West OC Chiropractic
3611 S. Harbor Blvd. Suite 180 Santa Ana, CA 92704
tel: (949) 409-4002 I fax: (833) 931-0192
www.westocchiropractic.com

1 PATIENT INFORMATION

Patient Name: Dr./Mr./Mrs./Ms._____
Last Legal First Middle Initial

Today's Date:_____Phone #:(___)_____Cell #:(___)_____

E-mail:_____

Address:_____City:_____ State:_____ Zip:_____

Age:_____ Birth Date:___/___/_____ Sex: ☐M ☐F DL #:_____

Please circle: Single/Married/Other:_____

In case of emergency contact:_____ Relationship:_____ Phone #:_____

Patient's Employer: _____

Work Address: _____City:_____State:_____ Zip:_____

Phone #: (___)_____Ext:_____ Occupation: _____

Who may we thank for referring you? Event you attended?: _____

_____

Preferred Appointment Reminder Method: ☐Text ☐Email ☐Card

2 PAYMENT/INSURANCE

Who is responsible for payment: ☐ Self ☐ Other (Relationship to patient) _____

Form of payment: ☐ Cash ☐ Credit Card ☐ Debit Card ☐ Insurance ☐ Personal Injury ☐ Other_____

INSURANCE (if applicable)

Name of Insurance:_____

Subscriber Name:_____ID Number: _____Group Number: _____

Address:_____City:_____ State:___ Zip:_____

Phone #:(____)_____ Birth Date: ___/___/___

Insured's Employer (if different from patient): _____ Phone #:(_____)_____

Work Address: _____ City:_____ State:___ Zip:_____

Note: *Fill out this section only if insured is different than patient.*

Subscriber Name:_____Relationship to insured: _____

Address: ☐ Same as above (If different fill out below)

Address:_____City:_____ State:___ Zip:_____

Phone #:( )_____ Birth Date: __/__/__

Insured's Employer (if different from patient): _____ Phone #:( )_____

Work Address: _____ City:_____ State:___ Zip:_____

3 CHIEF COMPLAINT

1. Are your present symptoms or conditions related to, or the result of an auto accident, work-related injury, or other personal injury *someone else might be legally liable for*? ☐ Yes ☐No
2. Chief Complaint:_____

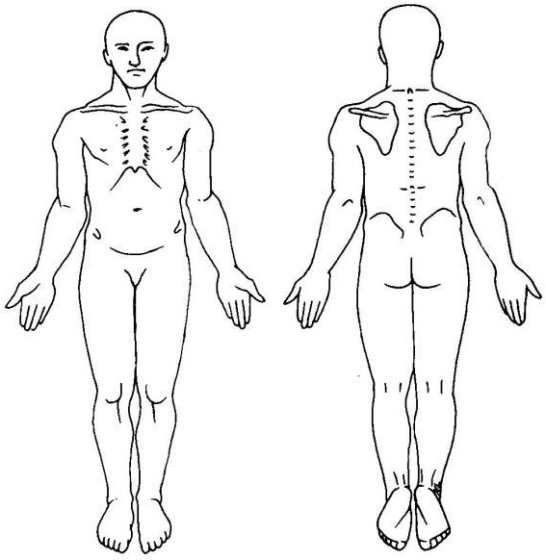
_____

3. When did your condition first begin? Year:_____Month:_____ Day/Date:_____
4. Is this condition getting progressively worse? ☐ Yes ☐No ☐Unknown
5. Have you had anything like this before? No/Yes: when?:_____
6. How often does the problem re-occur?:_____
7. Is the pain constant or does it come and go? _____
8. Does it interfere with your: ☐Work ☐Sleep ☐Daily Routine ☐ Recreation ☐N/A ☐Other:_____
9. What makes it feel better?_____
10. What makes it feel worse?_____
11. Type of pain: ☐Sharp ☐Dull ☐Throbbing ☐ Numbness ☐Aching ☐Shooting

☐Burning ☐Tingling ☐Cramps ☐ Stiffness ☐Swelling ☐Other_____

PLEASE MARK THE AREA(S) ON THE DIAGRAM WITH THE APPROPRIATE SYMBOL(S) FOR THE SENSATION(S) YOU FEEL:

ACHING: == SHARP/STABBING: // PINS & NEEDLES: 00 NUMBNESS: ++ BURNING: xx



PLEASE CIRCLE & PUT YOUR LEVEL OF PAIN NUMBER IN CIRCLE IN LEFT DIAGRAM:
(1=minimal pain; 10=worst pain imaginable)

PAIN CURRENTLY

1 2 3 4 5 6 7 8 9 10

4 MEDICAL HEALTH HISTORY

Have you ever been to chiropractor before? No/Yes, What for?_____

Are you, or might you be pregnant? No/Yes Do you have a pacemaker? No/Yes

What treatment have you already received for your condition?

☐NSAIDS	☐Medications	☐Surgery	☐Physical Therapy
☐Pain Meds	☐Chiropractic	☐None	☐Other:_____

In total how much time have you spent on any of the above treatments? ☐ 0-4 wks ☐ 4-8 wks ☐ More than 8 wks

Name and address of other doctor(s) who have treated you for your condition?_____

_____

When was your last physical exam?_____Results:_____

_____

Date of Last:
Physical Exam: _____ Spinal Exam: _____ Spinal X-ray: _____ Chest X-ray: _____

MRI, CT-Scan, Bone Scan: _____ Blood Test: _____ Urine Test: _____

Mark "Yes" or "No" to indicate whether you have experienced each of the following and complete the information below:

AIDS/HIV	☐Yes ☐No	Alcoholism	☐Yes ☐No	Hernia	☐Yes ☐No	Pinched Nerve	☐Yes ☐No
Allergies	☐Yes ☐No	Chicken Pox	☐Yes ☐No	Herniated Disk	☐Yes ☐No	Pneumonia	☐Yes ☐No
Anemia	☐Yes ☐No	Clotting Disorder	☐Yes ☐No	Hypertension	☐Yes ☐No	Prostate Problem	☐Yes ☐No
Anxiety/Depr.	☐Yes ☐No	Diabetes	☐Yes ☐No	Liver Disease	☐Yes ☐No	Psychiatric Care	☐Yes ☐No
Appendicitis	☐Yes ☐No	Eating Disorder	☐Yes ☐No	Migraines	☐Yes ☐No	Rheu. Arthritis	☐Yes ☐No
Arthritis	☐Yes ☐No	Emphysema	☐Yes ☐No	Mononucleosis	☐Yes ☐No	Stroke	☐Yes ☐No
Auto. Disorder	☐Yes ☐No	Epilepsy/Seizure	☐Yes ☐No	MS	☐Yes ☐No	Thyroid Diseases	☐Yes ☐No
Cancer	☐Yes ☐No	Heart Disease	☐Yes ☐No	Osteoporosis	☐Yes ☐No	Other:_____	

Please list all current **medications, vitamin/mineral supplements, herbs**, including dosage:_____

_____

_____

List any known **allergies**:_____

If you **smoke or have ever smoked**, describe how much, and for how long:_____

Describe **your** typical **alcohol intake** (#of drinks per day/per week):_____

Please list and describe all significant **previous injuries with dates** (**sprains, fractures, accidents,** etc.):_____

_____

_____

Please list and describe all significant **previous surgeries with dates**:_____

_____

Please list your usual forms of **exercise and sports**, **work activity, values (family, financial, mental, spiritual, social, physical, work)**:

5 FAMILY HISTORY

Please list any significant **health problems** of parents, grandparents, or siblings **(cancer, diabetes, heart disease, high blood pressure, kidney disease, migraines, stroke, thyroid, etc.)**:

Now comes a man. Any one man is a SMALL thing. This man gives an adjustment. The adjustment is a SMALL thing. The adjustment replaces the subluxation. That is a SMALL thing. The adjusted subluxation releases pressure upon nerves. That is a SMALL thing. The released pressure restores health to a man. That is a BIG thing to that man

-D.D. Palmer

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CONSENT TO CHIROPRACTIC CARE

Congratulations for choosing the safest and most natural health care program ever conceived: Chiropractic.
This painless, logical, and effective approach to health has been serving everyday people for over 100 years. It is licensed in every state, and in many countries as well. Chiropractic has the least chance of side effects of any other type of health care. Mild headaches and muscles soreness may sometimes occur.

Let's look at a few statistics about possible serious side effects:

The #1 cause of death in the US is from correctly and incorrectly prescribed pharmaceutical drugs. (CDC, FDA, NIH sites, also Gary Null: Death By Medicine)
Stroke is one of the most common causes of death in the US. With people going to doctors all the time it is probable that many will have had a recent doctor visit. But causation is another matter entirely.
There is no absolutely known material risk of chiropractic care being greater than risks from medical treatment. In fact, when all the factors are taken together, deaths and injuries from a combination of medical mistakes and intentional drugs dwarf any injuries from chiropractic.

Risk of stroke from chiropractic? Virtually zero chance of stroke from chiropractic. The largest study ever done- the 2008 study in Canada- www.belleviewchiro.com/index.php?p=213660- looking at 12 million people over 9 years, showed that 53% of strokes had visited their MD within 30 days prior, while only 4% had visited their DC. No evidence of excess risk of stroke associated with chiropractic care.
In 2001 the Canadian Medical Association Journal found there is only a one-in-5.85-million risk that a cervical manipulation from an MD, PT, or DC would be followed by a stroke. Author David Cassidy, a professor of epidemiology at the University of Toronto said patients had already damaged the artery before seeking help from either a medical doctor or a chiropractor, and then the stroke occurred after the visit.
Speaking of risks associated with chiropractic, we should look also at the risk associated with NOT GETTING adjusted. This risk was one of the 4 components of risk in the Association of Chiropractic Colleges guidelines on informed consent in 2008. Disc degeneration, loss of mobility, loss of overall tone, decreased quality of life- these are real risks of the untreated spine as time goes by.
Doctors of Chiropractic who use manual therapy techniques are required to advise patients that there are or may be some risks associated with such treatment. In particular you should note:
a) While rare, some patients may experience short term aggravation of symptoms, rib fractures or muscle and ligament strains or sprains as a result of manual therapy techniques:
b) There are reported cases of stroke associated with many common neck movements including adjustments of the upper cervical spine. Present medical and scientific evidence does not establish a definite cause and *effect* relationship between upper cervical spine adjustment and the occurrence of stroke. Furthermore, the apparent association is noted very infrequently. However, you are being warned of this possible association because stroke sometimes causes serious neurological impairment, and may on rare occasion result in injuries including paralysis. The possibly of such injuries resulting from upper cervical spinal adjustment is extremely remote;
c) There is rare reported cases of disc injuries following cervical and lumbar spinal adjustments or chiropractic treatment.
Chiropractic treatment, including spinal adjustment, has been the subject of government reports and multi-disciplinary studies conducted over many years and has demonstrated to be effective treatment for many neck and back conditions involving pain, numbness, muscle spam, loss of mobility, headaches and other similar symptoms. Chiropractic care contributes to your overall well being. The risk of injuries or complications from chiropractic treatment os substantially lower than that associated with many medical or other treatments, medications, and procedures given for the same treatments.

I acknowledge the nature and purpose of chiropractic treatment in general and my treatment in particular (including spinal adjustment) as well as the contents of this Consent. I consent to the chiropractic treatments offered or recommended to me by my chiropractor, including spinal adjustment. I intend this consent to apply to all my present and future chiropractic care.

Please note, if you are a minor under age of 18, a parent or legal guardian must sign this consent form authorizing West OC Chiropractic to provide treatment to the underage patient.

_____	_____	_____
Patient Name	Signature	Date
_____	_____	_____
Parent/Legal Guardian Name	Signature	Date

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WEST OC CHIROPRACTIC NOTICE OF PRIVACY PRACTICES

We care about our patients' privacy and strive to protect the confidentiality of your medical information at this practice. New federal legislation requires that we issue this official notice of our privacy practices. You have the right to the confidentiality of your medical information, and this practice is required by law to maintain the privacy of that information.

This practice is required to abide by the terms of the Notice of Privacy Practices currently in effect, and to provide notice of its legal duties and privacy practices with respect to protected health information. If you have any questions about this Notice, please contact the Privacy Officer at this practice.

Who will follow this notice?

Any health care professional authorized to enter information into your medical record, all employees, staff and other personnel at this practice who may need access to your information must abide by this Notice. All subsidiaries, business associates (e.g. a billing service), sites and location of this practice may share medical information with each other for treatment, payment purposes or heath care operation as stated in this Notice. Except where treatment is involved, only the minimum necessary information needed to accomplish the task Will be shared.

How We May Use and Disclose Medical Information About You

The following categories describe different ways that we may use and disclose medical information without your specific consent or authorization. Examples are provided for each category *of* uses *or disclosures. Not all possible uses or disclosures* are *listed.*

For Treatment: We may use medical information about you to provide you with medical treatment or services. Example: In treating you for a specific condition, we may need to know if you have allergies or prior injuries or surgeries that could influence our treatment process.

For Payment: We may use and disclose medical information about you so that the treatment and services you receive from us may be billed and payment collected from you, an insurance company or a third party. Example: We may need to send your protected health information, such as your name, address, office visit date, and codes identifying your diagnosis and treatment to your insurance company for payment

For Health Care Operations: We may use and disclose medical information about you for health care operations to assure that you receive quality care. Example: We may use medical information to review our treatment and services and evaluate the performance of our staff in caring for you.

Other Uses or Disclosures That Can be Made Without Your Consent or Authorization

- As required during an investigation by law enforcement agencies
- To avert a serious threat to public health or safety
- As required by military command authorities for their medical records
- To worker's compensation or similar programs for processing of claims
- In response to a legal proceeding
- To a coroner or medical examiner for identification of a body
- If an inmate. to the correctional institution or law enforcement official
- As required by the US Food and Drug Administration {FDA)
- Other healthcare providers treatment activities
- Other covered entities' and providers' payment activities
- Other covered entities' healthcare operations activities (to the extent permitted under HIPPA)
- Uses and disclosures required by law
- Uses and disclosures in domestic violence or neglect situations
- Health oversight activities

- Other public health activities

We may contact you to provide appointment reminders or information about treatment and other health related benefits and services that may be of interest to you.

Uses and Disclosures of Protected Health Information Requiring Your Written Authorization

Other uses and disclosures of medical information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you give us authorization to use or disclose medial information about your, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will thereafter no longer use or disclose medical information about you for the reasons covered by your written authorization. We are unable to take back any disclosures we have already made with your authorization and we are required to retain our records of the care we have provided you.

Your Individual Rights Regarding:

Disclosures and Changes to Your Medical Information

Right to Request Restrictions: You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or heath care operations or to someone who is involved in your care or the payment of your care. We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment. To request restrictions, you must submit your request in writing to the Privacy Officer at this practice. In your request you must tell us what information you want to limit.

Right to an Accounting of Non-standard Disclosures: You have the right to request a list of the disclosures we made of medical information about you. To request this list, you must submit your request in writing to the Privacy Officer at this practice. Your request must state the time period for which you want to receive a list of disclosures that is no longer than six years, and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (example: paper or electronically). The first list you request within a 12-month period will be free. For additional lists, we reserve the right to charge you for the cost of providing the list.

Right to Amend: If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept. To request an amendment, our request must be made in writing and submitted to the Privacy Officer at this practice. In addition you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition we may deny your request if the information was not created by us, is not part of the medical information kept at this practice, is not part of the information which you would be permitted to inspect and copy, or which we deem to be accurate and complete. If we deny your request for amendment, you have the right to file statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Statements of disagreement and any corresponding rebuttals will be kept on file and sent out with any future authorized requests for information pertaining to the appropriate portion of your record.

Your Access to Medical Information

3611 S. Harbor Blvd. Suite #180
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Right to Inspect and Copy: You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually this includes medical and billing records but does not include psychotherapy notes, information compiled for use in a civil, criminal or administrative action or proceeding, and protected health information to which access is prohibited by law. To inspect and copy medical information that may be used to make decisions about your, you must submit your request in writing to the privacy officer at this practice. If you request a copy of the information, we reserve the right to charge a fee for the costs of copying, mailing or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed heath care professional chosen by this practice will review your request and the denial. The person conducting the review will not be that person who denied your request. We will comply with the outcome of the review.

Right to a Paper Copy of This Notice: You have the right to a paper copy of this Notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy. To obtain a paper copy of the current notice, please request one in writing from the Privacy Office at this practice.

Right to Request Confidential Communications: You have the right to request how we should send communications to you about medical matters, and where you would like those communication sent. To request confidential communication, you must make your request in writing to the Privacy Officer at this practice. We will not ask you the reason for your request. We will accommodate any reasonable requests. Your request must specify how or where you wish to be contacted. We reserve the right to deny a request if it imposes an unreasonable burden on the practice.

Complaints. If you believe your privacy rights have been violated, you may file a complaint with the Privacy Officer at this practice or with the Secretary of the Department of Health and Human Services. All complains must be submitted in writing. You will not be penalized or discriminated against for filing a complaint.

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RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

I _____, have received a copy of West OC Chiropractic's Notice of Privacy Practices.

_____

Print Patient's Name

_____

Patient Signature or Legal Guardian

_____

Date:

For Office Use Only
If patient wishes not to sign this notice, please indicate time and date notice was given, also state reason and provide documentation that the patient refused to sign waiver.
(Employee signature is sufficient)

West OC Chiropractic Financial Agreement

We will work diligently with your insurance company to ensure your claims are processed and paid. Ultimately, if the insurance company denies payment, it may become your responsibility to render payment for services. We work hard to ensure you receive the best treatment possible and working together is necessary for this approach. Please notify WEST OC CHIROPRACTIC when a credit card number has changed or expired.

PLEASE READ EACH BULLET POINT.

- If my insurance company does not make payment to WEST OC CHIROPRACTIC for services rendered, I will become personally responsible for the charges. I will have **15 days** to clear my account by calling my insurance company after being notified by this office. If the account is not cleared **within 15 days**, I hereby authorize WEST OC CHIROPRACTIC to charge any outstanding amount to my credit card.

- Insurance checks that I receive will be promptly brought to the office. Inability to do so **within 30 days of receipt of insurance checks** authorizes WEST OC CHIROPRACTIC to charge the credit card on file for the unpaid charges on my account.

- Cash balance on my account will be paid within **30 days of notification** of the amount owed. If a balance remains past 30 days, I hereby authorize WEST OC CHIROPRACTIC to charge the full amount to my credit card on file.

- When not using health insurance for my treatment, I authorize the use of this card ***for payment of services rendered at WEST OC CHIROPRACTIC at the time services are rendered until written notice is provided to terminate.*** (i.e. Physical Therapy, Acupuncture and Chiropractic copays, massages, medical payments, etc.)

- I understand there is a **$35.00 NO SHOW / SAME DAY CANCELLATION FEE** for all services except chiropractic, unless a 24-hour notice is provided prior to appointment.

I authorize the above named business to charge the credit card indicated in this authorization form for services rendered. I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company when charged for services rendered.

I understand and agree to all the information written above.

Patient's Name: _____

Cardholder's Name:_____

Credit Card Number:_____

Expiration Date: _____ CVC: _____

Cardholder's Signature:_____ Date: _____

West OC Chiropractic Financial Agreement

Fess associated with personal injury claims may be different from previous charges due to med-legal documentation requirements and necessity. If you have questions or would like to be informed of these fees, please ask the front desk or the doctor and we will be happy to assist you.

Print Name: _____

Signature: _____ Date: _____

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WEST OC CHIROPRACTIC ASSIGNMENT OF PROCEEDS, CONTRACTUAL LIEN AND AUTHORIZATION

I herby direct any and all insurance carriers, attorneys, agencies, governmental departments, companies, individuals, and/or other legal entities which may elect or be obligated to pay benefits to me for any medical conditions, accidents, injuries, or illnesses, past or future, to pay directly to and exclusively in the name of, West OC Chiropractic. WOCC such sums may be owing to WOCC for charges incurred by me, including but not limited to, charges for treatment, narrative reports, depositions, testimony, and any other charges incurred by me at the office. I further grant a contractual lien to WOCC with respect to my charges, applicable to all payers, however, I understand that nothing in this agreement shall be construed as an election by WOCC to claim protection under any statutory lien law. For the purposes of this agreement, "benefits" shall include, but shall not be limited to , proceeds from any settlement, judgment, or verdict, as well as any process relating to commercial health or group insurance, disability benefits, worker's compensation benefits, medical payments benefits, personal injury protection, lost wages benefits, lost services benefits, no-fault coverage, uninsured motorist coverage, third-party liability distributions, malpractice proceeds, attorney retainer agreements, and any other benefits or proceeds payable to me for the purposes stated herein, regardless of whether such proceeds are related to my charges or not.

I further agree that, in the event a payer refuses to pay WOCC, I herein assign, insofar as permitted by law, all of my rights, remedies, and benefits to WOCC to extent of my charges, as well as any and all causes of action that I might have against such payer, to prosecute such causes of action either in my name or in the Office's name, and to settle or otherwise resolve such causes of action as the office sees fit.

In the event that I retain one or more attorneys to represent me in this matter, I will direct each attorney to issue a letter of protection to this office regarding my charges. Upon issuance, I hereby agree that such letter(s) of protection cannot be revoked or modified without the expressed written consent of this office. I further direct each attorney to provide immediate notice of to the office regarding any funds received by the attorney relating to my accident, to promptly pay such office, and to provide a full accounting of such funds to the office upon its request.

I herby direct payers to release to WOCC any information regarding any coverage or benefits which I may have including, but not limited to, the amount of the coverage, the amount paid thus far, and the amount of any outstanding claims.

I authorize this office to release any information regarding my treatment or pertinent to my case(s) to all payers as defined above to facilitate collection under this Agreement. I hereby direct this office to file a copy of this agreement, together with any applicable charges, with any or all payers, regardless of whether a claim has been established with said payers. I hereby authorize WOCC to endorse/sign my name on any and all checks listing me as a payee, which are presented to this office for payment of an account relating to me, my spouse, or any of my dependents. I further authorize WOCC to apply any credit balances incurred by me to any other outstanding charges still owed by me, my spouse, or my dependents, regardless of whether these other charges are related to my condition.

I understand that I remain personally responsible for the total amounts due WOCC for their services. This agreement does not constitute any consideration for this office to await payments and it may demand payments from me immediately upon rendering services at its option. If this office must take action to collect any outstanding balance on my account, I will be responsible for payments and will reimburse WOCC for all costs of such collection efforts, including, but not limited to, all court costs and all attorney fees.

This agreement shall not be modified or revoked without the mutual written consent of WOCC and myself. I hereby revoke any previously sign authorization, whether executed at this office or any other office to the extent that the terms of those authorizations conflict with the terms of this agreement.

I agree that each and every provision of this agreement is reasonable necessary for the protection of the rights and interests of WOCC and myself. However, should any provision of this agreement be found to be invalid, illegal or unenforceable or for any reason cease to be binding on any party hereto, all other portions and provisions for this agreement shall, nevertheless, remain in full force and effect.

I agree to have my attorney withhold sums from any settlement due and owing to West OC Chiropractic.

Patient Name (please print): _____

Patient/Legal Guardian Signature: _____Date: _____/_____/_____

Name of attorney (please print): _____Date: _____/_____/_____

Attorney Signature: _____Date: _____/_____/_____

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Personal Injury Information

1. **DATE OF ACCIDENT: _____/_____/_____ _____**

YOUR AUTO INSURANCE INFORMATION

Please provide us with a copy of your Auto Insurance Declaration Page from your policy so we can verify your coverage in our office

a. Name of Insurance Company: _____

b. Name of policy holder: _____

c. Policy # _____

d. Claim # _____

e. Adjuster's Name & Phone #: _____

f. Do you have health care coverage on your auto insurance? _____

g. Has this accident been reported to your insurance? _____

2. **3RD PARTY INFORMATION**

a. Name of 3rd party: _____

b. 3rd Party Auto Insurance company: _____

c. Claim #: _____

d. 3rd party auto insurance claims adjuster & phone #: _____

3. **PROPERTY DAMAGE AMOUNT: $_____**

4. **TYPE OF CAR YOU WERE DRIVING**

Year_____ Make_____ Model_____

Damage was done to: _____

5. **YOUR HEALTH INSURANCE INFORMATION**

a. Name of health Insurance company:_____

b. Name of insured:_____

c. Social Security # of insured: _____

d. ID # _____

6. **DO YOU HAVE AN ATTORNEY AND COMPLETED PAPERWORK? YES_____ NO_____**

Attorney Information:

Name: _____ Case Manager: _____ email:_____

Address:_____ Phone #:_____

3RD PARTY INSURANCES DO NOT PAY THE DOCTORS, THEY NEGOTIATE PAYMENT WITH THE PATIENT AND MOST TIME PRIOR TO COMPLETING TREATMENT, THEREFORE, WE DO NOT BILL 3RD PARTY INSURANCE DIRECTLY UNLESS THEY HAVE CONTACTED OUR BILLING MANAGER AT westocchiro0@gmail.com TO GUARANTEE IN WRITING THERE WILL BE DIRECT PAYMENT TO WEST OC CHIROPRACTIC.

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Personal Financial Policy

The doctors and staff at West OC Chiropractic are excited to have you as a patient. Please allow us to introduce our office policies to you in order for us to accept you as a Personal injury patient.

Please read the following options for billing and re-imbursement of your care here in our office. Please ask us if you have any questions regarding the following questions:

____Option 1	A personal auto policy that has medical payment coverage in excess of $2500
____Option 2	A personal health insurance coverage that will cover the cost of your care
____Option 3	Have an attorney retained to represent your interest and will guarantee payment of your chiropractic bill once your treatment has been completed.
____Option 4	Pay for your care at time of services rendered.

*A majority of patients will be able to take advantage of using a combination of the first three options. If you require help retaining an attorney please let your doctor know and he will be happy to help you. It costs the same for a good or a bad attorney. We know the good ones!

Please understand it is against our office policy to accept a personal injury case where the only source of payment for our care is through third party insurance carries. Third party refers to insurance coverage carried by someone other than yourself. For example, the insurance of the owner of the other vehicle involved in an accident.

It is our experience that your best interests are served by reporting your accident to your insurance carrier (which is a requirement for us to accept your personal injury case). You pay your insurance premium on a monthly basis and in some cases for years without even using it. Be sure to let your insurance carrier know you have had an accident and want to make a claim so we can take care of your financial needs in regards to your care.

_____ Initials

In some cases, your insurance carrier will attempt to have you only pursue the other party's insurance (third party insurance) for re-imbursement of your care. Let your insurance know that you have been paying for month after month to take care of your needs if at all possible.

I_____ understand the financial policy of West OC Chiropractic. I would like to use the options checked above. I understand that I am ultimately responsible to pay for my care. I will provide all the information that is necessary to make a claim for my care. If at any time there is a change with any of the options above, I will immediately notify West OC Chiropractic to make alternate arrangements.

Patient Name (please print): _____

Patient Signature: _____

Date: ____/____/_____

AUTO / WORK RELATED ACCIDENT

one

two a

two b

ABOUT YOU

Today's Date: ___/___/___ File #: _____

Name: _____

WORK RELATED ACCIDENT

Date & Time of Accident: _____ ❑ a.m. ❑ p.m.

Was your accident directly related to your work?
❑ Yes ❑ No

Briefly describe the events that occurred just before and during your accident: _____

_____

_____

Give the address where accident occurred: (if other than employer's address) _____

_____

Was anyone else present during your accident?
❑ Yes ❑ No

Did you report your accident to your employer?
❑ Yes ❑ No

What recommendations did your employer make just after your accident? _____

_____

Has this type of accident happened to you before?
❑ Yes ❑ No

To the best of your knowledge, has this accident occurred in your workplace before? . . . . . ❑ Yes ❑ No

In general:

Is your job physically stressful? . . . . . ❑ Yes ❑ No
Is your job mentally stressful? . . . . . ❑ Yes ❑ No
Is your workplace noisy? . . . . . ❑ Yes ❑ No
Have you changed jobs in the last year? ❑ Yes ❑ No

AUTO RELATED ACCIDENT

Date & Time of Accident: _____ ❑ a.m. ❑ p.m.

Were you the: ❑ Driver ❑ Front Passenger ❑ Rear Passenger

If a traffic violation was issued, to whom was it issued?

_____

Number of people in accident vehicle? _____

Did the police come to the accident site? . . ❑ Yes ❑ No
Was a police report filed? . . . . . ❑ Yes ❑ No
Were there any witnesses? . . . . . ❑ Yes ❑ No
Were you wearing your seat belt? . . . . . ❑ Yes ❑ No
Was this vehicle equipped with airbags? . . ❑ Yes ❑ No
If yes, did it/they inflate? . . . . . ❑ Yes ❑ No

In relation to the base of your skull, where was the headrest? . . . . . ❑ Above ❑ Below ❑ At base of skull

What did your vehicle impact? ❑ Another vehicle ❑ Other

If other, explain: _____

Did any part of your body strike anything in the vehicle? ❑ Yes ❑ No

If yes, please describe: _____

_____

Make & model of the vehicle you were occupying?

_____

Name of the location/street on which you were traveling?

_____

In which direction were you headed? ❑N ❑S ❑E ❑W

What was the approx. speed of your vehicle? _____

Did the impact to your vehicle come from the:
❑ Front ❑ Rear ❑ Right Side ❑ Left Side ❑ Other

During impact, were you facing: ❑ Right ❑ Left ❑ Forward

Were you ❑ aware or ❑ surprised by the impact?

If accident vehicle made impact with another vehicle...

Make and model of that other vehicle? _____

_____

Direction other vehicle was headed? ❑N ❑S ❑E ❑W

Speed of the other vehicle? _____

In your words, please describe the accident: _____

_____

_____

_____

PLEASE CONTINUE ON BACK

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AFTER INJURY

Did accident render you unconscious? . . . . ❑ Yes ❑ No

If yes, for how long? _____

Please describe how you felt immediately after the accident:

_____

_____

Have you gone to a Hospital or seen any other Doctor? ❑ Yes ❑ No

When did you go? ❑ Just after accident ❑ The next day ❑ 2 days plus

How did you get there? ❑ Ambulance or ❑ Private transportation

Name of Hospital and/or Attending doctor: _____

_____

Was he/she a: ❑ D.C. ❑ M.D. ❑ D.O. ❑ D.D.S.

Describe any treatment you received: _____

_____

Were X-rays taken? . . . . . ❑ Yes ❑ No

Was medication prescribed? . . . . . ❑ Yes ❑ No

Have you been able to work since this injury? ❑ Yes ❑ No

Are your work activities restricted as a result of this injury? ❑ Yes ❑ No

Indicate ☑ the symptoms that are a result of this accident:

❑ Dizziness	❑ Difficulty sleeping	❑ Jaw problems	❑ Nausea
❑ Memory loss	❑ Irritability	❑ Arms/Shoulder pain	❑ Back pain
❑ Headache(s)	❑ Fatigue	❑ Numb Hands/Fingers	❑ Lower back pain
❑ Blurred vision	❑ Tension	❑ Chest pain	❑ Back stiffness
❑ Buzzing in ear	❑ Neck pain	❑ Shortness of breath	❑ Leg pain
❑ Ears ringing	❑ Neck stiff	❑ Stomach upset	❑ Numb Feet/Toes

❑ Other _____

Is your condition getting worse?

❑ Yes ❑ No ❑ Constant ❑ Comes & goes

Indicate your degree of comfort while performing the following activities:

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

Have you retained an attorney: ❑ Yes ❑ No

If yes, whom: _____

His/Her Phone #: _____

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RECOVERY

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

How many hours are in your normal work day? _____

Please indicate ☑ your daily job duties and any activities which you are occasionally asked to perform.

❑ Standing	❑ Driving	❑ Operating equipment
❑ Sitting	❑ Twisting	❑ Work with arms above head
❑ Walking	❑ Crawling	❑ Typing
❑ Lifting	❑ Bending	❑ Stooping

❑ Other _____

What positions can you work in with minimum physical effort and for how long? _____ ❑ N/A

Prior to the injury were you capable of working on an equal basis with others your age? . . ❑ Yes ❑ No ❑ N/A

Do you work with others who can help you with any heavy lifting? . . . . . ❑ Yes ❑ No ❑ N/A

While in recovery, is there any light duty work you could request? . . . . . ❑ Yes ❑ No ❑ N/A

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ADDITIONAL INSURANCE

2nd Insurance Source or Auto Insurance

Type of Insurance: _____

Co. Name: _____

Address: _____

Phone #: _____

Insured's Name: _____

Policy #: _____ Claim #: _____

Insured's SS #: _____ D.O.B. ___/___/___

Insured's Employer: _____

Agent's Name: _____

If any of your medical or account information has changed, please inform our front desk personnel.

Please remember you are ultimately responsible for your account.

_____ SIGNATURE _____ / / DATE

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PLEASE RECYCLE SO THAT WE MAY PRESERVE THE HEALTH OF OUR PLANET

West OC Chiropractic

3611 S. Harbor Blvd. Suite 180 Santa Ana, CA 92740
Tel: (949) 409-4002 Fax: (833) 931-0192

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize _____ to release healthcare information of the patient named above to:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: _____

_____

☐ All healthcare information

☐ Other: _____

☐ Yes ☐ No I authorize the release of any records regarding chiropractic treatment, XRAYS, and progress notes to the person(s) listed above.

Patient Signature: _____ Date Signed: _____

THIS AUTHORIZATION EXPIRES ONE YEAR AFTER IT IS SIGNED.

Understanding Insurance after your Accident

Our office is here to help during these challenging times after an accident which is why we want to take a moment to explain your options after an accident. Determining insurance coverage after a car accident can be a difficult challenge because not only do you have to stress about getting your car fixed but many times you are in pain and frustrated by the process of seeking treatment.

Our office will perform a FREE insurance verification to determine your benefits and assist you in the process. This will help to determine the best route to take because we want to try our hardest to make sure that there is No out-of-pocket expense for you after an accident.

Does your Health Insurance have coverage?
Typically, your health insurance will assist with payment after we have sent medical bills to the auto-insurance. Every Californian is required to carry car insurance and most of these plans will have medical coverage associated with them to take care of your treatment after an accident. Some auto-insurance will require the office to send in claims initially to health insurance for a denial letter (i.e. Mercury) then charges will be re-submitted for payment to the auto insurance provider. This will all be determined during our Free insurance verification in the office.

Does my Auto insurance have a role in this process if the accident was not my fault?
Every individual who drives is required to carry auto insurance in California. The easiest and most stress-free route to have your treatment covered is to send it to your auto insurance and have them take care of the charges, which they will later be refunded by the auto insurance of the individual who was at fault. This does NOT have any negative effect on your insurance if you are not at fault and being a policy holder with your insurance carrier makes it much easier for you and our office to communicate with them about your needs and care in our office. This allows you to receive chiropractic care, massage, acupuncture, etc. with No out-of-pocket cost after an accident and requires little effort on your part because our office can communicate directly with the insurance company on your behalf.

What role does 3rd party Auto insurance (aka the person at faults insurance) have with my treatment?
The individual at fault for the accident is ultimately responsible for payment and having their insurance refund treatment cost to your insurance company. However, the 3rd party insurance adjuster has one specific job after their insured is responsible for an accident. That is to close out the case and have you sign off on liability for the cheapest amount possible. This often leads to dishonest tactics such as them telling the victims of accidents inaccurate information such as, "you must pay for treatment out of pocket, then will be reimbursed at the end of care." Or they make statements minimizing the effects of the accident even though these claims adjusters have no medical training.

Many of these insurance carriers are publicly traded companies and their goals are driven by profits over people. When we contact the insurance of the individual responsible for the accident many times the claims adjusters will not give us any necessary information to help you with your care. This is because they want the person who was hit by their insured to be stuck with the numerous phone calls and hassle of getting their car fixed and treatment paid for. When our office contacts them on your behalf they typically offer little to no information because they state that they have no liability to our office. Therefore, the patient will need to contact them directly

for resolution of the matter. This is done for two reasons. Number one is our office is well trained in dealing with insurance matters after an accident, so they seek to misinform or set more favorable settlement terms for themselves with the victim in the accident and number two is the more work they create for the accident victim the more quickly the individual will seek to close out the claim.

It is a widespread practice over the past several years for these insurance companies to offer a low offer of $500 to $1000 to sign off on liability for the accident, but they won't tell you that you are now 100% liable for any future medical costs after this accident and if a doctor determines you need further testing then it could cost you thousands of dollars out of pocket. This is why it is always a good idea to consult your doctor or attorney before signing any insurance documents to make sure that what you are signing is in your best interest. These dishonest practices are why our office will try to avoid dealing with 3rd party insurance after an accident so we can provide the necessary care after your accident with the least amount of stress and work on your part as possible. If it is a 100% necessary that you require us to bill the 3rd party insurance carrier then it is highly recommended that you be represented by an attorney to avoid them from taking advantage of you during this vulnerable time. If you need a referral to an honest reputable attorney our office can assist you with finding one that will not cost you anything out of pocket because they only take a percentage of the settlement payment they obtain from the insurance for you.

Our #1 goal is to make sure we take the best care of you possible during this challenging time. This includes trying to keep your hard-earned money where it belongs, in your pocket. We appreciate your co-operation with our office policies which allow us to offer the best quality care available. If you have any questions please feel free to discuss this with your doctor or our office billing specialist.