

_____ _____
Print Name Relationship

_____ _____
Signature of Patient or Legal Representative Date

Aspen Chiropractic and Wellness, ***MAY NOT*** discuss any aspect of my health care with the following person/people, unless it is needed to provide emergency treatment.*

*As the patient, you may also request that any part of your Private Health Information (PHI) not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must be in writing and state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may request. If your physician believes it is in your best interest to permit use and disclosure of your PHI, your PHI will not be restricted. If your physician does agree to the requested restriction, we may not or disclose your PHI in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your physician.

_____ _____
Print Name Relationship

_____ _____
Print Name Relationship

_____ _____
Signature of Patient or Legal Representative Date

A complete copy of our Notice of Privacy Practice is available at this office for you at any time.

You have the right to rescind any part of this authorization with written notice.

ASPEN
CHIROPRACTIC & WELLNESS

ASPEN CHIROPRACTIC AND WELLNESS
PAYMENT POLICY AND BENEFIT ASSIGNMENT

Our practice is committed to providing you with the best quality and affordable medical care.
Please review our financial policy.

1. Insurance: We participate in most insurance plans. If you are not insured nor have a plan that we do not participate in, payment is expected in full at the time of your visit. It is the patient's responsibility to make sure that our office keeps your current insurance information. If you have any questions regarding coverage, please contact your insurance company directly.

2. Co-payment: All co-payments are due at the time services are rendered. For your convenience we accept Visa, MasterCard, AMEX, Checks or Cash.

3. Non-Covered Services: All non-covered services by insurance will be the responsibility of the patient.

4. Updates: Our staff will verify your information at each visit. It is patient 's responsibility to update with opportunity all personal/insurance information updates or changes.

5. Claims submission: Aspen Chiropractic and Wellness will submit your claims and assist you in any way we can to help get your claims paid. *It is your responsibility to comply in a timely manner to ensure coverage and payment.* Please note that the *balance of your claim is your responsibility whether or not your insurance pays your claims.* Your insurance benefit is a contract between you and your insurance company.

6. Delinquent Accounts: Accounts past due 60 days will receive a 10 day-grace period to bring your account to good standing. If a balance remains unpaid, your account will be referred to a collection agency. A fee of $50.00 will be added to any outstanding balance. Please contact our office if you desire to make payment arrangements with opportunity.

7. Referrals and Authorizations: If a referral is needed by your insurance, you will be asked to obtain a referral prior to your visit. We suggest you contact your insurance company to verify coverage, benefits and pre-authorizations requirements before your visit. Please be aware that referral and authorizations are not a guarantee of payment.

8. Missed Appointments:

Wellness Appointments: A $75.00 fee will be applied to those appointments not canceled with 24 hours of anticipation.

Massage Appointments: A $50.00 fee will be applied to those appointments not canceled with 24 hours of anticipation.

9. Returned checks (NSF): A $50.00 fee will be charged for any personal check returned for non-payment.

I hereby acknowledge that I have been presented with a copy of Aspen Chiropractic and Wellness Payment Policy and Benefit Assignment.

_____ _____

Patient Signature / Guardian Signature Date