Application for Patient Care

Patient Information

Name: ____
Last First MI

Email address: ____

Mailing Address: ____

Phone Number: Home__________________ Work__________________ Other__________________

Your preferred method of contact for appointment reminders? Email / Text by Cell Phone/ Phone Call

Date of Birth: ______________ Sex: ☐ Male ☐ Female SS# ____________________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Minor

Race: ☐ Caucasian ☐ African American ☐ Asian ☐ Native American ☐ Latin American ☐ Other__________

Ethnicity: ☐ Hispanic ☐ Latino ☐ Non-Hispanic/Non- Latino

Occupation: ____________________________ Employer: ____________________________

Employer Address:____________________________ Phone Number: ____________________

Emergency Contact: Name __________________ Relation: ______________ Phone # ______________

Accident Information

Is this visit due to an accident? ☐ Yes ☐ No If yes, what type? ☐ Auto ☐ Work ☐ Other__________

Has it been reported? ☐ Yes ☐ No If yes, to whom?____________________________

Attorney Information: ____________________________ Phone Number:____________________________

Insurance Information

Name of Health Insurance Carrier: ______________________ Secondary Insurance?______________________

Policy Holder Name: ______________________________ DOB ______________________________

Relationship to Patient (if other than self):______________________ Phone # ______________________

PLEASE PROVIDE THIS OFFICE WITH A COPY OF YOUR ID & INSURANCE CARD(S)

SIGNATURE (X) ______________________________ **DATE** ____________________

Patient Health History

Check off any of the following symptoms you have experienced in the past 6 months:

- ☐ Low Back Pain
- ☐ Pain between Shoulder
- ☐ Neck Pain
- ☐ Tension/Headaches
- ☐ Fibromyalgia
- ☐ Tension Across Top of Shoulders
- ☐ Numbness/Tingling in Arms/Hands
- ☐ Numbness/Tingling in Legs/Feet
- ☐ Pain in the legs
- ☐ Pain in the feet
- ☐ Tired/Fatigued
- ☐ Difficulty Sleeping
- ☐ Allergies
- ☐ Digestive
- ☐ Carpal Tunnel

Other (explain) ______________________________

Which of the above is the worst? ______________________________

How long have you had it? ______________________________

How often does it occur? ______________________________

What does it feel like?(describe) ______________________________

What have you done that has helped this problem? ______________________________

What activities would you like to do if this was not a problem? ______________________________

Does this cause you to be:
- ☐ Moody
- ☐ Irritable
- ☐ Interrupt sleep
- ☐ Restricted in your daily

Does this affect your work:
- ☐ Decision making
- ☐ Poor attitude
- ☐ Decreased productivity
- ☐ Exhausted at the end of the day
- ☐ Unable to work long hours

Does this affect your life:
- ☐ Lose patience with spouse/children
- ☐ Restricted household duties
- ☐ Hinders ability to exercise or
- ☐ Interferes with ability to do hobbies or other activities

What have you tried to help relieve/get rid of this problem and how much did it help? (circle appropriately)

- ■ Medications...Helped: Little Some Much
- ■ Physical Therapy...Helped: Little Some Muc
- ■ Chiropractic...Helped: Little Some Much
- ■ Exercise...Helped: Little Some Much
- ■ Nutrition...Helped: Little Some Much
- ■ Stretching...Helped: Little Some Much

Are you currently under drug and/or medical care? ☐ Yes ☐ No

Who is your primary care doctor? ______________________________

Please all medications: (<u>**Be sure to include dosage and frequency**</u>) ______________________________

____

Supplements (vitamins/herbs/minerals): ______________________________

Allergies: ______________________________

Approximate Date of last Flu vaccine:______ ***WOMEN ONLY:*** Date of LMP:_________ ***Any possibility of pregnancy: YES or NO***

Surgical History:

Surgeries and/or hospitalizations (<u>type & date</u>): ______________________________

____

Family History: Is there a family history of any of the following conditions? (<u>Indicate parents, grandparents, children, & siblings</u>)

☐ Heart Disease ______________ ☐ Diabetes ______________

☐ Cancer ______________ ☐ Arthritis ______________ ☐ Other ______________

Social History:

Intake of the following: **Cigarettes** ____ packs/day **Alcohol** ___ drinks/week **Caffeine** ___cups/day

Exercise frequency: ☐ Never ☐ Daily ☐ Weekly ☐ Walks ☐ Runs ☐ Swims

Past Medical History and Review of Systems

Y	N	Neurological
___	___	Migraines
___	___	Headaches: how often?
___	___	Slurring of speech

Y	N	Ear/Nose/Throat
___	___	Altered taste/smell
___	___	Night Blindness
___	___	Sore Throat
___	___	Gingivitis
___	___	Nose bleeds

Y	N	Endocrine
___	___	Diabetes
___	___	Thyroid problems

Y	N	Cardiovascular
___	___	High blood pressure
___	___	High cholesterol
___	___	Chest pain
___	___	Palpitations-racing heart beat
___	___	Swelling in hands/feet
___	___	Anemia

Y	N	Respiratory
___	___	Recurrent Respiratory Infections
___	___	Asthma
___	___	Chest Congestion
___	___	Wheezing

Y	N	GI
___	___	Stomach Pains or Cramping
___	___	Constipation
___	___	Reflux or Heartburn
___	___	Bloating/Gas
___	___	Nausea or Vomiting

Y	N	Musculoskeletal
___	___	Joint Pain
___	___	Arthritis
___	___	Chronic pain
___	___	Muscle Aches

Y	N	Skin
___	___	Eczema
___	___	Dermatitis
___	___	Excessive Sweating
___	___	Rashes
___	___	Brittle Nails
___	___	Hair Loss
___	___	Easy Bruising
___	___	Increased Bleeding
___	___	Numbness/tingling

Y	N	Genitourinary
___	___	Uterine fibroids
___	___	Ovarian cysts
___	___	Cancer (breast, ovarian, prostate, uterine)
___	___	Prostate problems

Y	N	Emotional/Mental
___	___	Depression
___	___	Anxiety
___	___	Mood Swings
___	___	Irritability
___	___	Memory Loss
___	___	Confusion

Y	N	Energy
___	___	Fatigue
___	___	Hyperactivity
___	___	Restlessness
___	___	Insomnia
___	___	Decreased Libido
___	___	Stress

Y	N	Weight
___	___	Decreased Appetite
___	___	Weight Gain
___	___	Inability to Lose Weight
___	___	Food Cravings
___	___	Binge Eating
___	___	Water Retention

Medicines previously tried, dosage, duration and outcome.

☐ Advil ☐ Aleve ☐ Tylenol ☐ Steroids ☐ Prescriptions for a period of ☐ 0-3mos, ☐ 3-6mos, ☐ 6-12 mos ☐ 12+mos

Please check ALL options you have previously tried to assist in above symptoms:

- ____Over the counter medications
- ____Prescriptions
- ____Dietary Changes
- ____Exercise
- ____Consult with specialist
- ____Supplements
- ____Alternative medication/treatment therapies

Duties Performed Under Duress at Work and Home

Patient name________________________________ Date of Injury __________ Today's Date___________

☐ Initial ☐ Update

Please check all that apply to your WORK because of the accident

- ☐ I go to work but work in pain
- ☐ I limit my work activities
- ☐ Bending at work hurts
- ☐ Stooping at work hurts
- ☐ Sitting at work hurts
- ☐ Using the computer at work hurts
- ☐ Pushing at work hurts
- ☐ Kneeling at work hurts
- ☐ I have lost status in my company
- ☐ I have lost job security
- ☐ I didn't get a promotion
- ☐ I don't enjoy work as much as before
- ☐ I doze off at work
- ☐ I take unpaid time off work to go to Dr.
- ☐ I daydream at work more than before
- ☐ I feel tired at work
- ☐ ________________________________
- ☐ ________________________________
- ☐ I work in pain because I have bills to pay
- ☐ I can't take time off because I would lose my job
- ☐ I keep working so I don't lose status at company
- ☐ My business would fail if I took time off
- ☐ I believe in working even when I'm in pain
- ☐ I feel obligated to work even though I'm in pain
- ☐ My business would lose money if I took time off
- ☐ My work is not as good as it was before accident
- ☐ My boss reprimanded me for poor performance
- ☐ I got a different job within the same company
- ☐ I got a different job in another company
- ☐ I make less money than before the accident
- ☐ I cannot do the same work/job as before accident
- ☐ I can't concentrate as well at work
- ☐ I take paid time off to go to Dr.
- ☐ I make mistakes at work I didn't use to
- ☐ I hide my poor work performance from my boss
- ☐ ________________________________
- ☐ ________________________________

Please check all that apply to your HOME/DOMESTIC because of the accident

- ☐ My house is not as clean now
- ☐ My yard is not as neat now
- ☐ My garden is not as productive now
- ☐ I do yard work, but do it in pain
- ☐ I cannot do my normal yard work
- ☐ I do house work, but do it in pain
- ☐ I cannot do my normal house work
- ☐ Doing laundry hurts me
- ☐ I cannot do laundry now
- ☐ Washing dishes hurts me
- ☐ I cannot vacuum now
- ☐ Cooking hurts me
- ☐ I cannot cook now
- ☐ Washing the car hurts me
- ☐ I cannot wash my car
- ☐ ________________________________
- ☐ ________________________________
- ☐ I cannot take time off because I care for children
- ☐ I have ________children ages_______________
- ☐ I had to hire a paid housekeeper
- ☐ I asked someone for unpaid housekeeping help
- ☐ I had to hire a paid gardener
- ☐ I asked someone for unpaid yard work help
- ☐ Mowing the lawn hurts me
- ☐ I cannot mow the lawn
- ☐ Taking out the trash hurts me
- ☐ I cannot take out the trash
- ☐ I do not enjoy my gardening/yardwork like I used to
- ☐ I do not enjoy my housework like I used to
- ☐ Gardening hurts me
- ☐ I cannot do my gardening at all since the accident
- ☐ Others living with me do my share of the work now
- ☐ Others living with me do my share of the yard now
- ☐ Others living with me do my share of the gardening
- ☐ ________________________________

____________________ ____________________

Signature Date

Loss of Enjoyment of Sports, Hobbies, Travel, Daily activities, & School (1 of 2 pages)

Patient's name______________________ Date of Injury____________ Today's date__________

☐ Initial ☐ Update

Please check all that apply to your EXERCISE & SPORTS Activity because of the accident

☐ My exercise was affected by this crash	☐ I have gained______ pounds since the accident
☐ I go to the gym & work out in pain	☐ I had to quit my _______ team after the accident
☐ I no longer go to the gym to work out	☐ I had to quit my _______team after the accident
☐ I run but in pain	☐ I had to quit my _______team after the accident
☐ I no longer run	☐ I had to quit my _______team after the accident
☐ I take walks & have pain while walking	☐ I don't enjoy the sport of ___________anymore
☐ I no longer take walks	☐ I didn't enjoy the sport of ______for ____weeks
☐ I used to make income at sports	☐ I don't enjoy the sport of ___________anymore
☐ I have lost sports income since crash	☐ I didn't enjoy the sport of ______for ____weeks
☐ I am an amateur athlete	☐ I don't enjoy the sport of ___________anymore
☐ I am a professional athlete	☐ I didn't enjoy the sport of ______for ____weeks
☐ ______________________________	☐ I don't enjoy the sport of ___________anymore
☐ ______________________________	☐ I didn't enjoy the sport of ______for ____weeks

Please check all that apply to your HOBBY Activities because of the accident

☐ My hobbies were affected by accident	☐ Hobby #3________________________
☐ Hobby #1________________________	☐ I can't do hobby #3 anymore
☐ I can't do hobby #1 anymore	☐ I do hobby #3 but in pain
☐ I do hobby #1 but in pain	☐ I have lost money from not doing #3
☐ I have lost money from not doing #1	☐ I didn't do hobby #3 for ______ weeks
☐ I didn't do hobby #1 for ______ weeks	☐ Hobby #4________________________
☐ Hobby #2________________________	☐ I can't do hobby #4 anymore
☐ I can't do hobby #2 anymore	☐ I do hobby #4 but in pain
☐ I do hobby #2 but in pain	☐ I have lost money from not doing #4
☐ I have lost money from not doing #2	☐ I didn't do hobby #4 for ______ weeks
☐ I didn't do hobby #2 for ______ weeks	☐ ______________________________

Please check all that apply to your TRAVEL Activities because of the accident

☐ Business travel was affected by crash	☐ Travel Plan #1
☐ Pleasure travel was affected by crash	☐ I did not go on travel plan #1
☐ I hurt driving in my own car	☐ I went, but did not enjoy #1 as much
☐ I am in too much pain to drive	☐ I went and the accident had no effect on #1
☐ I hurt when a passenger in a car	☐ Travel Plan #2
☐ I am in too much pain to sit in a car	☐ I did not go on travel plan #2
☐ I have anxiety when I'm in a car	☐ I went, but did not enjoy #2 as much
☐ I hurt when I'm on an airplane	☐ I went and the accident had no effect on #2
☐ I am in too much pain too much pain to travel by plane	☐ I missed time with my family/friends b/c can't travel

Loss of Enjoyment of Sports, Hobbies, Travel, Daily activities, & School (2 of 2 pages)

Patient's name________________________ Date of Injury______________ Today's date___________

☐ Initial ☐ Update

Please check all the DAILY LIVING activities that cause you pain because of the accident

☐ Dressing
☐ Putting on pants
☐ Putting on shoes
☐ Tying my shoes
☐ Putting on shirt
☐ Drying my hair
☐ Combing my hair
☐ Washing my hair
☐ Taking a shower
☐ Taking a bath
☐ Leaning forward
☐ Laying in bed
☐ Sitting in my favorite chair
☐ Sleeping
☐ Going out with my friends
☐ Sitting at a restaurant
☐ Shopping
☐ Driving to/from work
☐ Sitting in Church
☐ Playing with my children
☐ Caring for my children
☐ Bending in a movie theatre
☐ Sitting in a movie theatre
☐ Exercise
☐ Eating
☐ Stooping
☐ Squatting down
☐ Kneeling
☐ Brushing my teeth

☐ Riding in a car
☐ Opening a jar
☐ Lifting a pan when cooking
☐ Closing the trunk on my car
☐ Opening the garage door
☐ Using my home computer
☐ Climbing stairs
☐ Sexual activity
☐ Turning my head to left or right
☐ Holding my head up all day
☐ Watching TV
☐ I have pain sitting & doing nothing
☐ Talking on the phone
☐ Reading
☐ Writing
☐ Opening doors
☐ Drying with a towel after a bath or shower
☐ Life has become a chore just to do normal things
☐ It is depressing to live like this
☐ ______________________________
☐ ______________________________
☐ ______________________________
☐ ______________________________
☐ ______________________________
☐ ______________________________
☐ ______________________________
☐ ______________________________

Please check all that apply to your SCHOOL & EDUCATION Activities because of the accident

☐ School was affected by the accident
☐ I am a student at ____________________
☐ I am in the ________________ year/grade
☐ I was ☐ full time ☐ part time
☐ I am now ☐ full time ☐ part time
☐ I had to take fewer classes b/c of crash
☐ I missed ________ days of school
☐ I had to drop out of school b/c of crash
☐ My grades are lower since the crash

☐ I have pain carrying my school books
☐ I hurt sitting in class more than ______ minutes
☐ My neck hurts when I look down to read
☐ I don't learn as quickly as before the crash
☐ I don't learn things as well as before the crash
☐ I have difficulty concentrating in class
☐ It takes much longer to study/do my homework
☐ ______________________________
☐ ______________________________

______________________________ ______________________

Signature of Patient Date

DYNAMIC

Patient Name: ______________________ Date: ____________

ACCIDENT INFORMATION

Have you been to the emergency room [] yes [] no, When ________________

Is this visit related to the auto accident? ☐ Yes ☐ No Date of Accident: ______________________

Please describe in detail the accident:

____

____

____

____

____

____

____

____

____

____

____

____

____

____

____

____

____

____

____

____

INFORMATION FOR MVA BILLING

****All information must be present****

Patient Name: ______________________________

Patient DOB: ______________________________

Specific DATE OF INJURY: ______________________________

Patient's Auto Insurance Carrier Name: ______________________________

Insurance Address: ______________________________

____

Patient' Auto Insurance Phone Number: ______________________________

Auto Insurance Claims Adjuster Name: ______________________________

Auto Insurance Claims Adjuster Phone Number: ______________________________

Accident CLAIM NUMBER: ______________________________

***If accident occurred in Indiana, we will need the other driver's insurance information also.**

Insurance Information Verified By: ____________________ **Date:** __________

NOTES: (FOR OFFICE USE ONLY)

APPLICATION FOR BENEFITS – PERSONAL INJURY PROTECTION

KENTUCKY NO-FAULT

IMPORTANT:
1. **To enable us to determine if you are entitled to benefits under the policyholder's contract, you must complete and sign this form.**
2. **You must also sign the attached authorizations(s).**
3. **Return promptly with any medical bills to arrive before sending this application to us. Please send this application back immediately.**

DATE	OUR POLICYHOLDER	DATE OF ACCIDENT	FILE NO.

Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Claim Dept.

YOUR NAME HOME PHONE NUMBER WORK PHONE NUMBER

YOUR ADDRESS (NO., STREET, CITY OR TOWN, STATE AND ZIP CODE)

DATE OF BIRTH SOCIAL SECURITY NUMBER

DATE AND TIME OF ACCIDENT:

BRIEF DESCRIPTION OF ACCIDENT:

DO YOU OR ANY MEMBER OF YOUR HOUSEHOLD OWN A MOTOR VEHICLE? YES NO

PLEASE LIST ALL AUTO INSURANCE CARRIERS CURRENTLY COVERING ANY OR ALL OF THE VEHICLES YOU OWN (NAME OF INSURANCE COMPANY AND POLICY #:

WERE YOU THE DRIVER OF THE MOTOR VEHICLE? YES NO

WERE YOU A PASSENGER IN THE MOTOR VEHICLE? YES NO

WERE YOU A PEDESTRIAN? YES NO

WERE YOU A MEMBER OF THE MOTOR VEHICLE OWNER'S HOUSEHOLD? YES NO

HAVE YOU REJECTED NO-FAULT COVERAGE (I.E. PERSONAL INJURY PROTECTION COVERAGE) AS PROVIDED BY THE KENTUCKY NO FAULT ACT (KRS304.39) BY SIGNING A REJECTION FOR THIS COVERAGE? YES NO

WERE YOU INJURED AS A RESULT OF THIS ACCIDENT YES NO

IF YOUR ANSWER IS YES, COMPLETE THE REST OF THIS FORM.
IF NO, SIGN HERE AND RETURN THIS FORM TO US.

SIGNATURE: ______________________ DATE: ______________________

DESCRIBE YOUR INJURY:

WERE YOU TREATED BY A DOCTOR: YES NO

DOCTOR'S NAME AND ADDRESS:

IF YOU WEREN TREATED IN A HOSPITAL WERE YOU IN-PATIENT OUT-PATIENT

HOSPITAL'S NAME AND ADDRESS:

AMOUNT OF MEDICAL BILLS TO DATE: $

WILL YOU HAVE MORE MEDICAL EXPENSES? YES NO

AT THE TIME OF YOUR ACCIDENT WERE YOU IN THE COURSE OF YOUR EMPLOYMENT? YES NO

DID YOU LOSE WAGES OR SALARY AS A RESULT OF YOUR INJURY? YES NO

IF YES, AMOUNT TO DATE:

WHAT IS YOUR AVERAGE WEEKLY WAGE/SALARY?

IF YOU LOST WAGES, DATE DISABILITY FROM WORK BEGAN:

DATE YOU RETURNED TO WORK:

HAVE YOU RECEIVED OR ARE YOU ELIGIBLE FOR BENEFITS UNDER:
- WORKMEN'S COMPENSATION LAWS? YES NO
- SOCIAL SECURITY BENEFITS? YES NO

IF YOU ARE CLAIMING LOST WAGES, COMPLETE THIS SECTION, DOING SO WILL HELP US PROMPLTY VERIFY YOUR SALARY RATE WITH YOUR EMPLOYER.

EMPLOYER AND ADDRESS	OCCUPATION	FROM	TO
EMPLOYER AND ADDRESS	OCCUPATION	FROM	TO

HAVE YOU HAD ANY OTHER EXPENSES AS A RESULT OF YOUR INJURY? YES NO
IF YES, EXPLAIN:

I hereby authorize release of medical information, including but not limited to medical bills and reports, to such persons as the company may deem necessary.

Signature Date

IMPORTANT: CHOOSE ONE OF THE REIMBURSEMENT METHODS LISTED BELOW.

___PLEASE PAY ME DIRECTLY __X__ PLEASE PAY MY MEDICAL PROVIDER DIRECTLY
IF WE PAY YOU DIRECTLY, YOU WILL BE RESPONSIBLE FOR PAYING YOUR MEDICAL PROVIDERS PROMPTLY, IF YOU FAIL TO PAY YOUR MEDICAL PROVIDERS PROMPTLY, COLLECTION PROCEEDINGS AND INTEREST CHARGES MAY BE BROUGHT AGAINST YOU.

YOU MAY DIRECT THE PAYMENT OF PERSONAL INJURY PROTECTION COVERAGE TO THE DIFFERENT COVERED EXPENSES (WAGE LOSS, REPLACEMENT SERVICES, AND/OR MEDICAL EXPENSES) UNDER PIP ON A PROSPECTIVE BASIS. PLEASE DESCRIBE, IN WRITING, HOW YOU WOULD LIKE YOU PERSONAL INJURY PROTECTION BENEFITS TO BE DISTRIBUTED AMONG THE DIFFERENT COVERED EXPENSES UNDER PIP.

IF YOU DO NOT DESCRIBE, IN WRITING, HOW YOU WOULD LIKE YOUR PERSONAL INJURY PROTECTION BENEFITS TO BE DISTRIBUTED, THEN BENEFITS WILL BE PAID ON A MONTHLY BASIS AS YOU INCUR MEDICAL EXPENSES, WAGE LOSS, AND/OR REPLACEMENT SERVICES LOSS. NOTE THAT THE MAXIMUM AMOUNT WE WILL PAY FOR WAGE LOSS OR REPLACEMENT SERVICES IN ANY ONE WEEK IS $200.

IF YOU ARE CLAIMING LOST WAGES, PLEASE SIGN THE FOLLOWING:

AUTHORIZATION FOR WAGE AND SALARY INFORMATION

This authorization or photocopy hereof will authorize you to furnish all information you may have regarding my wages or salary while employed by you. You are authorized to provide this information in accordance with Personal Injury Protection Benefits (Kentucky No-Fault) Law.

Signature ______________________________ Date

Social Security No. ______________________

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

AUTHORIZATION FOR DISCLOSURE OF MEDICAL INFORMATION

I authorize any licensed physician, surgeon, dentist, psychiatrist, psychologist, other medical practitioner, nurse, hospital, clinic, health care facility, rehabilitation facility, convalescent facility, custodial facility, ambulance owner, and any insurance company to provide information to ______________________. I authorize the use of the above information to permit ______________________ and its authorized representatives to investigate, process, and determine the amount payable, if any, arising from the incident on ___________.

I understand as part of the claim handling process, __________________ may disclose medical or other information obtained by this authorization to physicians, dentists, other medical or healthcare providers or other professionals for their review and professional opinion. This information may also be released to other insurance companies for their use in connection with insurance transactions, or as required or permitted by law. Information obtained pursuant to this authorization may later be re-disclosed and may not be protected under the Health Insurance Portability and Accountability Act (HIPAA) privacy rule. I understand that I may refuse to authorize disclosure of all or some of the requested information, but that refusal may potentially cause a delay in processing, or result in the denial of, insurance benefits for the pending injury claims(s).

I have the right to revoke this authorization, except to the extent that __________________ has taken action in reliance on the authorization prior to revocation, in writing by providing a signed, written, dated notice of revocation to __________________.

This authorization is valid for the duration of the claim(s), and a photocopy is as valid as the original. This authorization specifically applies to records made before, during, and after the date of signing this authorization for as long as the authorization is in effect. I have read the authorization and signed this document as a free and voluntary act for the purposes noted above. I understand that I may obtain a copy of this authorization upon written request submitted to ________________________.

Pursuant to Kentucky Statute 304.47-030(2), Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Printed Name: __________________ Signature: ______________________

Date: ______________________ Representative: ____________________

DOB: ______________________ Social Security No. __________________

Lien

DYNAMIC MEDICAL, CHIROPRACTIC & REHAB
3707 Chamberlain Ln. Ste 101
Louisville, KY 40241
Tel:502-426-9200/Fax:502-426-9259

TO MY ATTORNEY:

I do hereby authorize Dynamic Healthcare to furnish you as my attorney, with a full report of examination, diagnosis, treatment and prognosis of my condition resulting from the accident in which I was involved on _________.

I hereby authorize and direct as my attorney to pay directly to said doctor such sums as may be due and owing for services rendered me both by reason of this accident and by reason of any other bills that are due his/her office and to protect Dynamic Healthcare. I further direct my attorney to deduct payment for these bills directly from the proceeds of my settlement for the accident of __________.

I understand that I am directly and fully responsible to Dynamic Healthcare for all medical bills submitted by it for services rendered to me and that this protection and I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

____________________ Patient's Signature: ______________________________
Date (Client Name)

I represent the above named client in connection with a claim for personal injuries involving an accident, which occurred on the above date.

________________________ has agreed for me to make payment for his/her bill with Dynamic Healthcare once his/her case has been concluded.

____________________ ______________________________
Date Attorney Signature
Counsel for ______________________

INSURANCE COMPLIANCE INFORMATION

We would like to take a moment to welcome you to our office and assure you that your treatment is our top priority. We find that many patients are very confused when using their insurance and are concerned about their financial obligations. This form is utilized to explain your responsibilities when our office files your insurance.

At Dynamic our staff provides you with all insurance filing at the time of service. We will verify all insurance benefits to assure your chiropractic/medical coverage's in full. However, we need to make you aware that these benefits are not a guarantee of payment and you will ultimately be responsible for all services that are not paid by your insurance company. It is very important that you understand that our office, as a service to our patients, will submit and make all attempts to collect all outstanding payments. We will not enter into any disputes with your insurance company. If your account remains in an outstanding status, our staff may request your help in expediting payment from your insurance company.

Each patient is required to meet their deductible in full before their insurance company will pay their portion. At this time, our staff will notify you of your out of pocket expense at your time of service. Most insurance company policies require a payment of 30%-50% of the patients visit. Our staff is required to collect this amount at the time of service. If your insurance policy requires a co-pay, this amount will be requested at the time of service. It has become a standard that doctors' request all payment in full at the time of service. Our office continues to service our patients the old fashion way and will do the work for you. This allows you to focus on your health.

Personal Injury Patient With Health Insurance:
If you were involved in an automobile accident and have a health care policy, our office will submit all charges at the time of service. You will not be responsible to pay for any deductible or co-pay at the time of service. Any outstanding balance will be reimbursed by your attorney when your case is settled.

What To Do When My Insurance Company Sends Me A Check:
Many insurance companies will send the member (patient) a check to your home instead of our office by accident. If this situation occurs, please be advised that you are to bring the check and accompanying explanation of benefits to the office so that it can be posted to your account.

What Do I Do If My Insurance Company Sends Me Forms That I Do Not Know How To Answer?
Many times an insurance company will send a patient a questionnaire for them to fill out. These forms purposely are used as stall tactics and are quite confusing for you to understand. When you receive these letters, please either call our office or bring them to our office manager for proper clarification.

Financial Consent/Patient Agreement:
I understand and agree to the services that my doctor has offered to me. I agree to be fully responsible for any services that are not paid by my insurance company and understand that my doctor will send all outstanding accounts to a collection agency after 60 days if not reconciled by the responsible party.

I am not an agent or representative of any insurance company or any other business trying to collect information. All injuries/problems mentioned are true and I am here solely for the treatment of the said problems.

Patient Initials: ________ Date: __________

IRREVOCABLE ASSIGNMENT, LIEN AND AUTHORIZATION
INSURANCE BENEFITS

TO WHOM IT MAY CONCERN:

I hereby authorize and direct you, my insurance carrier to pay directly to Dynamic such sums as may be due and owing this office for services rendered me, both by reason of accident or illness and by reason of any other bills that are due this office and withhold such sums from any disability benefits, medical payment benefits, no-fault benefits, health and accident, Workers' Compensation benefits, or any other insurance benefits obligated to reimburse me from any settlement, judgment or verdict on my behalf as may be necessary to adequately protect Dynamic I hereby further give lien to said office against any and all insurance benefits named herein and any and all proceeds of any settlement, judgment or verdict which may be paid to me as a result of the injuries or illness for which I have been treated for by Dynamic. This is to act as an assignment of my rights and benefits to the extent of the office's services provided.

I understand that I remain personally responsible for the total amounts due the office for services rendered. I further understand and agree that this Assignment, Lien and Authorization does not constitute any consideration for the office to await payments, and they may demand payments from me immediately upon rendering services at their option.

I authorize the office to release any information pertinent to my case to any insurance carrier or adjuster to facilitate collection under this Assignment, Lien and Authorization.

I further understand and agree that if Dynamic must take any action to collect an outstanding balance on this account, I will be responsible for payment of and will reimburse this office for all costs of such collection efforts, including but not limited to all court costs and all attorney fees.

_______________________________(SEAL)　　　　　________________
Patient Signature　　　　　　　　　　　　　　　　　Date

____
Insurance Company Name and Address　　　　　　　　Attorney Name, Address, and Phone

PATIENT ACKNOWLEDGEMENT OF
RECEIPT OF NOTICE

I hereby acknowledge receipt of the Notice of Privacy Practices for Dynamic regarding my health information. I have been informed and understand the manner in which my health information shall be maintained, utilized and disclosed by Clinic and my respective rights contained there in. I also understand that the Notice furnished to me is subject to change at any time. I am aware that I may obtain a current copy of this Notice at any time by contacting Dynamic 3707 Chamberlain Ln Louisville, KY 40241 (502) 426-9200

My signature herein below constitutes full acknowledgement that I have furnished a copy of the Notice of Privacy Practices for Dynamic

PRINT Patient's Name:______________________________________

SIGNATURE of Patient:_____________________________Date:__________

SIGNATURE of Parent or Guardian:____________________Date:__________

Witness:____Date:__________

Patient Name: ______________________ Date: ____________

HIPAA/PRIVACY NOTICE

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.

In the course of your care as a patient Dynamic, we may use or disclose personal and health related information about you in the following ways:

- Your personal health information, including your clinical records, may be disclosed to another healthcare provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.
- Your healthcare records as well as your billing records may be disclosed to another party, such as an insurance carrier, an HMO, a PPO, or your employer, if they are or may be responsible for the payment of your services.
- Your name, address, phone number, and healthcare records may be used to contact you regarding appointment reminders, information about alternative to your present care, or other health related information that may be of interest to you.

If you are not at home to receive an appointment reminder, a message may be left on your answering machine. Furthermore, you have the right to inspect or obtain a copy of the information we will use for these purposes. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization it will not affect the care provided to you or the reimbursement avenues associated with your care.

Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in the following circumstances:

- If we are providing healthcare to you based on the orders of another healthcare provider.
- If we provide healthcare services to you in an emergency.
- If we are required by law to provide care to you and we are unable to obtain our consent after attempting to do so.
- If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.
- If we are ordered by the courts or another appropriate agency.

Any use or discloser of your protected health information, other than as outlined above, will only be made upon your written authorization.

We normally provide information about your health to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your healthcare or about the status of your account. If you would like to receive this information at an address other than your home or if you would like the information in a different form, please advise us in writing as to your preferences.

You have the right to inspect and/or copy your health information for seven years from the date that the record was created or as long as the information remains in our files. In addition you have the right to request an amendment to your health information. Requests to inspect, copy or amend our health related information should be provided to us in writing.

We are required by state and federal law to maintain the privacy of your patient file and the protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information.

We are further required by law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice we will notify you in writing as soon as possible following the information that we use or disclose based on this privacy notice may be subject to re-discloser by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities you should direct your complaint to: Kristin Miricle. If you would like further information about our privacy policies and practices please contact: Krisitin Miricle.

This notice is effective as of December 1, 2011. This notice, and any alterations or amendments made hereto will expire seven (7) years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

______________________	______________________	______________
Name (Print)	Signature	Date

Patient Name: ______________________ Date: ____________

TERMS OF ACCEPTANCE AND CONSENT FOR CARE

The clinic will attempt to identify and diagnose any ailments you may have that may be corrected through physical medicine, massage therapy, chiropractic care, and/or active/passive rehabilitation. If any condition or disease appears to be present out of our scope of practice, we will refer you to an appropriate physician to diagnose and/or treat that condition. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare cases underlying physical defects, deformities or pathologies, may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare, if he/she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known these things which otherwise might not come to the attention of the physician (deformities, illnesses, etc).

I agree to settle any claim or dispute I may have against or with any of these persons or entities, whether related to the prescribed care or not, by binding arbitration under the current malpractice terms which can be obtained by written request.

I also understand that the fee paid for treatment x-rays is for analysis only. The file itself is the property of this office. Once films are taken, they cannot be released, but may be copied. There is a fee for copying of the xrays.

Also, for your protection, portions of our office where patients do not disrobe are under video surveillance, specifically, but not limited to, the front desk check-out stations.

I have read and I accept the terms above and understand them fully. I hereby give consent to the clinic to evaluate me to determine my condition and treat me for such conditions. I also understand that I may at any time discontinue with the exam and/or x-rays or any treatment if I so choose.

I also understand that if I suspend or terminate my care at this office, any outstanding charges for professional services rendered to me will be immediately due and payable. I agree that I will be responsible for all attorney and legal fees if legal action becomes necessary to collect this amount.

I, ______________________ have read and fully understand the above statements.
(PRINT NAME)

______________________ ______________________
(SIGNATURE) (DATE)

FOR MINORS: I, ______________________ being the parent or legal guardian of ______________________,
(Print Guardian Name) *(Print Minor's Name)*
have read and fully understand the above terms of acceptance & grant permission for my child to receive treatment.

______________________ ______________________
(SIGNATURE) (DATE)

X-ray Questionnaire: For women only Our consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze your condition. Should x-rays be necessary we would like to confirm that you are not pregnant at this time.

Name: ______________________ Date of last menstrual period: ______________

☐ There is a possibility that I a may be pregnant at this time
☐ No, I am definitely not pregnant at this time
☐ Yes, I am definitely pregnant
☐ I request that x-ray films not be taken because:

______________________ ______________________
Patient's Signature Date