

ACCIDENT LIABILITY POLICY

1. I understand that I am being treated for injuries sustained in a motor vehicle accident and that failure to keep my appointments may jeopardize the insurance carrier's responsibility for medical costs and/or compensation for pain and suffering.
2. I understand that this office is extending me credit for treatment, and that if I miss two (2) office visits without a reasonable excuse all bills may be due immediately and a \$25 missed office visit fee will be incurred.
3. I understand that if I sever ties with my attorney before settlement or my attorney will no longer represent my case, all bills may be due immediately.

Patient Signature

Date

CONSENT FOR TREATMENT

Patient Name: _____ Date: _____

All patients in the State Of Georgia are required to approve of all services rendered by their doctor before any services are performed. Refusal to comply with Georgia Law releases your doctor of all liabilities and his/her right to refuse treatment.

I, _____, hereby request and give consent to my doctor to perform all necessary chiropractic examinations, adjustments, therapy, rehabilitation, and medical diagnostic x-rays. I understand that my doctor will consult with me before any procedures are performed, at which time, I will give him permission to perform all necessary procedures to treat my condition.

I understand that during my treatment that care may be rendered by other doctors at Horizon Health Care Group. I understand that I will be made aware of any such circumstances before being treated.

I understand that I have any opportunity to discuss with the doctor and/or with the office manager, the nature and purpose of my chiropractic care before any treatment is rendered.

Patient Signature _____ Date: _____

HORIZON HEALTH CARE GROUP

I, the undersigned, hereby authorize **Horizon Health Care Group** to furnish my attorney any medical information requested concerning the condition or treatment of injuries sustained by me, my spouse or children, on _____.

In consideration for **Horizon Health Care Group** having agreed to treat me without payment at the time of service and enabling me to obtain treatment for my accident/injury/illness, without financial hardship, I give you a lien on any settlement, claim, judgment, verdict or result of said accident/injury/illness and I agree to irrevocably instruct my attorney to pay you in full from any proceeds of settlement, claim or judgement related to this accident/injury/illness.

I also understand that if the settlement does not cover the entire bill at this Clinic, I am still responsible for the remainder and the payment by me of this bill is not contingent on any settlement, claim, or judgement which I may eventually recover.

Furthermore, in consideration for **Horizon Health Care Group** refraining from attempting to collect immediate payment for services rendered for my accident/injury/illness, I do hereby waive and toll any applicable statute of limitations on the collection of my account until I notify **Horizon Health Care Group** the conclusion of my efforts to obtain a settlement or judgement through the assistance of my attorney and for a period of three months thereafter.

Patient Name (Please Print)

Patient Signature

Date

INSTRUCTION TO COUNSEL

I do hereby irrevocably instruct you, my Attorney, named below, to pay **Horizon Health Care Group** in full for services rendered to me for my accident/injury/illness from any proceeds of settlement, claim, or judgement regarding said accident/injury/illness. You are to pay **Horizon Health Care Group** prior to distributing any proceeds to me and I instruct you not to reduce by means of negotiation my doctor's bill for the services that have been provided to me for the accident/injury/illness which I have agreed to pay in full.

Firm Name

Patient Signature

Attorney Name

Date

ATTORNEY'S ACCEPTANCE OF LIEN

Being the attorney of record or authorized representative, I acknowledge receipt of my clients instructions to Counsel and Lien and agree to honor the same.

Attorney Signature

Date

FOR OFFICE USE ONLY

Total Billed Amount for Lien Filing:

\$ _____ , _____ . _____

• HORIZON HEALTH CARE GROUP. •
5942 ROSWELL RD NE.
ATLANTA, GA 30328
PHONE: 404.252.2520 • FAX: 404.255.6703

HEALTH CARE AUTHORIZATION FORM

Patient's Name _____

Patient's SS# _____ Date of Birth _____

THE PATIENT IDENTIFIED ABOUT AUTHORIZES **HORIZON HEALTH CARE GROUP** TO USE AND OR DISCLOSE PROTECTED HEALTH INFORMATION IN ACCORDANCE WITH THE FOLLOWING:

SPECIFIC AUTHORIZATIONS

- _____ (Initial) I give permission to Horizon Health Care Group to use my address, phone number, and clinical records to contact me with appointment reminders, missed appointment notification, birthday cards, holiday related cards, information about treatment alternatives, or other health related information.
- _____ (Initial) If Horizon Health Care Group contacts me by phone I give them permission to leave a phone message on my answering machine or voicemail.

(OPEN ROOM AUTHORIZATION)

- _____ (Initial) I give Horizon Health Care Group permission to treat me in an open room where other patients are also being treated. I am aware that other persons in the office may overhear some of my protected health information during the course of care. Should I need to speak with a doctor at any time in private, the doctor will provide a room for the conversations.
- _____ (Initial) By signing this form you are giving Horizon Health Care Group permission to use and disclose your protected health information in accordance with the directives listed above.

RIGHT TO REVOKE AUTHORIZATION

You have the right to revoke this AUTHORIZATION, in writing at anytime. However, your written request to revoke this AUTHORIZATION is not effective to the extent that we have provided service or taken action in reliance on your authorization.

You may revoke this AUTHORIZATION by mailing or hand delivering a written notice to the Privacy Official of Immediate Response. The written notice must contain the following information:

Your name, social security number, and date of birth;
A clear statement of your intent to revoke this AUTHORIZATION;
The date of your request; and
Signature.

The revocation is not effective until it is received by the Privacy Official.

This AUTHORIZATION is requested by Immediate Response for its own use/disclosure of PHI.
(Minimum necessary standards apply)

PERSONAL HISTORY

Name: _____ Address: _____
 City: _____ State: _____ Zip: _____ Birth Date: _____ Age: _____
 Home Phone: _____ Cell Phone: _____ Business Phone: _____ Sex: M F
 Social Security _____ Driver's License No. _____ Email Address: _____
 Check One: Married Single Widowed Divorced Separated
 Business Employer: _____ Type of Work: _____
 Business Address: _____
 Name of Spouse: _____ Spouse's Social Security # _____
 Type of Work: _____
 Business Phone: _____
 Names and Ages of Children: _____
 Name and Number of Emergency Contact: _____ Relationship: _____
 Who Is Responsible For Your Bill, You and Spouse Workers' Comp. Auto Insurance Medicare
 Personal Health Insurance (Name) _____ Health Card # _____

CURRENT HEALTH CONDITION

Purpose of This Appointment: _____
 Other Doctors Seen For This Condition: Yes No Who? _____
 Type of Treatment: _____ Results: _____
 When Did This Condition Begin? _____ Has This Condition Occurred Before? Yes No
 Is Condition: Job Related Auto Accident Home Injury Fall Other: _____
 Date of Accident: _____ Your Auto Insurance Company: _____ Time of Accident: _____
 Have You Made a Report of Your Accident To Your Employer? Yes No
 Drugs You Now Take: Nerve Pills Pain Killers / Muscle Relaxers Blood Pressure Medicine Insulin
 Other _____
 Do You Suffer From Any Condition Other Than That Which You Are Now Consulting Us? _____

PAST HEALTH HISTORY

HOSPITALIZATIONS			PREGNANCY HISTORY		
Year	Hospital	Reason for Hospitalization and outcome	Year of Birth	Sex of Birth	Complications, if any

Major Accident or Falls: _____

SYMPTOMS Check (✓) symptoms you currently have or have had in the past year.

<p>GENERAL</p> <input type="checkbox"/> Chills <input type="checkbox"/> Depression <input type="checkbox"/> Dizziness <input type="checkbox"/> Fainting <input type="checkbox"/> Fever <input type="checkbox"/> Forgetfulness <input type="checkbox"/> Headache <input type="checkbox"/> Loss of sleep <input type="checkbox"/> Loss of weight <input type="checkbox"/> Nervousness <input type="checkbox"/> Numbness <input type="checkbox"/> Sweats	<p>GASTROINTESTINAL</p> <input type="checkbox"/> Appetite poor <input type="checkbox"/> Bloating <input type="checkbox"/> Bowel changes <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Excessive hunger <input type="checkbox"/> Excessive thirst <input type="checkbox"/> Gas <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Indigestion <input type="checkbox"/> Nausea <input type="checkbox"/> Rectal bleeding <input type="checkbox"/> Stomach pain <input type="checkbox"/> Vomiting <input type="checkbox"/> Vomiting blood	<p>EYE, EAR, NOSE, THROAT</p> <input type="checkbox"/> Bleeding gums <input type="checkbox"/> Blurred vision <input type="checkbox"/> Crossed eyes <input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Double vision <input type="checkbox"/> Earache <input type="checkbox"/> Ear discharge <input type="checkbox"/> Hay fever <input type="checkbox"/> Hoarseness <input type="checkbox"/> Loss of hearing <input type="checkbox"/> Nosebleeds <input type="checkbox"/> Persistent cough <input type="checkbox"/> Ringing in ears <input type="checkbox"/> Sinus problems <input type="checkbox"/> Vision - Flashes <input type="checkbox"/> Vision - Halos	<p>MEN only</p> <input type="checkbox"/> Breast lump <input type="checkbox"/> Erection difficulties <input type="checkbox"/> Lump in testicles <input type="checkbox"/> Penis discharge <input type="checkbox"/> Sore on penis <input type="checkbox"/> Other:
<p>MUSCLE / JOINT / BONE Pain, weakness, numbness in:</p> <input type="checkbox"/> Arms <input type="checkbox"/> Hips <input type="checkbox"/> Back <input type="checkbox"/> Legs <input type="checkbox"/> Feet <input type="checkbox"/> Neck <input type="checkbox"/> Hands <input type="checkbox"/> Shoulders	<p>CARDIOVASCULAR</p> <input type="checkbox"/> Chest pain <input type="checkbox"/> High blood pressure <input type="checkbox"/> Irregular heart beat <input type="checkbox"/> Low blood pressure <input type="checkbox"/> Poor circulation <input type="checkbox"/> Rapid heart beat <input type="checkbox"/> Swelling of ankles <input type="checkbox"/> Varicose veins	<p>SKIN</p> <input type="checkbox"/> Bruise easily <input type="checkbox"/> Hives <input type="checkbox"/> Itching <input type="checkbox"/> Change in moles <input type="checkbox"/> Rash <input type="checkbox"/> Scars <input type="checkbox"/> Sore that won't heal	<p>WOMEN only</p> <input type="checkbox"/> Abnormal Pap smear <input type="checkbox"/> Bleeding between periods <input type="checkbox"/> Breast lump <input type="checkbox"/> Extreme menstrual pain <input type="checkbox"/> Hot flashes <input type="checkbox"/> Nipple discharge <input type="checkbox"/> Painful intercourse <input type="checkbox"/> Vaginal discharge <input type="checkbox"/> Other:
<p>GENTO-URINARY</p> <input type="checkbox"/> Blood in urine <input type="checkbox"/> Frequent urination <input type="checkbox"/> Lack of bladder control <input type="checkbox"/> Painful urination			Date of last Menstrual period _____ Date of last Menstrual period _____ Have you had a mammogram? _____ Are you pregnant? _____ Number of Children: _____

CONDITIONS Check (✓) conditions you currently have or have had in the past.

<input type="checkbox"/> AIDS <input type="checkbox"/> Alcoholism <input type="checkbox"/> Anemia <input type="checkbox"/> Anorexia <input type="checkbox"/> Appendicitis <input type="checkbox"/> Arthritis <input type="checkbox"/> Asthma <input type="checkbox"/> Bleeding Disorders <input type="checkbox"/> Breast Lump <input type="checkbox"/> Bronchitis <input type="checkbox"/> Bulimia <input type="checkbox"/> Cancer <input type="checkbox"/> Cataracts	<input type="checkbox"/> Chemical Dependency <input type="checkbox"/> Chicken Pox <input type="checkbox"/> Diabetes <input type="checkbox"/> Emphysema <input type="checkbox"/> Epilepsy <input type="checkbox"/> Glaucoma <input type="checkbox"/> Goiter <input type="checkbox"/> Gonorrhea <input type="checkbox"/> Gout <input type="checkbox"/> Heart Disease <input type="checkbox"/> Hepatitis <input type="checkbox"/> Hernia <input type="checkbox"/> Herpes	<input type="checkbox"/> High Cholesterol <input type="checkbox"/> HIV Positive <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Liver Disease <input type="checkbox"/> Measles <input type="checkbox"/> Migraine Headaches <input type="checkbox"/> Miscarriage <input type="checkbox"/> Mononucleosis <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Mumps <input type="checkbox"/> Pacemaker <input type="checkbox"/> Pneumonia <input type="checkbox"/> Polio	<input type="checkbox"/> Prostate Problem <input type="checkbox"/> Psychiatric Care <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Scarlet Fever <input type="checkbox"/> Stroke <input type="checkbox"/> Suicide Attempt <input type="checkbox"/> Thyroid Problems <input type="checkbox"/> Tonsillitis <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Typhoid Fever <input type="checkbox"/> Ulcers <input type="checkbox"/> Vaginal Infections <input type="checkbox"/> Venereal Disease
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MEDICATIONS List medications you are currently taking.	ALLERGIES To medications or substances
Pharmacy Name _____ Phone _____	

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I authorize this clinic to release any information you deem appropriate concerning my physical condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred by me as a result of professional services rendered by you, and I hereby release you of any consequence thereof. Furthermore, I understand that the Doctor's Office will assist me in making my collection. I authorize the direct payment to you of any sum, I now or hereafter owe you, by my attorney out of proceeds of any settlement of my case and/or any insurance company obligated to reimburse me for the charges for your services or otherwise obligated to make payment to me based in whole or in part upon the charges made for your services.

I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate, any fees for professional services rendered to me will be immediately due and payable.

_____ Date _____

Patient / Guardian Signature

HORIZON HEALTH CARE GROUP

Name: _____

Date: _____

To All Patients:

Please let us know how you heard about our office:

Patient

Insurance Book

Sign/Walk-in

Physician

New Neighbor

Health Screening

Pajinas Amarillas

Wellness Pass

Attorney _____

Other _____

Friends/Relative: _____

*We would like to acknowledge this person.

Telling Your Friends About Our Office Will Be Greatly Appreciated

HIPAA Notice of Privacy Practices

I
Horizon Health Care Group
5942 Roswell Rd Ne
Atlanta, GA 30328
404-252-2520

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law .

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information 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 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 physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name: _____ Signature _____ Date _____

OFFICE POLICIES

Appointment Scheduling

Visit frequency is to be kept by the patient according to the doctor's recommendations. To save time we ask that you **pre-schedule** all of your appointments in advance. To keep your progress on schedule, it is necessary that you reschedule all missed appointments **within 24 hours**. If you arrive early for your appointment, we will do our best to work you in, however, all scheduled patients will be seen first. Late appointments will be worked in or rescheduled by our staff. In order to provide the care you need, your scheduled appointments are for adjustments and rehabilitation. If you should need to talk to the doctor about any other concerns, we will schedule a special time for you to meet with the doctor. Initials _____

Deductibles and Co-Pays

All patients are expected to pay deductibles and co-payments for their care. There are very strict laws governing doctors that do not collect insurance deductibles and co-payments. Our office will not engage in any waiving of these payments. Initials _____

There Is No Discussing Finances With The Doctors

Your doctor's responsibility is to deliver the very best in health care for your needs. Horizon Health Care Group has a billing staff that will always be available to discuss your finances when they are a concern to you. **Please do not talk to the doctors about any financial arrangements.** Initials _____

Broken Appointments

Our office has very strict policies for missed appointments. We ask all patients to respect both the doctors and patients by calling 24 hours in advance if you need to cancel an appointment. We realize that unforeseen circumstances will occur during your treatment, however, we will only allow 2 cancelled or no show appointments before **we will charge your account a \$25 office visit fee.** Each missed appointment will be documented in our records and will be discussed individually before you are charged. **The doctor will also have the discretion to release any patient for missed treatment.** Initials _____

Financial Agreements

It is your prompt payment that allows us to continue providing the highest levels of professional care to you and your family. We will file all of your insurance claims as a service to you, however, we will not enter into any dispute with your insurance company. We will verify your benefits for you, but we need to make you aware that insurance companies may give wrong information about policies without our knowledge. **If this situation occurs, you will still be responsible for your medical bills.** If you do not have insurance, our office will do our best to help you receive care. Patients that are treated with no insurance will be eligible for reduced fees if paid at the time of service. Any patient needing treatment longer than 90 days may be eligible for special financial arrangements. Please discuss any questions with our billing department. Initials _____

Maintenance Care

Maintenance treatment is becoming more popular with patients that are treated in chiropractic offices. This treatment is usually recommended for patients that are not experiencing any acute or chronic pain, however, they would like to prevent any future pain or problems. Patients being treated for maintenance care will be seen on an "as needed basis" or once every 30-60 days. **Unfortunately, insurance companies will not pay for maintenance care.** Insurance companies are only responsible for what they define as medically necessary treatment. **All patients receiving maintenance care will be responsible to pay our fees at the time of service and may file their own insurance.** Initials _____

Complimentary Care For Your Family

Within 30 days of your first visit our office will allow any family member or friend to receive a complimentary consultation and examination by your doctor. We will not offer any complimentary care after 30 days. Initials _____

Chiropractic Care For Your Children

Children need to have their spines examined just like adults. Many children grow up with adolescence scoliosis and other back related conditions that are commonly misdiagnosed. Unfortunately, children don't complain, leaving serious health conditions going undetected. Our pledge to you is that we will perform complimentary scoliosis screenings on all children. **Please ask our staff about our fees for treating your child.** Initials _____

Signature _____ Date: _____

Personal Injury Settlement Agreement
Horizon Health Care Group
P.O. Box 720726
Atlanta, GA 30358
404-252-2520

I, _____, hereby authorize my attorney to directly pay all outstanding medical bills to Horizon Health Care Group. I understand that if my attorney reimburses me with any settlement amounts that I am held solely responsible to pay all medical bills to Horizon Health Care Group.

Failure to pay all remaining medical bills may incur legal and collections action. I understand that this will be avoided assuming my attorney directly reimburses Horizon Health Care Group its full medical bills. I understand that this form will be faxed to my attorney's office.

Signature of Patient/Guardian

Date

VEHICLE ACCIDENT INFORMATION

PATIENT INFORMATION

Date _____

Patient Name _____

Date of Accident _____ Time of Accident _____ a.m.

p.m.

Please describe the accident in your own words: _____

Were you the: Driver Front Passenger Rear Passenger Pedestrian

How many people were in the accident vehicle? _____

ACCIDENT SITE

Road/Street Name _____

City/State _____

Nearest intersection with road/street _____

Driving conditions Dry Wet Icy Other _____

Which direction were you headed? _____

Speed you were traveling? _____

VEHICLE

Make and model of vehicle you were in: _____

Were you wearing a seatbelt? Yes No

If yes, what type? Lap Shoulder

Was 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 headrest?

Low Midposition High

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 impact were you:

Looking straight ahead Looking to the right

Looking to the left Looking down

Looking up

Were both hands on the steering wheel? Yes No

If no, which hand was on the wheel? Right Left

Was your foot on the brake? Yes No

If yes, which foot was on the brake? Right Left

Were you: Surprised by impact Braced for impact

OTHER VEHICLE

(if applicable)

Make and model of other vehicle _____

Which direction was other vehicle headed? _____

Speed other vehicle was traveling _____

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? _____

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 days or more after the accident

How did you get to the hospital? Ambulance Private transportation

Name of hospital _____ Name of doctor _____

Diagnosis _____

Treatment received _____

X-rays taken _____

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

If you have had any of the following symptoms since your injury, please check:

- | | | |
|--|---|--|
| <input type="checkbox"/> Arm/shoulder pain | <input type="checkbox"/> Feet/toe numbness | <input type="checkbox"/> Neck pain |
| <input type="checkbox"/> Back pain | <input type="checkbox"/> Hand/finger numbness | <input type="checkbox"/> Neck stiff |
| <input type="checkbox"/> Back stiffness | <input type="checkbox"/> Headaches | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Irritability | <input type="checkbox"/> Sleep difficulty |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Jaw problems | <input type="checkbox"/> Stomach upset |
| <input type="checkbox"/> Ear buzzing | <input type="checkbox"/> Leg pain | <input type="checkbox"/> Tension |
| <input type="checkbox"/> Ear ringing | <input type="checkbox"/> Memory loss | <input type="checkbox"/> Vision blurred |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Nausea | |

Is this condition getting progressively worse? Yes No Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.

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

Type of pain: Sharp Dull Throbbing Numbness
 Aching Shooting Burning Tingling
 Cramps Stiffness Swelling Other _____

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

Movements that are painful to perform: Sitting Standing Walking
 Bending Lying Down



To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

Signature of Patient, Parent, Guardian or Personal Representative

Date

Please print name of Patient, Parent, Guardian or Personal Representative

Relationship to Patient