2292 West Magee Road, Suite 170
Tucson, AZ 85742
Phone (520) 797-2922
Fax (520) 742-0732

CONFIDENTIAL PATIENT INTAKE FORM

Is today's appointment concerning: ☐ Wellness ☐ Specific Symptom ☐ Auto Accident ☐ Workman's Compensation ☐ Other:_____

Patient Name_____ **Birth Date** _____

Martial Status: M S W D How many children?_____ Social Security Number _____

E-mail _____Home Phone_____ Cell Phone _____

Preferred method of contact: Home Phone Cell Phone Work Phone

Address _____ City/State/Zip _____

How did you hear about us? _____

Race: _____ Ethnicity: _____

What is your: Height _____ Weight_____

Occupation _____ Employer _____Office Phone _____

Name and Phone Number of Primary Care Physician:

Primary insureds Name _____ **Birth Date** _____

Name of Spouse/Partner_____ Insureds Social Security No_____

Insureds Employer _____ Occupation _____

Patient's Emergency Contact_____

Address _____Phone # _____

PAYMENT IS EXPECTED AT THE TIME OF VISIT

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Shipley Chiropractic 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 Shipley Chiropractic will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient Signature _____ Date:_____

Guardian or Spouse's Signature _____ Date _____

1. How would you rate your overall Health?
☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

2. What type of exercise do you do?
☐ Strenuous ☐ Moderate ☐ Light ☐ None

3. Indicate if you have any immediate family members with any of the following and the relation to you:
☐ Rheumatoid Arthritis ☐ Diabetes ☐ Lupus ☐ ALS ☐ Heart Problems ☐ Cancer
☐ Other_____

4. For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

Past	Present		Past	Present		Past	Present	
☐	☐	Headaches		☐	Chronic Sinusitis	☐	☐	Visual Disturbances
☐	☐	Neck Pain		☐	High Blood Pressure	☐	☐	Dizziness
☐	☐	Upper Back Pain		☐	Heart Attack	☐	☐	Diabetes
☐	☐	Mid Back Pain		☐	Chest Pains	☐	☐	Excessive Thirst
☐	☐	Low Back Pain		☐	Stroke	☐	☐	Frequent Urination
☐	☐	Shoulder Pain		☐	Angina	☐	☐	Smoking/Tobacco Use
☐	☐	Elbow/Upper Arm Pain		☐	Kidney Stones	☐	☐	Drug/Alcohol Dependence
☐	☐	Wrist Pain		☐	Kidney Disorders	☐	☐	Allergies
☐	☐	Hand Pain		☐	Bladder Infection	☐	☐	Depression
☐	☐	Hip Pain		☐	Painful Urination	☐	☐	Systemic Lupus
☐	☐	Upper Leg Pain		☐	Loss of Bladder Control	☐	☐	Epilepsy
☐	☐	Knee Pain		☐	Prostate Problems	☐	☐	Dermatitis/Eczema/Rash
☐	☐	Ankle/Foot Pain		☐	Abnormal Weight Gain/Loss	☐	☐	HIV/AIDS
☐	☐	Jaw Pain		☐	Loss of Appetite			
☐	☐	Joint Pain/Stiffness		☐	Abdominal Pain	**For Females Only**		
☐	☐	Arthritis		☐	Ulcer	☐	☐	Birth Control Pills
☐	☐	Rheumatoid Arthritis		☐	Hepatitis	☐	☐	Hormonal Replacement
☐	☐	Cancer		☐	Liver/Gall Bladder Disorder	☐	☐	Pregnancy
☐	☐	Asthma		☐	General Fatigue			
				☐	Muscular Incoordination			

Others not listed:
_____

5. Smoking status: (please circle) Everyday Some days Former Never

6. List all prescription medications you are currently taking including dosage:
_____

7. List <u>all allergies</u> and reactions:
_____

8. List all of the over-the-counter medications you are currently taking including dosage:
_____

9. List all the supplements you are currently taking:
_____

10. List all surgical procedures you have had:
_____

11. What activities do you do at work?

□ **Sit:**	☐ Most of the day	☐ Half the day	☐ A little of the day
□ **Stand:**	☐ Most of the day	☐ Half the day	☐ A little of the day
□ **Computer work:**	☐ Most of the day	☐ Half the day	☐ A little of the day
□ **On the phone:**	☐ Most of the day	☐ Half the day	☐ A little of the day

12. What activities do you do outside of work?

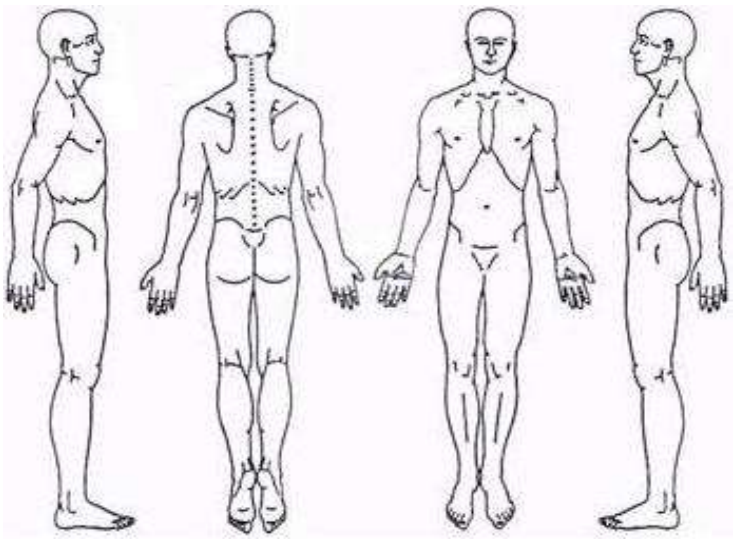
_____

13. Have you ever been hospitalized? ☐ No ☐ Yes
If yes, why _____

14. Have you seen a chiropractor before? ☐ No ☐ Yes
If yes, do you remember how long ago? _____
If yes, what were your results? (great, good, mixed, etc) _____
15. Have you had significant past trauma? ☐ No ☐ Yes
If yes, explain: _____

16. Anything else pertinent to your visit today? _____

Indicate on the drawings below where you have pain/symptoms:



HEADACHES:

(Initial here (___) if this section DOES NOT apply, go to next section)

Where is the pain:
☐ Left Front ☐ Left Side ☐ Left Back ☐ General ☐ Front ☐ Back/Base of head
☐ Right Front ☐ Right Side ☐ Right Back

How often do you experience your symptoms?
☐ Constantly (76-100% of the time) ☐ Frequently (51-75% of the time)
☐ Occasionally (26-50% of the time) ☐ Intermittently (1-25% of the time)

How would you describe the pain?
☐ Sharp ☐ Numb ☐ Stiff ☐ Sharp with motion ☐ Shooting with motion
☐ Dull ☐ Tingly ☐ Stabbing with motion ☐ Electric-like with motion
☐ Diffuse ☐ Achy ☐ Burning ☐ Shooting ☐ Other _____

How are your symptoms changing with time?
☐ Getting Worse ☐ Staying the same ☐ Getting better

Using a scale from 0-10 (10 being the worst) how would you rate your problem?
0 1 2 3 4 5 6 7 8 9 10 *(Please circle)*

How much has the problem interfered with your work activities?
☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

How much has the problem interfered with your social activities?
☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

Who else have you seen for your problems?

☐ Chiropractor ☐ Neurologist ☐ Primary Care Physician ☐ ER Physician
☐ Orthopedist ☐ Massage Therapist ☐ Physical Therapist ☐ No one
☐ Other _____

How long have you had this problem? **Do you know the date it began?**

How do you think your problem began?

_____

Do you consider this problem to be severe?

☐ Yes ☐ Yes, at times ☐ No

What aggravates your problem?

_____

What alleviates the problem?

_____

What concerns you the most about your problem; what does it prevent you from doing?

_____

NECK:

(Initial here (___) if this section DOES NOT apply, go to next section)

Where is the pain?

☐ Left Side ☐ Upper Left ☐ Entire Neck ☐ Upper Neck ☐ Lower Neck
☐ Right Side ☐ Upper Right ☐ Lower Right

How often do you experience your symptoms?

☐ Constantly (76-100% of the time) ☐ Frequently (51-75% of the time)
☐ Occasionally (26-50% of the time) ☐ Intermittently (1-25% of the time)

How would you describe the pain?

☐ Sharp ☐ Numb ☐ Stiff ☐ Sharp with motion ☐ Shooting with motion
☐ Dull ☐ Tingly ☐ Stabbing with motion ☐ Electric-like with motion
☐ Diffuse ☐ Achy ☐ Burning ☐ Shooting ☐ Other _____

How are your symptoms changing with time?

☐ Getting Worse ☐ Staying the same ☐ Getting better

Using a scale from 0-10 (10 being the worst) how would you rate your problem?

0 1 2 3 4 5 6 7 8 9 10 *(Please circle)*

How much has the problem interfered with your work activities?

☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

How much has the problem interfered with your social activities?

☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

Who else have you seen for your problems?

☐ Chiropractor ☐ Neurologist ☐ Primary Care Physician ☐ ER Physician
☐ Orthopedist ☐ Massage Therapist ☐ Physical Therapist ☐ No one
☐ Other _____

How long have you had this problem? **Do you know the date it began?**

How do you think your problem began?

_____

Do you consider this problem to be severe?
☐ Yes ☐ Yes, at times ☐ No

What aggravates your problem?

_____

What alleviates the problem?

_____

What concerns you the most about your problem; what does it prevent you from doing?

_____

UPPER BACK/SHOULDER:

(Initial here (___) if this section DOES NOT apply, go to next section)

Where is the pain?
☐ Left Side ☐ Center ☐ Right Side ☐ Entire Upper Back

How often do you experience your symptoms?
☐ Constantly (76-100% of the time) ☐ Frequently (51-75% of the time)
☐ Occasionally (26-50% of the time) ☐ Intermittently (1-25% of the time)

How would you describe the pain?
☐ Sharp ☐ Numb ☐ Stiff ☐ Sharp with motion ☐ Shooting with motion
☐ Dull ☐ Tingly ☐ Stabbing with motion ☐ Electric-like with motion
☐ Diffuse ☐ Achy ☐ Burning ☐ Shooting ☐ Other _____

How are your symptoms changing with time?
☐ Getting Worse ☐ Staying the same ☐ Getting better

Using a scale from 0-10 (10 being the worst) how would you rate your problem?
0 1 2 3 4 5 6 7 8 9 10 *(Please circle)*

How much has the problem interfered with your work activities?
☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

How much has the problem interfered with your social activities?
☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

Who else have you seen for your problems?
☐ Chiropractor ☐ Neurologist ☐ Primary Care Physician ☐ ER Physician
☐ Orthopedist ☐ Massage Therapist ☐ Physical Therapist ☐ No one
☐ Other _____

How long have you had this problem? **Do you know the date it began?**

How do you think your problem began?

_____

Do you consider this problem to be severe?
☐ Yes ☐ Yes, at times ☐ No

What aggravates your problem?

_____

What alleviates the problem?

_____

What concerns you the most about your problem; what does it prevent you from doing?

_____

Are there any other areas you wish to tell the doctor about? If so, please briefly explain.

_____

ARM:

(Initial here (___) if this section DOES NOT apply, go to next section)

Where is the pain?
☐ Entire Left Arm ☐ Upper Left Arm ☐ Lower Left Arm ☐ Entire Right Arm ☐ Lower Right Arm

How often do you experience your symptoms?
☐ Constantly (76-100% of the time) ☐ Frequently (51-75% of the time)
☐ Occasionally (26-50% of the time) ☐ Intermittently (1-25% of the time)

How would you describe the pain?
☐ Sharp ☐ Numb ☐ Stiff ☐ Sharp with motion ☐ Shooting with motion
☐ Dull ☐ Tingly ☐ Stabbing with motion ☐ Electric-like with motion
☐ Diffuse ☐ Achy ☐ Burning ☐ Shooting ☐ Other _____

How are your symptoms changing with time?
☐ Getting Worse ☐ Staying the same ☐ Getting better

Using a scale from 0-10 (10 being the worst) how would you rate your problem?
0 1 2 3 4 5 6 7 8 9 10 *(Please circle)*

How much has the problem interfered with your work activities?
☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

How much has the problem interfered with your social activities?
☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

Who else have you seen for your problems?
☐ Chiropractor ☐ Neurologist ☐ Primary Care Physician ☐ ER Physician
☐ Orthopedist ☐ Massage Therapist ☐ Physical Therapist ☐ No one
☐ Other _____

How long have you had this problem? **Do you know the date it began?**

How do you think your problem began?

_____

Do you consider this problem to be severe?
☐ Yes ☐ Yes, at times ☐ No

What aggravates your problem?

_____

What alleviates the problem?

_____

What concerns you the most about your problem; what does it prevent you from doing?

_____

MID BACK:

(Initial here (___) if this section DOES NOT apply, go to next section)

Where is the pain?
☐ Left Side ☐ Center ☐ Right Side ☐ Entire Mid Back

How often do you experience your symptoms?

☐ Constantly (76-100% of the time) ☐ Frequently (51-75% of the time)
☐ Occasionally (26-50% of the time) ☐ Intermittently (1-25% of the time)

How would you describe the pain?
☐ Sharp ☐ Numb ☐ Stiff ☐ Sharp with motion ☐ Shooting with motion
☐ Dull ☐ Tingly ☐ Stabbing with motion ☐ Electric-like with motion
☐ Diffuse ☐ Achy ☐ Burning ☐ Shooting ☐ Other _____

How are your symptoms changing with time?
☐ Getting Worse ☐ Staying the same ☐ Getting better

Using a scale from 0-10 (10 being the worst) how would you rate your problem?
0 1 2 3 4 5 6 7 8 9 10 *(Please circle)*

How much has the problem interfered with your work activities?
☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

How much has the problem interfered with your social activities?
☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

Who else have you seen for your problems?
☐ Chiropractor ☐ Neurologist ☐ Primary Care Physician ☐ ER Physician
☐ Orthopedist ☐ Massage Therapist ☐ Physical Therapist ☐ No one
☐ Other _____

How long have you had this problem? **Do you know the date it began?**

How do you think your problem began?

_____

Do you consider this problem to be severe?
☐ Yes ☐ Yes, at times ☐ No

What aggravates your problem?

_____

What alleviates the problem?

_____

What concerns you the most about your problem; what does it prevent you from doing?

_____

LOW BACK/HIP:

(Initial here (___) if this section DOES NOT apply, go to next section)

Where is the pain?
☐ Left Side ☐ Center ☐ Right Side ☐ Entire Mid Back

How often do you experience your symptoms?
☐ Constantly (76-100% of the time) ☐ Frequently (51-75% of the time)
☐ Occasionally (26-50% of the time) ☐ Intermittently (1-25% of the time)

How would you describe the pain?
☐ Sharp ☐ Numb ☐ Stiff ☐ Sharp with motion ☐ Shooting with motion
☐ Dull ☐ Tingly ☐ Stabbing with motion ☐ Electric-like with motion
☐ Diffuse ☐ Achy ☐ Burning ☐ Shooting ☐ Other _____

How are your symptoms changing with time?
☐ Getting Worse ☐ Staying the same ☐ Getting better

Using a scale from 0-10 (10 being the worst) how would you rate your problem?
0 1 2 3 4 5 6 7 8 9 10 *(Please circle)*

How much has the problem interfered with your work activities?
☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

How much has the problem interfered with your social activities?
☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

Who else have you seen for your problems?
☐ Chiropractor ☐ Neurologist ☐ Primary Care Physician ☐ ER Physician
☐ Orthopedist ☐ Massage Therapist ☐ Physical Therapist ☐ No one
☐ Other _____

How long have you had this problem? **Do you know the date it began?**

How do you think your problem began?

_____

Do you consider this problem to be severe?
☐ Yes ☐ Yes, at times ☐ No

What aggravates your problem?

_____

What alleviates the problem?

_____

What concerns you the most about your problem; what does it prevent you from doing?

_____

LEG:

(Initial here (___) if this section DOES NOT apply, go to next section)

Where is the pain?
☐ Entire Left Leg ☐ Upper Left Leg ☐ Lower Left Leg ☐ Entire Right Leg ☐ Lower Right Leg ☐ Lower Left Leg

How often do you experience your symptoms?
☐ Constantly (76-100% of the time) ☐ Frequently (51-75% of the time)
☐ Occasionally (26-50% of the time) ☐ Intermittently (1-25% of the time)

How would you describe the pain?
☐ Sharp ☐ Numb ☐ Stiff ☐ Sharp with motion ☐ Shooting with motion
☐ Dull ☐ Tingly ☐ Stabbing with motion ☐ Electric-like with motion
☐ Diffuse ☐ Achy ☐ Burning ☐ Shooting ☐ Other _____

How are your symptoms changing with time?
☐ Getting Worse ☐ Staying the same ☐ Getting better

Using a scale from 0-10 (10 being the worst) how would you rate your problem?
0 1 2 3 4 5 6 7 8 9 10 *(Please circle)*

How much has the problem interfered with your work activities?
☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

How much has the problem interfered with your social activities?
☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

Who else have you seen for your problems?
☐ Chiropractor ☐ Neurologist ☐ Primary Care Physician ☐ ER Physician
☐ Orthopedist ☐ Massage Therapist ☐ Physical Therapist ☐ No one
☐ Other _____

How long have you had this problem? _____ **Do you know the date it began?** _____

How do you think your problem began?

_____

Do you consider this problem to be severe?

☐ Yes ☐ Yes, at times ☐ No

What aggravates your problem?

_____

What alleviates the problem?

_____

What concerns you the most about your problem; what does it prevent you from doing?

_____

I AFFIRM I HAVE ANSWERED ALL SECTIONS REGARDING MY HEALTH TO THE BEST OF MY ABILITY.

Patient Signature _____ Date: _____

Guardian or Spouse's Signature _____ Date _____

DOCTOR-PATIENT RELATIONSHIP IN CHIROPRACTIC
INFORMED CONSENT

Shipley Chiropractic - 2292 West Magee Road, Suite170 - Tucson, AZ 85742
(520) 797-2922 Fax (520) 742-0732

CHIROPRACTIC
It is important to acknowledge the difference between the health care specialties of chiropractic, osteopathy and medicine. Chiropractic health care seeks to restore health through natural means without the use of medicine or surgery. This gives the body maximum opportunity to utilize its inherent recuperative powers. The success of the chiropractic doctor's procedures often depends on environment, underlying causes, physical and spinal conditions.
It is important to understand what to expect from chiropractic health care services.

ANALYSIS
A doctor of chiropractic conducts a clinical analysis for the express purpose of determining whether there is evidence of Vertebral Subluxation Syndrome (VSS) or Vertebral Subluxation Complexes (VCS). When such VSS and VSC complexes are found, chiropractic adjustments and ancillary procedures may be given in an attempt to restore spinal integrity. It is the chiropractic premise that spinal alignment allows nerve transmission throughout the body and gives the body an opportunity to use its inherent recuperative powers. Due to the complexities of nature, no doctor can promise you specific results. This depends upon the inherent recuperative powers of the body.

DIAGNOSIS
Although doctors of chiropractic are experts in chiropractic diagnosis, the VSS and VSC, they are not internal medical specialists. Every chiropractic patient should be mindful of his/her own symptoms and should secure other opinions if he/she has any concern as to the nature of his/her condition. Your doctor of chiropractic may express an opinion as to whether or not you should take this step, but you are responsible for the final decision.

INFORMED CONSENT FOR CHIROPRACTIC CARE
A patient, in coming to the doctor of chiropractic, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problem. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give a chiropractic adjustment, or health care, if he/she is aware that such care may be contraindicated. Again, it is the responsibility of the patient to make it known or to learn through health care procedures whatever he/she is suffering from: latent pathological defects, illnesses, or deformities which would otherwise not come to the attention of the doctor of chiropractic. The patient should look to the correct specialist for the proper diagnostic and clinical procedures. The doctor of chiropractic provides a specialized, non-duplicating health service. The doctor of chiropractic is licensed in a special practice an is available to work with other types of providers in your health care regime.

RESULTS
The purpose of chiropractic services is to promote natural health through the reduction of the VSS or VSC. Since there are so many variables, it is difficult to predict the time schedule or efficacy of the chiropractic care. Many medical failures find quick relief through chiropractic. In turn w must admit that conditions which do not respond to chiropractic care may come under the control or be helped through medical science. The fact is that the science of chiropractic and medicine may never be so exact as to provide definite answers to all problems. Both have made great strides in alleviating pain and controlling disease.

TO THE PATIENT
Please discuss any questions or problems with the doctor **before** signing this statement of policy.

I have read, and understand the foregoing.

_____ _____
Signature Date

OFFICE POLICY

Shipley Chiropractic - 2292 West Magee Road, Suite170 - Tucson, AZ 85742
(520) 797-2922 Fax (520) 742-0732

Our goal is to provide and maintain a good physician-patient relationship. Letting you know in advance of our office policy allows for a good flow of communication and enables us to achieve our goal. *Please read each section carefully and initial.* If you have any questions, do not hesitate to ask a member of our staff.

Appointments

1) We value the time we have set aside to see you. We do not double book appointments. If you are not able to keep an appointment, we would appreciate 24-hour notice.
2) Walk-ins welcome, however, appointments will be seen first.
3) If you are not able to keep a **massage** appointment, we require a 24-hour notice. If you do miss an appointment or do not cancel a massage appointment 24 hours prior to your scheduled appointment time, a cancellation fee will apply. For a half hour massage- $30 will be charged, for a1 hour massage- $60 will be charged, and for an hour and a half massage- $85 will be charged.
4) If you are late for your appointment (>15 minutes), we will do our best to accommodate you.
5) We strive to minimize any wait time; however, emergencies do occur and will take priority over a scheduled visit. We appreciate your understanding.
6) If you have not been in the office in 3+ months, or if you have a new or different injury, a re-exam will be carried out and charged to you or your insurance company.

Initial_____

Insurance Plans

1) It is your responsibility to keep us updated with your correct insurance information. **If the insurance company you designate is incorrect, you will be responsible for payment of the visit and to submit the charges to the correct plan for reimbursement.**
2) It is your responsibility to know if a written referral or authorization is required to see specialists. If a referral is required, it is up to you to get a referral from your primary care physician. If a referral is required and not received, your insurance company will not pay; you will be responsible for payment.
3) It is your responsibility to understand your benefit plan with regard to chiropractic and physical therapies.
4) According to your insurance plan, you are responsible for any and all co-payments, deductibles, and coinsurances.
5) **Co-payments** are due at the time of service.
6) Self-pay patients are expected to pay for services in FULL at the time of the visit.
7) Patient balances are billed immediately on receipt of your insurance plan's explanation of benefits. Your remittance is due within **10** business days of your receipt of your bill.
8) We accept cash, checks, Visa, and MasterCard credit and debit.
9) A $25 fee will be charged for any checks returned for insufficient funds.

Initial_____

I have read and understand this office policy and agree to comply and accept the responsibility for any payment that becomes due as outlined previously.

_____
Patient's Name

_____ _____
Signature Date

2292 West Magee Road, Suite 170
Tucson, AZ 85742
Phone (520) 797-2922
Fax (520) 742-0732

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

_____
Patient Name (please print)

_____ _____
Signature Date

_____ _____
Parent, Guardian or Patient's legal representative Date

I authorize Shipley Chiropractic to release medical and billing information to the people I list below:

Name:_____ Relationship:_____

Name:_____ Relationship:_____

THIS FORM WILL BE PLACED IN THE PATIENT'S CHART AND MAINTAINED FOR SIX YEARS

FINANCIAL AGREEMENT
PERSONAL INJURY

Shipley Chiropractic - 2292 West Magee Road, Suite170 - Tucson, AZ 85742
(520) 797-2922 Fax (520) 742-0732

We would like to take a moment to welcome you to our clinic and to assure you that you will be receiving the very best care available for your condition. To familiarize you with the financial policies or our clinic, I would like to explain how your medical bills will be handled.

You have requested that we treat you for personal injuries that resulted from an incident where a third party is allegedly liable for your injuries.

Party Responsibility
If you were involved in an auto accident and are the owner of the vehicle, we will bill the "medical" insurance portion of your own **automobile insurance policy**. If you were ***a passenger in someone else's car***, we will bill the ***driver's*** auto insurance company. These policies will be billed in addition, and prior to, any claim that your attorney may be presenting to an insurance company on your behalf.

Insurance Rates
It is important to remember that when a medical claim is submitted to the "medical payments" portion of your insurance policy, your standing with the insurance company will not be affected, and your rates will not normally be increased, unless the accident is determined to be your fault.

Billing Other Insurance Policies
It is also to your advantage for our clinic to bill your own health insurance policy and/or automobile medical policy for your medical bills, providing your policy does not state otherwise. You are being treated for a Personal Injury and it IS NOT THE POLICY OF THIS OFFICE TO BILL YOUR HEALTH INSURANCE. If you would like us to bill your health insurance for the auto injury we can. We will also bill your personal injury case for the remaining balance (if any) left from your health insurance to equal the total charges in full. If you sign below you are expressing your decision to **NOT** bill your health insurance.

Responsibility for Payment
As a courtesy to you, we will gladly submit your medical bills to your insurance company(ies) and/or attorney; however, all services rendered by this clinic will be charged directly to you, and ultimately, you will be personally responsible for payment of these bills regardless of any settlement you may or may not receive.

Once again, we welcome you to this clinic. We hope that this has answered any questions that you might have about our financial arrangements. If, at any time, you have further questions about your care, please don't hesitate to ask.

I have read and agree to the above

_____ _____
Patient's Signature Date

2292 West Magee Road, Suite 170
Tucson, AZ 85742
Phone (520) 797-2922
Fax (520) 742-0732

NOTICE OF DOCTOR'S LIEN

Patient: _____

Date of Accident: _____

I do hereby authorize [SHIPLEY CHIROPRACTIC] to furnish you, my attorney, with full report of his examination, diagnosis, treatment, prognosis, etc. of myself in regard to the accident in which I was recently involved.

I hereby authorize and direct you, my attorney, to pay directly to said doctor such sums as may be due and owing him for medical service rendered me both by reason of this accident and by reason of any other bills that are due his office and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect and fully compensate said doctor. And I hereby further give a Lien on my case to said doctor against any and all proceeds of my settlement, judgment or verdict which may be paid to you, my attorney, or myself, as the result of the injuries for which I have treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by him for service rendered me an that this agreement is made solely for said doctor's additional protection and in consideration of his awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

I agree to promptly notify said doctor of any change or addition of attorney(s) used by me in connection with this accident, and I instruct my attorney to do the same and to promptly deliver a copy of this lien to any such substituted or added attorney(s).

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

_____ _____

Patient's Signature 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, judgment, or verdict, as may be necessary to adequately protect and fully compensate said doctor above named. 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 date, sign and return one copy to doctor's office, also keep one copy for your records.

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MEDICAL RECORDS RELEASE FORM

To: _____ City:_____ State: _____

Phone:_____ Fax: _____

I hereby authorize you to release the medical records, as requested below, pertaining to treatment rendered to me during my care at your office.

X-Ray Films _____ X-Ray Report _____

Series:

AP/LAT Cervical (3-view) _____ Medical Records _____

AP/LAT Lumbar (2-view) _____ MRI Report _____

AP/LAT Thoracic (2-view) _____

Patient Name _____ DOB _____

Please forward requested information to:

Shipley Chiropractic
2292 West Magee Road, Suite 170
Tucson, AZ 85742

_____ _____

Patient Signature Date

AUTHORIZATION FOR DISCLOSURE OF MEDICAL INFORMATION

CLAIM #_____

I hereby voluntarily grant permission to and authorize the use and/or disclosure of my health information as described below, to requestor(s).

PATIENT IDENTIFICATION:

Name: _____

Date of Birth: _____

Soc. Sec.: _____

PURPOSE OF DISCLOSURE: The above information is being obtained to assist said authorized entities in evaluating my claim for benefits or damages. A copy of this document shall be considered as effective and valid as the original.

INSURANCE COMPANIES INFORMATION MAY BE RELEASED TO :

Your Insurance Company: _____

Third Party Insurance Company: _____

REVOCATION: Unless otherwise revoked in writing, this authorization shall terminate upon final resolution of all claims related to the claim number set for above.

INFORMATION THAT MAY/WILL BE DISCLOSED:

- Medical information – All medical records including but not limited to SOAP notes, all other notes, records, charts, any letters, physical therapy records.
- Medical Billing – Including CPT and ICD-10 codes.
- X-Rays/Film – Any and all reports.
- Insurance Records – Including all claims, itemized billing, correspondence, payments, and all documents within the file.

RE-DISCLOSURE: I understand that authorizing the disclosure of this health information is voluntary and that I am entitled to a copy of this Authorization and acknowledge receipt of a copy thereof. I can refuse to sign this Authorization. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

_____ _____ _____

SIGNATURE OF PATIENT OF LEGAL REPRESENTATIVE | RELATIONSHIP TO PATIENT | DATE

FOR YOUR PROTECTION, ARIZONA LAW REQUIRES THE FOLLOWING STATEMENT TO APPEAR ON THIS FORM. “ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS IS SUBJECT TO CRIMINAL AND CIVIL PENELTIES”

Personal Injury Insurance Information

Patient _____Accident Date_____

Attorney Information

Name:_____Phone:_____

Address:_____

Auto Insurance Information

Company_____

Policy #:_____

Claim #:_____

Phone #: _____

Adjuster:_____

Address_____

Med-Pay_____

Other Party's Insurance Information

Company_____

Policy #:_____

Claim #: _____

Phone #:_____

Adjuster:_____

Address_____

_____

(For Office Use Only - Questions to Ask Attorney or Insurance company)

1. Does Liability look questionable? Yes □ No □
2. Is the insurance policy active and will cover this accident? Yes □ No □
3. Was a police report filed? Yes □ No □
4. Is there Med-Pay? Yes □ No □ What amount?_____
   Limits?_____
   Med-Pay Verified Date:_____Spoke with_____

Shipley Chiropractic

2292 West Magee Road, Suite170
Tucson, AZ 85742
(520) 797-2922 FAX (520) 742-0732

PERSONAL INJURY QUESTIONNAIRE

Name_____ Date of Accident _____ Time _____ AM PM

How did accident occur? □ Auto Collision □ Other _____

If not an auto collision, please describe the circumstances_____

_____

_____

How many vehicles were involved? _____

What was the estimated cost of damage to your vehicle?_____

What was damaged in your vehicle? (Check all that apply)

□ windshield □ seat frame □ rear bumper □ front left door □ mirror
□ steering wheel □ side window □ front bumper □ back right door □ trunk
□ dashboard □ rear window □ front right door □ knee bolster □ completely totaled

Choose the items that dented inward: □ floorboards □ side door □ dashboard

Choose the doors that would not open as a result of the accident:

□ front left □ front right □ rear left □ rear right

What was the cross streets?_____

What was the City and State of the accident? _____

You were heading: □ North □ East □ South □ West on _____(street or highway)

Other vehicle was headed: □ North □ East □ South □ West on _____(street or highway)

You were struck from: □ Behind □ Right Side □ Left Side □ Front □ Auto was Parked

Did your car strike the other(s) involved? □ Yes □ No Or did the other car strike yours? □ Yes □ No □ Undetermined

Did your vehicle hit anything immediately after the accident? (Explain)_____

_____

During and after the crash what happened to your vehicle? (check all that apply)

□ kept going straight □ spun around □ kept going straight hitting a car in front
□ spun around and hit a stationary object □ was hit by another vehicle □ hit a stationary object

Were you: □ Driver □ Front Passenger □ Rear Left Passenger □ Rear Right Passenger
□ Rear Center Passenger □ Pedestrian

Did you know the accident was coming? □ Yes □ No If yes, did you: □ Relax □ Brace yourself

What type of vehicle were you in? (i.e. compact car, van, truck)_____

What type of vehicle impacted yours? (i.e. compact car, van, truck) _____

At the time of the impact, how fast was your vehicle moving? _____

At the time of impact, how fast was the other vehicle moving? _____

Did you lose consciousness? □ Yes □ No

How was your head positioned during the accident? _____

How was your torso positioned during the accident? _____

How were your hands positioned during the accident?_____

Did your head hit anything during the accident? □ Yes □ No If yes, please describe: _____

Did your face hit anything during the accident? □ Yes □ No If yes, please describe: _____

Did your shoulders hit anything during the accident? □ Yes □ No If yes, please describe: _____

Did your neck hit anything during the accident? □ Yes □ No If yes, please describe: _____

Did your chest hit anything during the accident? □ Yes □ No If yes, please describe: _____

Did your hips hit anything during the accident? □ Yes □ No If yes, please describe: _____

Did your knees hit anything during the accident? □ Yes □ No If yes, please describe: _____

Did your feet hit anything during the accident? □ Yes □ No If yes, please describe: _____

What kind of headrest was in your vehicle? □ movable fixed headrest □ nonmovable fixed headrest □ no headrest

Where was the headrest positioned on your head? (i.e. middle/lower portion of the back of your head)_____

Did you have your seatbelt on during the accident? □ Yes □ No

If yes, did you slide out of your seatbelt during the accident?_____

Did you require post-accident hospitalization? □ Yes □ No

Did you go to a hospital? Yes No If yes, when? _____

How did you get to the hospital? ____Ambulance ____Private transportation; Driven by _____

Name of hospital _____ Attended by Dr.

Were you admitted to the hospital? □ Yes □ No If yes, how long? _____

Were you x-rayed at the hospital? □ Yes □ No What regions?_____

Did you receive stitches for any cuts at the hospital? □ Yes □ No

What treatment was rendered?_____

Circle what you were prescribed at the hospital: □ pain medication □ muscle relaxors □ neck brace

Were police notified? □ Yes □ No

As a result of the accident, were traffic citations issued? □ Yes □ No If yes, to whom?_____

Check symptoms you have noticed since accident:

□ Headache	□ Dizziness	□ Light Bother Eyes	□ Diarrhea	□ Fatigue
□ Neck Pain	□ Head Seems Too Heavy	□ Loss of Memory	□ Feet Cold	□ Fainting
□ Neck Stiff	□ Pins and Needles in Arms	□ Hands Cold	□ Tension	□ Ears Ring
□ Sleeping Problems	□ Pins and Needles in Legs	□ Face Flushed	□ Stomach Upset	□ Fever
□ Back Pain	□ Numbness in Fingers	□ Buzzing in Ears	□ Constipation	□ Irritability
□ Nervousness	□ Numbness in Toes	□ Loss of Balance	□ Cold Sweats	□ Depression
□ Loss of Taste	□ Shortness of Breath	□ Loss of Smell	□ Painful Joints	□ Chest Pain

Symptoms other than above _____

Have you lost any days of work? □ Yes □ No Dates _____

Insurance Companies involved: _____

My Company _____

Company of person responsible for injuries? _____

Have you been contacted by an insurance adjuster or company representative regarding this claim? □ Yes □ No

Do you have an attorney that has advised you in this care? □ Yes □ No

_____

Patient Name

_____ _____

Patient Signature Date

Messages

Please call: ☐ My Home ☐ My Work ☐ My Cell

If unable to reach me:

☐ You may leave a detailed message

☐ Please leave a message for me to return you call

☐ _____

The best time to reach me is (day)_____ Between (time)_____

Text Message Reminder

Would you like an Appointment reminder text message?

☐ Yes ☐ No

If yes, please tell us your Mobile Phone Carrier:

_____

Print Name _____ Date of Birth ____/___/____

Signature _____ Date _____