Ferguson Family CHIROPRACTIC

AUTO ACCIDENT QUESTIONAIRE

Name: _____ DOB: _____ Phone: _____

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

Your Automobile Insurance Information:

Your Ins. Co: _____ Policy# _____

Have you filed a claim with YOUR policy? ☐Yes ☐ No Claim #:_____

Adjuster Name: _____ Adjuster Phone:_____

At-Fault Party's Automobile Insurance Information:

Responsible Party's Name: _____ Claim #:_____

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

Policy Holders Name: _____ Policy# _____

Adjuster Name: _____ Adjuster Phone: _____

Attorney: Do you have an attorney? ☐ Yes ☐ No

Name: _____ Phone: _____ Fax/Email:_____

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

NATURE OF ACCIDENT

1. Date of Accident: _____ Time of Accident: _____
2. Were you: ☐ Driver ☐Passenger ☐ Front Seat ☐ Backseat
   Does your car have headrests? ☐Yes ☐No
   If yes, what height was it at the time of impact? ☐Bottom of Neck ☐ Bottom of Head ☐Middle of Neck
3. Number of People in Vehicle _____ Were you wearing seat belts? _____
4. What direction were you headed? ☐North ☐South ☐East ☐West
5. What direction was the other vehicle headed? ☐North ☐South ☐East ☐West
6. Were you struck from: ☐Behind ☐Front ☐Left Side ☐Right Side
7. Approximate speed of your car? _____mph Other Car _____mph
8. Were you knocked unconscious? ☐Yes ☐No If yes, how long? _____
9. Were police notified? ☐Yes ☐No
10. In your own words, please describe the accident: _____

    _____

    _____

11. Did you have any physical complaints before the accident: ☐Yes ☐No If yes, please describe:

    _____

    _____

12. Please describe how you felt:
    a. DURING the accident: _____
    b. IMMEDIATELY AFTER the accident: _____
    c. LATER THAT DAY: _____
    d. THENEXT DAY: _____

13. What are your PRESENT complaints and symptoms? _____

    _____

    _____

14. Do you have any congenital (from birth) factors which relate to this problem? □Yes □No
    If YES, please describe: _____

15. Do you have any previous illnesses which relate to this case? □Yes □No
    If yes, please describe:_____

16. Have you ever been involved in an accident before? □Yes □No If yes, please describe, including dates and types of accidents, as well as injury(ies) received: _____

    _____

17. Where were you taken after the accident? _____

18. Have you been treated by another doctor since the accident? □Yes □No If yes, please list doctor's name and address: _____
    What type of treatment did you receive? _____

19. Since this injury occurred, are your symptoms □Improving □Getting Worse □Unchanged

20. **CHECK SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT:**

□ Headaches	□ Irritability	□ Numbness in toes	□ Face Flushed	□ Feet Cold
□ Neck Pain	□ Chest Pain	□ Shortness of Breath	□ Buzzing in ears	□ Hands Cold
□ Neck Stiff	□ Dizziness	□ Loss of Balance	□ Stomach Upset	□ Fatigue
□ Depression	□ Fainting	□ Hands Seem too Heavy	□ Sleep Problems	□ Constipation
□ Back Pain	□ Loss of Smell	□ Pins/Needles in Arms	□ Light bothers eyes	□ Cold Sweats
□ Nervousness	□ Loss of Taste	□ Pins/Needles in Legs	□ Loss of Memory	□ Fever
□ Tension	□ Ears Ringing	□ Numbness in Fingers	□ Diarrhea	□ Other

    Symptoms other than above_____

21. Have you lost time from work as a result of this accident? □Yes □No (If yes please complete this question.)
    a. Last Day Worked: _____
    b. Type of Employment: _____
    c. Present Salary: _____
    d. Are you being compensated for time lost from your work? ? □Yes □No If yes, please state type of compensation you are receiving: _____

22. Do you notice any activity restrictions as a result of this injury? □Yes □No If yes, please describe: _____

    _____

23. Other pertinent information: _____

Print Name: _____ **Sign & Date:**_____

Ferguson Family CHIROPRACTIC

PERSONAL HEALTH HISTORY

Date: _____

Name: _____

Address: _____ City/State/Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Cell Provider (for texts): _____

Email Address: _____

Date of Birth: _____ Guardian Name: _____

Marital Status: S M D W O Spouse's Name: _____ Age: ____

Children's Name/Age: _____

Name of Employer: _____ Occupation: _____

How did you hear about us?: _____ Hobbies: _____

Name of Previous Chiropractors: _____

When was your last visit: _____ how long were you receiving chiropractic adjustments: _____

Reason for coming in: _____

INJURIES:

What accidents have you had (ex. bicycle, car, motorcycle, sports, slips/falls) at work or at home?

Include dates: _____

_____

Were you ever knocked unconscious? YES NO

What fractures or broken bones have you had? Include dates: _____

_____

SURGERY:

What major surgery have you had? Include dates: _____

_____

What minor surgery have you had? (Tonsillectomy, appendectomy, wart/cyst removal, dental extr.)

_____

MEDICATION:

Present Prescription drugs	Past prescription drugs	Over-the counter drugs (aspirin, cold tablets, cough syrup)
_____	_____	_____
_____	_____	_____
_____	_____	_____

THERAPY:

Are you presently under any therapeutic care? _____ What type? _____
What therapeutic care have you been under in the past two years? (radio, chemo, physio, electro, etc.) Include Dates: _____

BIRTH RECORD:

Type of birth (vaginal, cesarean, forceps, etc.) _____
Complications during your mother's pregnancy or during birth: _____
Complications after your birth: _____

CURRENT HEALTH:

How do you describe your current health: _____
How would you describe your family's health: _____
Describe your: Vision: _____ Hearing: _____ Coordination: _____
Do you use any of the following: TOBACCO ALCOHOL COFFEE/TEA SODA MILK
Level of stress in your life: MILD MODERATE EXTREME Rating of stress: 1 2 3 4 5 6 7 8 9 10
Do you purchase any of the following?
_____Bottled drinking water _____Vitamins _____Health food products (organic products etc.)

FINANCIAL INFORMATION:

Who is responsible for this account? SELF SPOUSE OTHER Name if other: _____
What method of payment will you be using? INSURANCE CASH CHECK CREDIT CARD

Please check any of the following that give you difficulty or you had had recently

__Headaches	__Fainting	__Shortness of breath	__Numb legs/feet
__Shooting head pains	__Loss of balance	__Mid-back pain	__Constipation
__Sinus trouble	__Ringing in ears	__Heart attack	__Kidney trouble
__Loss of smell	__Blurred vision	__Low blood pressure	__Menstrual cramps
__Allergies	__Lights bother eyes	__High blood pressure	__Menstrual irregularity
__Hayfever	__Neck pain	__Anemia	__Diabetes
__Asthma	__Muscle spasms in neck	__Nerves/nervousness	__Painful joints
__Inflammation of throat	__Shldr/arm tightness	__Inner tension	__Swollen joints
__Thyroid trouble	__Shldr/arm pain	__Irritability	__Pins & needles in leg
__Facial twitch	__Pins & needles in arms	__Gall bladder trouble	__Swollen ankles
__Loss of memory	__Pins & needles in hands	__Indigestion	__Cold Feet
__Fatigue	__Cold Hands	__Intestinal gas	__Pain in legs/feet
__Depression	__Numbness in arms/hands	__Low back pain	__Hip pain
__Spinal curvature	__Prostate trouble	__Stroke	__Jaw pain/TMJ
__Chest pain	__Bed wetting	__Arthritis	__Ulcers
__Ear ache	__Cancer	__Seizures	

Print Name: _____ **Sign & Date:**_____

Ferguson Family
CHIROPRACTIC

TERMS OF ACCEPTANCE

If a patient seeks chiropractic care and we accept a patient for such care, it is essential for both of us to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: an adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is specific adjustments of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of verve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advise, diagnosis, or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

CONSENT TO CARE

I do hereby authorize the doctors of Ferguson Family Chiropractic to administer such care that is necessary for my particular case. This may include consultation, examination, adjustments, or any other procedure which is advisable and necessary for my health care.

I further understand that a fee for services rendered will be charged and that I am responsible for this fee whether results are obtained or not.

I also understand any sum of money paid under assignment by any insurance shall be credited to my account, and shall be personally liable for any and all of the unpaid balance to the doctor.

I, _____ have read, understand and hereby request chiropractic care based on the terms of acceptance and the consent to care.

Signature: _____ Date: _____

Signature of parent or guardian if minor

Ferguson Family
CHIROPRACTIC

HEALTH CARE AUTHORIZATION FORM

I have been provided with a copy of the Notice of Privacy Practices for Protected Health Information. The Notice of Privacy Practices describes the types of uses and disclosures of my Protected Health Information (PHI) that will occur in my treatment, payment of my bills or in the performance of health care operations of this chiropractic office. A copy of our notice is attached and we encourage you to read it and request a copy if you would like one.

This Notice of Privacy Practice also describes my rights and duties of the chiropractor with respect to my Protected Health Information. I hereby give permission to Ferguson Family Chiropractic (FFC) to use and/or disclose Protected Health Information in accordance with the following.

SPECIFIC AUTHORIZATIONS

- I give permission to FFC to use my address, phone number and clinical records to contact me with appointment reminders, missed appointments notification, birthday cards, holiday related cards, newsletters, information about treatment alternatives or other health related information.
- If FFC contacts me by phone, I give them the permissions to leave a phone message on my answering machine or voice mail.
- I give permission to FC to use my name on a welcome board, referral board and birthday board.
- I give permission to FFC to use my photograph on the patient picture bulletin board and other marketing materials such as their brochure, website and ads in print media.
- I give permission to FFC to use any testimonial written by me for marketing purposes such as, sharing with other patients or potential patients, in their brochure, on the their website or in ads in print media.
- I give FFC 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 the doctor at any time in private, the doctor will provide a room for these conversations.
- By signing this form you are giving FFC permission to use and disclose your protected health information in accordance with the directives listed above.

The use of this format is intended to make your experience with our office more efficient and productive as well as to enhance you access to quality health care and health information. This authorization will remain in effect for the duration of my care at FFC plus 7 years or until revoked by me.

RIGHT TO REVOKE AUTHORIZATION

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

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

Your name, Social Security number & date of birth;
A clear statement of you intent to revoke this AUTHORIZATION;
The date of your request; and
Your signature

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

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

I have the right to refuse to sign this AUTHORIZATION. If I refuse to sign this AUTHORIZATION, FFC will not refuse to provide treatment however, it will not be possible for FFC to file third party billing on my behalf and I will be responsible for 1) payment in full at the time services are provided to me 2) scheduling my own appointments since FFC will be unable to contact me 3) all contact with FFC regarding my care. *Additionally, any collection activity as permitted by law is not waived by refusal to sign the authorization.*

I have the right to inspect or cop, within boundaries, the protected health information to be used/disclosed. A reasonable fee for copying will apply. A copy of the signed authorization will be provided to me.

HEALTHCARE AUTHORIZATION

I have read and understand this Healthcare Authorization Form and acknowledge receipt of The Notice of Privacy Practices for Protected Health Information. My signature below represents agreement with these practices.

SSN: _____ DOB: _____

My Name (please print): _____

My Signature: _____

Today's date: _____

Name of personal Representative (if someone is designated to act on your behalf)

Name (please print):_____

Signature of Personal Representative: _____

Description of Representative's Authority to Act on Patients Behalf: _____

LIFE University

P.E.A.K.

PRACTICE EXCELLENCE ART AND KNOWLEDGE

P.E.A.K. Patient Disclosure and Consent

I, the undersigned, have been informed that Doctor _____ is participating in the Life University Clinic PEAK Program, which is a senior chiropractic clinic preceptorship course. *The intern will be identified by displaying a Life University student ID badge while on duty as a PEAK intern.*

I have been informed that a Chiropractic Student Intern may be assigned to perform some part of my clinical care at this office and the intern is NOT yet a licensed Doctor of Chiropractic. I understand that the Intern is working under the authority and auspices of this office.

( ) I agree to allow the Intern to perform assigned clinical services under the supervision of the Extension Faculty Doctor. *I further understand that I may withdraw this permission at any time by notifying the doctor or the intern.*

( ) I DO NOT agree to allow the Intern to perform assigned clinical services under the supervision of the Extension Faculty Doctor.

PRINT NAME _____

Signature _____

Date Signed _____

JM: July 2016

What is a Doctor's Lien?

Ferguson Family Chiropractic only accepts automobile accident cases on a Doctor's Lien status whether the patient is a current patient in our office or new to our office. If you have any questions regarding signing the Doctor's Lien, please read the information below. We cannot perform your initial exam or continue your care until one is signed for each member involved in your automobile accident case who is being treated in our office.

Because not everyone can afford to pay cash up front for medical expenses, it may be difficult for some individuals to seek treatment following an accident. **While the party at fault may be responsible for payment of the injured party's medical costs, settlement could be months or even years away, leaving the individual with no means with which to seek treatment for his or her injuries.**

A doctor's lien is a way to take care of the problem. Physicians agree to treat a patient immediately and wait to be paid until the case has been settled or won. The patient, and, in some cases, his or her attorney, signs the agreement agreeing that all medical bills will be paid from the proceeds of settlement prior to the individual receiving any funds.

The agreement is a legally binding contract between the doctor and the patient and the attorney or insurance company who are obligated to abide by the terms of the agreement. In other words, when your case settles or ends with a jury verdict, your attorney or adjuster must first pay your doctor's bills prior to releasing any of the funds to you.

Treatment on a lien can be an effective way to get the care that you need without worrying about providers turning accounts over to collection companies and harming your credit while your attorney is working to settle your accident claim. Many physicians who agree to treatment in this way also agree to perform expensive but necessary diagnostic tests and surgeries.

Ferguson Family Chiropractic does not charge any more for our services than they do for patients who are paying for costs as they are treated or who have health insurance. Once your personal injury attorney or insurance claims adjuster settles your claim, your attorney/adjuster will prepare a final settlement statement detailing how the proceeds of settlement are to be disbursed.

If you retained an attorney, your attorney will first collect their fees and costs, then your medical bills will be paid in full, and, then, you should receive the balance of the proceeds. While some physicians will negotiate the amount to be paid from settlement, they are under no legal obligation to accept less than they are owed for service rendered.

Doctors and other professionals who provide services in this way make it possible for individuals without health insurance or other means of payment to receive the best treatment possible for their injuries. A physician's willingness to put his or her bill on hold to ensure that a patient is given the treatment necessary to recover from an accident is a sign that the doctor is putting his or her patient's needs above his or her own.

_____ ***(Please initial)*** I have read and understand my financial obligation to Ferguson Family Chiropractic as specified in the above information and specified legally by signing the Doctor's Lien on the reverse side of this paper.

Ferguson Family
CHIROPRACTIC

4609 South Main Street
Acworth, GA 30101
Ph#770-966-1800
Fax#770-966-0413
Email: office@fergusonfamilychiropractic.net
Or: Fergusonfamilychiropractic@yahoo.com

Notice of Doctor's Lien

I do hereby authorize Ferguson Family Chiropractic to furnish you, my attorney, with a full report of my examination, diagnosis, chiropractic care, prognosis, etc., in regard to the accident in which I was recently involved.

I hereby authorize and direct you, my attorney, to pay directly to Ferguson Family Chiropractic such sums as may be due for chiropractic services rendered me both by reason of the accident and by reason of any other bills that are due to this office and to withhold such sums from any settlement, judgement, or verdict as may be necessary to adequately protect Ferguson Family Chiropractic. I hereby further give a lien on my case to Ferguson Family Chiropractic against any and all proceeds of my settlement, judgement, or verdict which may be paid to you, my attorney, or myself, as a result of the injuries for which I have been treated or injuries in connection therewith.

I agree never to rescind this document and that a rescission will not be honored by my attorney. I hereby instruct that in the event another attorney is substituted in this matter, the new attorney honor this lien as inherent to the settlement and enforceable upon the case as if it were executed by him/her.

I fully understand that I am directly and fully responsible to Ferguson Family Chiropractic for all chiropractic bills submitted by the office for service rendered me, and that this agreement is made solely for Ferguson Family Chiropractic's additional protection and in consideration of them awaiting payment. I further understand that such payment is not contingent on any settlement, judgement, or verdict by which I may eventually recover said fee.

Please acknowledge this letter by signing below and returning it to Ferguson Family Chiropractic. I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, Ferguson Family Chiropractic will not await payment but may declare the entire balance due and payable.

Patient Name (print): _____
Patient Signature: _____ Date: _____
Legal Guardian Print Name (if patient is a minor): _____
Legal Guardian Signature (if patient is a minor): _____ Date: _____

The undersigned being attorney of record for the above patient does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgement, or verdict as may be necessary to adequately protect Ferguson Family Chiropractic. Attorney further agrees that in the event this lien is litigated that the prevailing party will be awarded attorney fees and costs.

Attorney's Signature: _____ Date: _____

Please sign, date and return one copy of this document to Ferguson Family Chiropractic.

Dr. Karen Ferguson, D.C.
Ferguson Family Chiropractic
4609 South Main Street
Acworth, GA 30101

Phone (770) 966-1800
Fax (770) 966-0413

Name of Patient *(Including any aliases):*	
Address:	
Phone Number:	Birthdate:

Name of Guardian:	Phone Number:
Address:	

I hereby authorize Ferguson Family Chiropractic, Dr. Karen Ferguson and employees to release all health information about me (Entire medical record defined as patient histories, office notes, treatment record and diagnostic record, test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent by other health care providers.) that relates to service beginning from
☐ ____/_____/_____ to ____/_____/_____, or ☐ any and all records to following persons/organizations:

Person/Organization to Receive Information:	
Address:	
Phone Number:	Fax Number:
Email:	

_____I understand and agree that health information about me, which is used or disclosed pursuant to this authorization, may be subject to re-disclosure by the recipient and may no longer be protected by law.
_____This authorization is valid for _____ following the date of my signature shown below. A copy, electronic copy, image or facsimile of this authorization is as valid as the original. I have the right to revoke this authorization in writing at any time. I acknowledge that such a revocation is not effective to the extent the above person/organization has relied on the use or disclosure of my health information.
_____By my signature below, I acknowledge that any prior agreement I have made to restrict or limit the disclosure of information about my health does not apply to this authorization.
_____I have read (or have had read to me) this authorization, and I agree to its terms as indicated by my signature below. I am entitled to a copy of this authorization.

Patient's Signature:	Patient's Name:	Date:
Guardian or Legal Representative's Signature:	Guardian or Legal Representative's Name:	Date: