OPTIMAL CHIRO-REHAB CENTER
8303 Arlington Blvd, Suite 202
Tel. 703-573-4773
Fairfax, VA
Fax. 703-573-2552
22031
www.oc-rc.com

# [AUTO ACCIDENT PATIENT FORMS]

| Today's date: | Primary Care Physician: |
|---|---|

## PATIENT INFORMATION

| **Patient's last name:** | **First:** | **Middle:** | ❑ Mr. ❑ Miss ❑ Mrs. ❑ Ms. | Marital status (circle one) Single / Mar / Div / Sep / Wid |
|---|---|---|---|---|

| **Is this your legal name?** | **If not, what is your legal name?** | **(Former name):** | **Birth date:** | **Age** | **Sex:** |
|---|---|---|---|---|---|
| | | | | | |

| Street address: | Social Security no.: - - | Home phone: ( ) |
|---|---|---|
| City: / State: / ZIP Code: | | Cell phone: ( ) |
| Occupation: | Employer: | Work phone: ( ) |
| Email address: | | |

## IN CASE OF EMERGENCY

| Name of local friend or relative (not living at same address): | Relationship to patient: | Phone No. : ( ) |
|---|---|---|
| | | |

## INSURANCE/CLAIM INFORMATION

| |
|---|
| Insurance Name: |
| Policy Number: |
| Claim Number: |
| Attorney/Representative Name: |
| Phone Number: ( ) Fax Number: ( ) |
| Referring Doctor: Phone Number: ( ) |

## PAST MEDICAL HISTORY

| **Have you ever:** | | | **Explanation/Dates of Treatment** |
|---|---|---|---|
| Broken bones? | ❑NO | ❑YES | |
| Been hospitalized? | ❑NO | ❑YES | |
| Any previous auto accidents? | ❑NO | ❑YES | |
| Previous sprains/strains? | ❑NO | ❑YES | |
| Are you pregnant? | ❑NO | ❑YES | |
| Are there any other conditions that we should be aware of? | ❑NO | ❑YES | |

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## AUTO ACCIDENT HISTORY

**Nature of injury:**
❑ Automobile
❑ Work
❑ Other

**In your own words, please describe the accident:**

**Date of Accident:**

( / / )

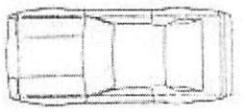
**Time of Accident:**

_____:_____ AM/PM

**Weather:**
❑ Snowing ❑ Raining
❑ Foggy ❑ Clear
❑ Windy

**Visibility:**
❑ Poor ❑ Fair ❑ Good

**Where was your car struck?**

FRONT  REAR

**Damages to your vehicle:**
❑ Mild
❑ Moderate
❑ Extensive
❑ Totaled

**Who Hit Who/What:**
❑ Patient hit other vehicle
❑ Other vehicle hit patient
❑ Patient hit other Object

**Point of Impact:**
❑ Front ❑ Rear
❑ Left Front ❑ Left Rear
❑ Right Front ❑ Right Rear
❑ Left Side ❑ Right Side

| | |
|---|---|
| Were you wearing your seatbelt? | ❑ Yes ❑ No |
| Does your car have headrests?<br>**If yes, what was the position?**<br>❑ Even with top of head<br>❑ Even with bottom of head<br>❑ Even with middle of neck | ❑ Yes ❑ No |
| Was the position altered by the accident? | ❑ Yes ❑ No |
| Did you see the accident coming? | ❑ Yes ❑ No |
| Did you brace for the impact? | ❑ Yes ❑ No |
| Did the airbags deploy?<br>**If yes**, were you struck by it?<br>**If yes, where (what body part)?** | ❑ Yes ❑ No<br>❑ Yes ❑ No<br>❑ Yes ❑ No |
| Did you strike anything in the vehicle?<br>**If yes, where (what body part)?** | ❑ Yes ❑ No |

| | |
|---|---|
| Did you lose consciousness?<br>**If yes, for how long?** | ❑ Yes ❑ No |
| Could you move all your body parts?<br>**If no, what parts could you not move?** | ❑ Yes ❑ No |
| Were you able to get out of the car unaided?<br>**If no, why not?** | ❑ Yes ❑ No |
| Did you get any bleeding cuts?<br>**If yes, where?** | ❑ Yes ❑ No |
| Did you get any bruises?<br>**If yes, where?** | ❑ Yes ❑ No |

**How did you feel immediately after the accident?**

**Later that day?**

**The next day?**

**Where did you go immediately after the accident?**
❑ Home
❑ Work
❑ Doctor's office
❑ Hospital (how long were you at the hospital?)

**Have you missed work due to the accident?** ❑ Yes ❑ No
How long?

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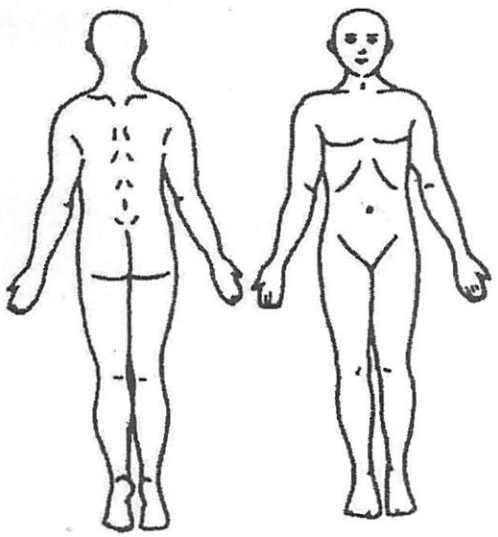
## PATIENT CHIEF COMPLAINTS

**Please mark the location of your pain.**



**Please list your current symptoms and on a scale of 0 – 10 (with 0 being no pain and 10 being the worst) how would you rate your pain?**

**Complaint 1:** _____

0 1 2 3 4 5 6 7 8 9 10

**Complaint 2:** _____

0 1 2 3 4 5 6 7 8 9 10

**Complaint 3:** _____

0 1 2 3 4 5 6 7 8 9 10

**Complaint 4:** _____

0 1 2 3 4 5 6 7 8 9 10

## ACTIVITIES OF DAILY LIVING

**Since the accident you have had problems with the following...**

- ❑ Seeing
- ❑ Tasting
- ❑ Smelling
- ❑ Hearing
- ❑ Eating
- ❑ Bathing
- ❑ Grooming
- ❑ Dressing
- ❑ Reading
- ❑ Typing
- ❑ Writing
- ❑ Grasping
- ❑ Holding
- ❑ Pinching
- ❑ Standing
- ❑ Leaning
- ❑ Walking
- ❑ Stooping
- ❑ Squatting
- ❑ Climbing
- ❑ Kneeling
- ❑ Bending
- ❑ Twisting
- ❑ Carrying
- ❑ Lifting
- ❑ Pushing
- ❑ Pulling
- ❑ Reaching
- ❑ Sitting
- ❑ Driving
- ❑ Traveling
- ❑ Sports
- ❑ Exercising
- ❑ Using the toilet
- ❑ Loss of concentration
- ❑ Nervous
- ❑ Irritable
- ❑ Anxious
- ❑ Change of personality
- ❑ Insomnia
- ❑ Restful sleeping

**Is your sleep disturbed due to pain?** ❑ Yes ❑ No

The information provided above was completed correctly and is true to the best of my knowledge. I understand it is my responsibility to inform the office of any changes to the information I have provided. I authorize Optimal Chiro-Rehab Center to treat my condition as they deem appropriate and to perform any necessary services needed during diagnoses and treatment.

Signature of patient or legal guardian: _____

Date: _____

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## FINANCIAL POLICY AND AGREEMENT

***Please read and initial the following:***

_____ I understand and agree ***that I am personally responsible for payment.*** I understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

_____ I understand and agree that in the event that an insurance company obligated by contractual agreement to **make payment upon demand by you, I become personally responsible for payment of that amount.** I will have thirty (30) days following notification by your office to clear the account by contacting my insurance company.

_____I agree to promptly **bring in any insurance checks that I receive to the office within five (5) business days.** I also understand agree that if **checks are lost or damaged I am personally responsible for payment.**

_____I understand that I can be charged **$25.00** if I fail to provide 24-hour notice for appointment cancellations and/or excessive abuse of scheduled appointments, and charged **$50.00** for all returned checks or non-sufficient funds transactions.

_____I understand that it is my responsibility to inform this office of any **address** or **contact phone number changes** on my account.

_____ I understand that will be responsible ***for any attorney's fees, court fees and collection agency fees incurred in the collection of any overdue balances and consent to Fairfax County as the exclusive venue for any litigation arising out of this agreement.***

_____I hereby authorize **Optimal Chiro-Rehab Center** and its agents to bill my credit card for charges incurred by me.

Print Name (as it appears on card): _____
Billing address: _____
_____

CC#: _____
Expiration date: _____ CID #: _____

Print name of patient or legal guardian: _____

Signature of patient or legal guardian: _____

Date: _____

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## MEDICAL REPORTS AND DOCTOR'S LIEN

I do hereby authorize **OPTIMAL CHIRO-REHAB CENTER** to furnish you, my attorney, with a full report of his examination, diagnosis, treatment, prognosis, etc, of myself in regard to the accident in which I was involved.

I hereby authorize and direct you, my attorney, to pay directly to said doctor such sums as may be due and owning 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 many be necessary to adequately protect 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 result of the injuries for which I have been 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 service rendered me and that this agreement is made solely for said doctor's additional protection and in consideration of his awaiting payment. And I further understand such payment is not contingent on any settlement, judgment or verdict by which eventually recover said fee.

Print name:_____

Dated:_____ Patient's signature:_____

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 sum sums from any settlement, judgment or verdict as may be necessary to adequately protect said doctor above named.

Dated:_____ Attorney's Signature:_____

Please date, sign and return one copy to doctor's office or fax to (703)573-2552.
Keep one copy for your records.

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## ASSIGMENT AND INSTRUCTION FOR DIRECT PAYMENT TO DOCTOR PRIVATE AND GROUP ACCIDENT AND HEALTH INSURANCE

Patient Name:_____
Date of Loss:_____
Claim#/Policy #:_____
SSN/ID#:_____

I hereby **authorize, direct**_____ Insurance Company to pay by check and made out to and mailed directly to my doctor at:

COMPANY NAME: OPTIMAL CHIRO-REHAB CENTER
ADDRESS: 8303 Arlington Blvd Ste.202
CITY/STATE/ZIP: Fairfax, VA 22031

OR

If my current policy prohibits direct payment to the doctor, then I hereby also instruct and direct you to make out the check to me and mail it as follows:

COMPANY NAME: OPTIMAL CHIRO-REHAB CENTER
ADDRESS: 8303 Arlington Blvd Ste.202
CITY/STATE/ZIP: Fairfax, VA 22031

For professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHT AND BENEFITS UNDER THE POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional fees for non covered services and/ or fees over and above the insurance payment or as required by my insurance company.

A photocopy of this assignment shall be considered as effective and valid as the original.

Dated this _____day of _____, 20 _____

_____ _____
Signature of Claimant Witness

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# Consent to Chiropractic and Acupuncture Treatment

**Please initial and sign:**

## _____ INFORMED CONSENT TO CHIROPRACTIC TREATMENT

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:

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.

Chiropractic treatment, 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. The risk of injuries or complications from chiropractic treatment is substantially lower than that associated with many medical or other treatments, medications, and procedures given for the same treatments.

## _____ INFORMED CONSENT TO ACUPUNCTURE TREATMENT

Licensed acupuncturists are encouraged to advise patients that there are or may be some risks associated with such treatment:

a) Acupuncture is a generally safe method of treatment, but it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days. Dizziness and fainting may occur, in particular if the patient is dehydrated or has a tendency to skip meals. Infection is another possible risk although the clinic uses disposable needles and maintains a clean and safe environment. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax).
b) Cupping, another method of treatment, has the common side effect of bruising.
c) Electrical Stimulation side effects may include, but are not limited to: electrical shock, pain or discomfort, and the possible aggravation of symptoms existing prior to treatment

***Most side effects disappear within 48 hours; however results may vary depending on the patient's age and overall health.***

I do not expect the doctor to be able to anticipate all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure(s) which the doctor feels at the time, based upon the facts then known, that are in my best interest. If there is any dispute about my care, I agree to a resolution by binding arbitration according to the American Arbitration Association guidelines.

I have read (or have had read to me) the above explanation of the chiropractic and acupuncture treatments. I state that I have been informed and weighed the risks involved in treatment at this health care office. I have decided that it is in my best interest to receive treatment. I hereby give my consent to that treatment. I intend for this consent to cover the entire course of treatment for my present condition(s) and for any future conditions(s) for which I seek treatment.

**Sign only after you understand and agree to the above.**

Patient Signature (Legal Guardian): _____

Name: _____
(Please print)

Date: _____

# NOTICE OF PRIVACY POLICY

**EFFECTIVE DATE: SEPTEMBER 13TH 2013**

**Optimal Chiro-Rehab Center** is committed to obeying all Federal, State and Local laws and regulations regarding Privacy Practices.

This form is to acknowledge that you have received for your records our Notice of Privacy Policy. The Policy handed to you covers the following:

**Your Personal Health Information**
**Uses or Disclosures of Your Personal Health Information**
**Your Rights With Respect to Your Personal Health Information**
**Complaints**
**On-going Access to Privacy Policy**
**Amendments to this Privacy Policy**

I have received a copy of the above mentioned Notice of Privacy Policy.

Name: _____ Date: _____
(Patient or Legal Guardian)

Signature: _____ Date: _____
(Patient or Legal Guardian)

# PATIENT FUNCTIONAL ASSESSMENT QUESTIONNAIRE

**PATIENT NAME:** _____ **DATE:** _____

| INSTRUCTIONS: Circle the level of difficulty for each activity. | | | 0 = Absolute no difficulty | 1 = Able to do w little difficulty | 2 = Able to do w lit-mod difficulty | 3 = Able to do w mod difficulty | 4 = Able to do w mod-signif difficulty | 5 = Able to do w signif difficulty | 6 = Unable to do at all | Not applicable |
|---|---|---|---|---|---|---|---|---|---|---|
| MOBILITY/WALKING | 1 | Walking short distances | 0 | 1 | 2 | 3 | 4 | 5 | 6 | n/a |
| | 2 | Walking long distances | 0 | 1 | 2 | 3 | 4 | 5 | 6 | n/a |
| | 3 | Walking outdoors | 0 | 1 | 2 | 3 | 4 | 5 | 6 | n/a |
| | 4 | Climbing stairs | 0 | 1 | 2 | 3 | 4 | 5 | 6 | n/a |
| | 5 | Hopping | 0 | 1 | 2 | 3 | 4 | 5 | 6 | n/a |
| | 6 | Running | 0 | 1 | 2 | 3 | 4 | 5 | 6 | n/a |
| CHANGE/MAINTAIN BODY POSITION | 1 | Rolling over | 0 | 1 | 2 | 3 | 4 | 5 | 6 | n/a |
| | 2 | Moving - lying to sitting | 0 | 1 | 2 | 3 | 4 | 5 | 6 | n/a |
| | 3 | Sitting | 0 | 1 | 2 | 3 | 4 | 5 | 6 | n/a |
| | 4 | Bending/Stooping | 0 | 1 | 2 | 3 | 4 | 5 | 6 | n/a |
| | 5 | Kneeling | 0 | 1 | 2 | 3 | 4 | 5 | 6 | n/a |
| | 6 | Standing | 0 | 1 | 2 | 3 | 4 | 5 | 6 | n/a |
| CARRY/MOVE/ HANDLE OBJECTS | 1 | Pushing | 0 | 1 | 2 | 3 | 4 | 5 | 6 | n/a |
| | 2 | Pulling | 0 | 1 | 2 | 3 | 4 | 5 | 6 | n/a |
| | 3 | Reaching | 0 | 1 | 2 | 3 | 4 | 5 | 6 | n/a |
| | 4 | Grasping | 0 | 1 | 2 | 3 | 4 | 5 | 6 | n/a |
| | 5 | Lifting | 0 | 1 | 2 | 3 | 4 | 5 | 6 | n/a |
| | 6 | Carrying | 0 | 1 | 2 | 3 | 4 | 5 | 6 | n/a |
| SELF CARE | 1 | Dressing/Clasp b/h back | 0 | 1 | 2 | 3 | 4 | 5 | 6 | n/a |
| | 2 | Doing light housework | 0 | 1 | 2 | 3 | 4 | 5 | 6 | n/a |
| | 3 | Prep meals/kitchen tasks | 0 | 1 | 2 | 3 | 4 | 5 | 6 | n/a |
| | 4 | Bathroom activities | 0 | 1 | 2 | 3 | 4 | 5 | 6 | n/a |
| | 5 | Sleeping Ability | 0 | 1 | 2 | 3 | 4 | 5 | 6 | n/a |
| | 6 | Hygiene (comb hair/brush teeth) | 0 | 1 | 2 | 3 | 4 | 5 | 6 | n/a |

_____ _____

**PATIENT SIGNATURE** **DATE**

_____ _____

**REVIEWED BY THERAPIST / CREDENTIALS** **DATE**