Hunt For Wellness
CHIROPRACTIC
Family & Injury Care

PERSONAL INFORMATION

Date / Fecha:___/___/___ Social Security #:___/___/____

First Name / Nombre:_____

Middle / Segundo:_____

Last Name:_____

Nickname / Apodo:_____

Address / Direccion:_____

City / Ciudad:_____ State/Estado:____ Zip:_____

Birthday / Cumpleanos:___/___/____ Age / Edad:_____

Cell Phone # / Telefono de casa:_____

Cell phone Carrier (for text reminders):_____

Work/ Home Phone # /Telefono de trabajo:_____

E-mail:_____

Referred by / Referido por:_____

Employer / Empleador:_____

Address / Direccion:_____

City / Ciudad:_____ State/Estado:____ Zip:_____

Occupation / Occupacion:_____

[ ] Single / Soltero **[ ]** Married / Casado

[ ] Divorced / Divorciado **[ ]** Separated / Separado

[ ] Widowed / Viudo

Do you have any children? / Tiene hijos? **[ ]** Yes/Si **[ ]** No

How many? / Cuantos?:_____

IN CASE OF EMERGENCY / EMERGENCIA

Contact Person / Persona de contacto: _____

Relation / Relacion: _____

Home Phone # / Telefono de casa: _____

Work Phone # / Telefono de trabajo:_____

Other Phone # / Otro Numero:_____

PERSONAL INJURY ONLY

Date of accident / Fecha de accidente:_____/_____/_____

Accident state occurred / Estado donde accidente occurio:____

Ins. Co. Name / Comp. De aseguransa: _____

Phone # / Telefono: _____

Fax # / # de fax: _____

Claim # / # de reclamo: _____

Adjustor's name / Nombre de adjuster: _____

Have you retained an attorney/ Tiene abogado(a)?
[ ] Yes/Si **[ ]** No
If yes, whom?/ Si tiene, quen es? _____

Phone/ Numero del abogado(a) #:
_____

Name:_____

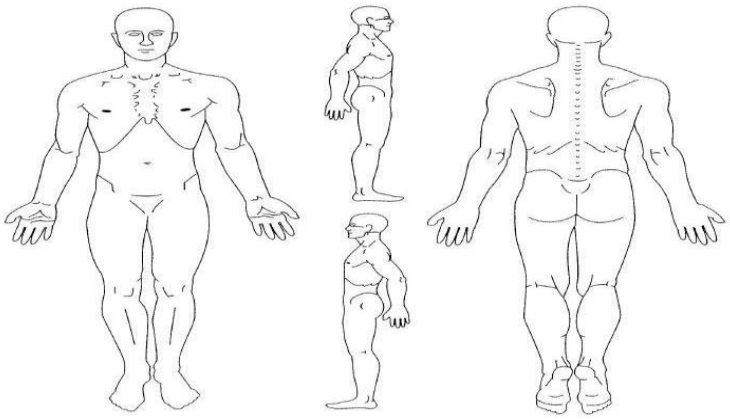
Today's Date: _____/_____/_____
Date & Time of accident: _____ **[ ]** am **[ ]** pm

AUTO RELATED ACCIDENT

Are you in pain today: [ ] Yes [ ] No

Rate your pain with the following pain scale:
discomfort--1--2--3-4--5--6--7--8--9--10--intense

Please use the diagram below to indicate the location of your pain/discomfort following your accident.



Please describe the accident: _____

_____

_____

_____

Were you able to drive your car following the accident?
[ ] Yes **[ ]** No Please Explain:

_____

_____

Have you ever been in a car accident before?
[ ] Yes **[ ]** No If Yes, how long ago? _____

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 a 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 the base of the 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 describe: _____
_____

Make & Model of the vehicle you were occupying?
_____
Name of the location/street on which you were traveling?
_____
In which direction were you headed? **[ ]**N **[ ]**S **[ ]**E **[ ]**W
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 the accident vehicle made impact with another vehicle, make and model of the other vehicle? _____
_____
Direction other vehicle was headed? **[ ]**N **[ ]**S **[ ]**E **[ ]**W
Speed of other vehicle? _____

Did the accident render you unconscious? [ ] Yes [ ] No
If yes, for how long? _____
Please describe how you felt immediately after the accident:
_____
_____

Did you go to a Hospital or see any other Doctor, related to this accident? [ ] Yes [ ] No
When did you go?
[ ] Immediately [ ] The next day [ ] 2 or more days

How did you get there? [ ] Ambulance [ ] Private Transportation
Name of Hospital and/or Attending Doctor: _____
_____
Were they a: [ ] D.C. [ ] M.D. [ ] D.O. [ ] D.D.S.
Describe any treatment you received: _____
_____

Were x-rays taken? [ ] Yes [ ] No
Was medication prescribed? [ ] Yes [ ] No
_____

Have you been able to work since this injury?
[ ] Yes [ ] No
Are your work activities restricted as a result of this injury?
[ ] Yes [ ] No

Indicate the symptoms that are a result of this accident:

[ ] Dizziness	[ ] Difficulty sleeping	[ ] Jaw problems
[ ] Memory loss	[ ] Irritability	[ ] Arm/Shoulder pain
[ ] Headache(s)	[ ] Fatigue	[ ] Numb hands/fingers
[ ] Blurred vision	[ ] Tension	[ ] Chest pain
[ ] Buzzing in ear	[ ] Neck pain	[ ] Shortness of breath
[ ] Ears ringing	[ ] Neck stiffness	[ ] Stomach pain
[ ] Nausea	[ ] Low back pain	[ ] Leg pain
[ ] Back pain	[ ] Back stiffness	[ ] Numb feet/toes
[ ] Other:		

Is your condition getting worse?
[ ] Yes [ ] No [ ] Constant [ ] Comes & goes

Indicate your degree of comfort while performing the following activities:

	Comfortable	Uncomfortable	Painful
Lying on back			
Lying on side			
Lying on stomach			
Sitting			
Standing			
Stretching			
Lovemaking			
Walking			
Running			
Sports			
Working			
Lifting			
Bending			
Kneeling			
Pulling			
Reaching			

RECOVERY

To evaluate the effect that continuing work will have on your recovery please complete the following:

*How many hours are in your normal work day? _____
*Please indicate your daily job duties and any activities which you are occasionally asked to perform:

[ ] Standing	[ ] Driving	[ ] Operating equipment
[ ] Sitting	[ ] Twisting	[ ] Work with arms above
[ ] Walking	[ ] Crawling	[ ] Typing
[ ] Lifting	[ ] Bending	[ ] Stooping
[ ] Other:		

*What positions can you work in with minimum physical effort and for how long? _____ [ ] N/A
*Do you work with others who can help you with any heavy lifting?
[ ] Yes [ ] No [ ] N/A
*While in recovery, is there any light duty work you could request?
[ ] Yes [ ] No [ ] N/A

Have you ever been treated by a Chiropractor?
[ ] Yes **[ ]** No If Yes, how long ago? _____
Clinic / Dr's name: _____ **Clinic Phone #:** _____

Are you taking any of the following medications? [ ] Nerve Pills [ ] Pain Killers (including aspirin) [ ] Muscle Relaxers [ ] Blood Thinners [ ] Tranquilizers [ ] Steroids [ ] Diabetic [ ] Insulin [ ] Thyroid [ ] Cholesterol [ ] Digestion [ ] Other(s)_____

_____

_____

Do you have or have you had any of the following diseases, medical conditions, or procedures? (please circle Y or N)

Y / N Heart Attack/Stroke	Y / N Heart Surgery/Pacemaker	Y / N Heart Murmur
Y / N Artificial Valves	Y / N Alcohol/Drug abuse	Y / N Venereal Disease
Y / N Shingles	Y / N Psychiatric Problems	Y / N Frequent Neck Pain
Y / N High/Low Blood Pressure	Y / N Fainting/Seizures/Epilepsy	
Y / N Ulcers/Colitis	Y / N Cancer	Y / N Rheumatic Fever
Y / N Difficulty Breathing	Y / N Chemotherapy	Y / N Sinus Problems
Y / N Congenital Heart Defect	Y / N Hepatitis	Y / N Low Back Problems
Y / N Severe/Frequent Headaches	Y / N Emphysema/Asthma	Y / N Glaucoma
Y / N Artificial Bones/Joints/Implants	Y / N HIV+/AIDS/ARC	Y / N Mitral Valve Prolapse
Y / N Kidney Problems	Y / N Tuberculosis	Y / N Anemia/Diabetes
		Y / N Arthritis

Please list any surgeries with dates and/or any other serious medical condition(s) not listed above:

_____

List any past serious accidents with dates: _____

Please list anything that you may be allergic to:_____

Family Health History: _____

_____

Do you take supplements or Vitamins? **[ ]** Yes **[ ]** No Do you exercise? **[ ]** Yes **[ ]** No Hours per week _____

Are you dieting or on a specific diet: **[ ]** Yes **[ ]** No Since: _____ Type:_____

Do you use tobacco? **[ ]** Yes **[ ]** No How much?_____ How long?_____

Do you drink alcohol? **[ ]** Yes **[ ]** No How much? _____

Are you wearing: **[ ]** Shoe Lifts **[ ]** In-Soles **[ ]** Arch Supports/Orthodics

For Women: Are you taking Birth Control? **[ ]** Yes **[ ]** No Are you pregnant? **[ ]** Yes **[ ]** No How many weeks? _____

_____ _____

ASSIGNMENT OF BENEFITS

IN CONSIDERATION of the willingness of Hunt For Wellness to treat me on credit without demand for payment at the services are rendered, I hereby agree and stipulate as follows:

I irrevocably assign to Hunt For Wellness any proceeds or compensation that I am or may become entitles to receive as a result of injuries that occurred on _____ to the extent of the chiropractic services rendered. I make this agreement without prejudice to any rights I may have to prosecute legal claims against any party who may be liable for my injuries, but I hereby authorize and instruct you to pay directly to Hunt For Wellness, from any disability benefits, medical payments benefits, liability benefits, health and accident benefits, workers compensation benefits, judgements, settlements, or proceeds of any kind that would otherwise be payable to me, such sums as are due to Hunt For Wellness for its services rendered.

I appoint Hunt For Wellness as my attorney in fact to affix my name as an endorsement upon the reverse of any check or draft upon which I am a named payee and to deposit said check or draft and apply the proceeds to any unpaid balance I may have with Hunt For Wellness.

I authorize Hunt For Wellness to release to any insurer with applicable coverage or to my attorney or successor attorney any information regarding my injuries, prior medical history, or treatment as may be necessary to facilitate collection of proceeds under this assignment.

I acknowledge that I remain personally liable for the total amount due to Hunt For Wellness for services rendered, including any balance remaining after the application of insurance payments and recover any unpaid balance on my account, I agree to reimburse for its costs of recovery, including reasonable attorney's fees.

I further agree this assignment of benefits (AOB) cannot be revoked and the right to receive payment cannot be transferred to any other party or re-asserted by me in any way.

NOTICE OF LIEN

Pursuant to N.C.G.S. 44-49 and 44-50, Hunt For Wellness hereby asserts and gives notice of a lien upon any sums recovered in damages for personal injury in any civil action and also upon all funds paid to the above-names patient in compensation for or settlement of injuries sustained, whether in litigation or otherwise.

Hunt For Wellness hereby requests that if its claim is not paid in full from the foregoing proceeds, a full disclosure and accounting of proceeds be provided in conformity with N.C.G.S. 44-50.1. Hunt For Wellness agrees to be bound by any confidentiality agreements regarding the contents of the accounting.

_____

Patient Date

_____

Witness Date

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.**

YOUR RIGHTS

Get an electronic or paper copy of your medical record
You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record
You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications
You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will say "yes" to all reasonable requests.

Ask us to limit what we use or share
You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.

ONLY if you pay for a service or health care item out-of-pocket, in full, at the time of service, can we comply with your request not to share that information for the purpose of payment or our operations with your health insurer. (i.e. - comply with your request not to file your claims to your insurance company). Otherwise, we will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information
You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice
You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you
If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated
You can complain if you feel we have violated your rights by contacting us. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. We will not retaliate against you for filing a complaint.

YOUR CHOICES

For certain health information, you can tell us your choices about what we share.
If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Contact you for fundraising efforts

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we *never* share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

In the case of fundraising: We may contact you for fundraising efforts, but you can tell us not to contact you again.

OUR USES AND DISCLOSURES

How do we typically use or share your health information? We typically use or share your health information in the following ways.

- **Treat you**
  We can use your health information and share it with other professionals who are treating you. *Example: A doctor treating you for an injury asks another doctor about your overall health condition.*
- **Run our organization**
  We can use and share your health information to run our practice, improve your care, and contact you when necessary. *Example: We use health information about you to manage your treatment and services.*
- **Bill for your services**

We can use and share your health information to bill and get payment from health plans or other entities. *Example: We give information about you to your health insurance plan so it will pay for your services.*

Help with public health and safety issues

We can share health information about you for certain situations such as preventing disease; helping with product recalls; reporting adverse reactions to medications; reporting suspected abuse, neglect, or domestic violence; and, preventing or reducing a serious threat to anyone's health or safety.

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you for workers' compensation claims, for law enforcement purposes, or with a law enforcement official. We can also use or share health information about you with health oversight agencies for activities authorized by law for special government functions such as military, national security, and presidential protective services.

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

OUR RESPONSIBILITIES

We are required by law to maintain the privacy and security of your protected health information. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. We must follow the duties and privacy practices described in this notice and give you a copy of it. We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

Patient Signature: _____ *Date:* _____/_____/_____