KAPSNER CHIROPRACTIC CENTERS

Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name:______________________________________

I hereby acknowledge that upon request, a copy of Kapsner Chiropractic Centers Notice of Privacy Practices is available to me. I understand that I have the right to refuse to sign this acknowledgement if I so choose.

______________________________ ______________________

Signature of Patient or Legal Representative **Date**

____

Printed Name of Patient's Representative *(if applicable)*

Parent or guardian of minor

Court appointed guardian

Executor or administrator of descendant's estate

Power Of Attorney

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of out Notice of Privacy Practices on the following date, ____________________ but acknowledgement could not be obtained because:

Patient/Representative refused to sign

Emergency situation prevented us from obtaining acknowledgement at this time (Will attempt again at a later date)

Communication barriers prohibited obtaining acknowledgement (Explain)

____

____

____

____

Other (Specify)

____

____

KAPSNER CHIROPRACTIC CENTERS

INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working, or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks in treatment, including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below, I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition(s) and for any future condition(s) for which I seek treatment.

To be completed by patient or patient's representative, if necessary (e.g., if patient is a minor or is physically or mentally incapacitated):

Print Patient's Name	Patient's Signature	Date

Print name of patient's representative	Signature and relationship of patient's representative

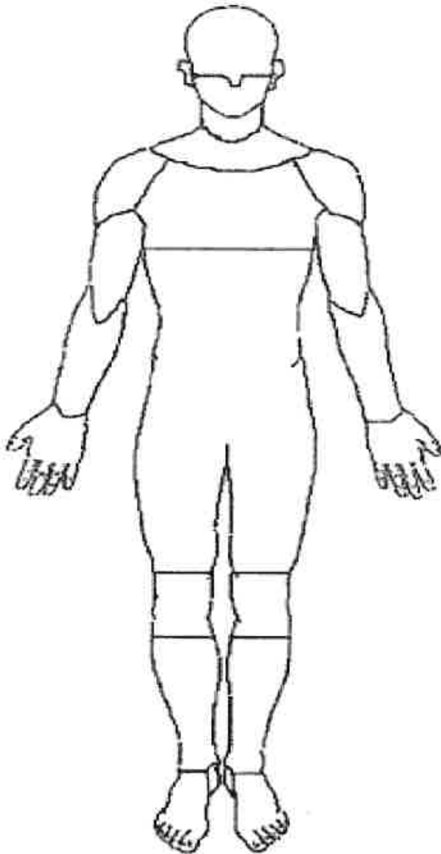
KAPSNER CHIROPRACTIC CENTERS

Name ____ Date ____________________
Nombre Fecha

PAIN DRAWING
DIBUJO DE DOLOR

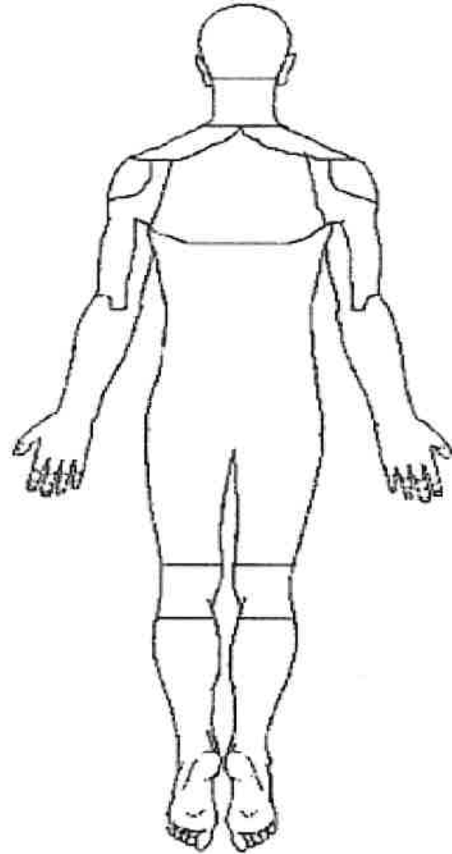
MARK WHERE YOU HAVE PAIN OR ALTERED SENSATION
MARQUE DONDE SIENTA DOLOR O SENSACION ALTERADA

Pain	**Tingling**	**Burning**	**Numbness**	**Stiffness**
Dolor	**Hormigueo**	**Ardor**	**Adormecimiento**	**Tiesedad**



Front

Enfrente



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KAPSNER CHIROPRACTIC CENTERS

Accident/Injury Questionnaire

Name ______________________________ **Date** ____________________

Check any of the following that you have experienced since, and/or as a direct result of this accident or injury. Please add comments accordingly.

___ Headaches
___ Dizziness
___ Anxiety
___ Depression
___ Visual Disturbance
___ Trouble Sleeping
___ TMJ (jaw) Pain or Discomfort
___ Numbness or Tingling
___ Loss of Consciousness
___ Loss of Memory
___ Contusions (black/blue)

Have you had difficulty with any of the following:

___ Housework
___ Lawn or Garden Activities
___ Exercise Routine
___ Standing
___ Walking
___ Hobbies
___ Sports
___ Sitting

Due to this injury/accident, have you undergone any of the following:

___ Medications
___ Injections
___ Surgery
___ Ambulance
___ Hospital/Emergency Room
___ Supports/Casts/Collars/Braces
___ Medical Doctor Treatment or Evaluation - Doctor's Name ______________________________ ___

___ Off Work Please List Dates ____

At the time of this accident/injury:

___ Were you wearing a seatbelt?
___ Were you braced, prepared, and or anticipating the accident?
___ Did you strike your head or face?
___ Were the road conditions icy or wet?
___ Did your seat, seatback, or seatbelt break or get damaged?
___ Did your airbag deploy?

Describe your body position at the time of the accident:

____

____

KAPSNER CHIROPRACTIC CENTERS

Patient Personal Injury & Financial Information

Name ______________________________ Date of Birth ____________
Address ______________________________
City __________________ State ________ Zip Code ____________
Home # __________________ Cell # __________________
Driver's License # __________________
Social Security # __________________

E-mail Address ______________________________

Employer ______________________________
Employer Address ______________________________
Occupation __________________
Work # __________________
Spouse Name __________________ Phone # of Spouse __________________
Name of Nearest Relative or Friend __________________ Relationship ____________
Relative/Friend's Phone # __________________

Financial Information

Personal Injury Protection (Your Policy): This is insurance that is not required by the state of Texas, but most owners carry on their policy. It may be used to cover medical expenses, or to cover a percentage of lost wages. You have the right to use it even if you were not at fault.

Company Name __________________ Adjuster __________________
Address __________________ Phone # __________________
Name of Insured __________________ Date of Birth __________________
Policy # __________________ Claim # __________________

Party at Fault Insurance Information:

Company Name __________________ Adjuster __________________
Address __________________ Phone # __________________
Name of Insured __________________ Date of Birth __________________
Policy # __________________ Claim # __________________

General Health Insurance:

Company Name ______________________________
Name of Insured __________________ Date of Birth __________________
Policy # __________________ Group # __________________

Signature ______________________________ **Date** ____________

Kapsner Chiropractic Centers

Personal Injury History Form

Patient's Name: ____________________

Today's Date: ____________

Date of Injury: ____________

Type of Work: ☐ Office/Clerical ☐ Light Labor ☐ Mod Labor ☐ Heavy Labor

Injury History: General

Was the crash on the job? ☐ Yes ☐ No
You were: ☐ Driver ☐ Front-passenger ☐ Rear passenger
Vehicle driven by: ____________
Vehicle you occupied (year, make, model): ____________
Time of Day: ☐ Daylight ☐ Dawn ☐ Dusk ☐ Dark
Road conditions: ☐ Dry ☐ Wet ☐ Other: ________
Headrest: ☐ None ☐ Up ☐ Down
If adjustable, was the position altered by crash? ☐ Yes ☐ No
Was the seat back adjustment altered by crash? ☐ Yes ☐ No
Was the seat broken? ☐ Yes ☐ No
Seat belt: ☐ Wearing ☐ Not Wearing ☐ Don't Know
Did air bag deploy? ☐ Yes ☐ No
If yes, were you struck? ☐ Yes ☐ No
Body Position: ☐ Good ☐ Forward lean ☐ Other:_____
____
Head Position: ☐ Forward ☐ Left ☐ Right ☐ Up ☐ Down
Hands: ☐ One on wheel ☐ Two on Wheel ☐ N/A
Brakes Applied? ☐ Yes ☐ No

Crash Description: ____________________
____
____
____
____
____
____
____

During the Crash:

Were you aware of the impending crash? ☐ Yes ☐ No
Did you strike any parts of the vehicle? ☐ Yes ☐ No
If yes, describe: ____________________
Did vehicle strike any objects after crash? ☐ Yes ☐ No
If yes, describe: ____________________
Wearing hat or glasses? ☐ Yes ☐ No
If yes, still on after crash? ☐ Yes ☐ No
Did you lose consciousness? ☐ Yes ☐ No
If yes, for how long? ____________________
Estimated damage to the vehicle you occupied ☐ None ☐ Minimal ☐ Moderate ☐ Major
Estimated damage to other vehicle(s): ☐ None ☐ Minimal ☐ Moderate ☐ Major
Police on-scene? ☐ Yes ☐ No Report made? ☐ Yes ☐ No

Were there other passengers in your vehicle? ☐Yes ☐ No

After the Crash:

Symptoms:
☐ Headache ☐ Dizziness ☐ Nausea
☐ Confusion
☐ Neck Pain
☐ Back Pain
☐ Numbness/tingling: where____________
☐ Extremity Pain If so, where?____________
When did symptoms appear? ☐ Immediately ☐ hours afterwards ☐ other____________
Where did you go after crash? ☐ Hospital ☐ Home ☐ Work
Pvt. Doctor: ____________________
Mode of transportation getting there: ____________

Emergency Department:
Hospital Name: ____________________
Radiographs (X-rays, MRI, etc) taken? ☐ Yes ☐ No
Body parts imaged: ____________________
Results:____________________
Treatment issued: ☐ Cervical Collar ☐ Ice ☐ Other:
____
Medications:____________________

Follow-up Instructions: ☐ None ☐ Other:____________

Treatment History

Dr: ____________________
Specialty: ____________ Date first seen:________
Treatment type: ____________
Treatment Frequency: ____________
Treatment Duration: ____________
Currently treating? ☐ Yes ☐ No
Referred to: ____________________
Did the treatment help? ☐ Yes ☐ No
Notes:
____
____

I understand and agree that health insurance and auto accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I clearly understand and agree that all services rendered me are charged directly to me and that I am responsible for payment. I allow this office to endorse co-issued remittances for the conveyance of credit to my account. I also authorize my auto insurance or the at fault person's auto insurance company to pay Kapsner Chiropractic Centers directly from any settlement payment.

____________________ ________
Patient's Signature Date

____________________ ________
Guardian's Signature Date

Authorization to Release Protected Health Information to Attorney or Third party insurance company.

Patient Name: ______________________________

Social Security No.: ______________________________

Date of Birth: ______________________________

Date of Incident: ______________________________

I authorize and voluntarily request Kapsner Chiropractic Centers to disclose my protected health information and billing records, related to the date of incident mentioned above to my law firm/attorney or party at fault insurance company.

I understand my records may include information concerning medical history, treatment, laboratory test results, xray report of findings, HIV or AIDS, mental illness, chemical or alcohol dependency or comparable related information. I also authorize Kapsner Chiropractic Centers to transmit said records by U.S. mail, electronic service or facsimile transmission. I understand that if the recipient authorized to receive this information is not a covered entity, e.g insurance company or healthcare provider, that the information released may not be protected thereafter by federal or state privacy regulations. I further understand that when the information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected health information.

This authorization shall expire 365 days from the date of my signature below or until my claim for the above-mentioned incident is resolved. I understand that I may revoke this authorization at any time by notifying Kapsner Chiropractic Centers in writing. I have read the above and authorize the disclosure of my protected health information.

______________________________ ______________

Signature of Patient or Representative Date