Dr. Donald Shiflet
Chiropractic Physician

The Back Alley Chiropractic & Massage
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PERSONAL INJURY INTAKE & QUESTIONAIRRE

Please take the time to complete these forms to the best of your ability. If you have any questions we will be glad to help you.

Patient Full Name _____ Gender: ☐ Male ☐ Female

Home Address _____

City _____ State _____ Zip Code _____

Billing Address _____

City _____ State _____ Zip Code _____

Email Address _____

Cell Phone _____ Home Phone _____

Employer _____ Work Phone _____

Date of Birth _____ / _____ / _____ Social Security Number _____ - _____ - _____

Spouse's Name _____ Phone # _____

Emergency Contact _____ Phone # _____

Primary Care Physician _____ Phone # _____

Name of person, place, or physician who referred you so that we may thank them _____

To the best of my ability, the information I have supplied is complete and truthful. At any time, I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and may be released. I grant permission to be called or emailed to confirm or reschedule an appointment and to be sent occasional cards, letters or emails as an extension of my care in this office.

Patient or Guardian Signature _____ Date _____

ACKNOWLEDGEMENT OF HIPAA PRIVACY NOTICE

I, _____, have received a copy of this office's Notice of Privacy Practices. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among health care providers who may be directly and indirectly involved in providing my treatment
- Obtain payment from third party payers
- Conduct normal health care operations such as quality assessments and accreditation

Patient or Guardian Signature _____ Date _____

CONSENT TO TREATMENT OF A MINOR

I, _____, hereby authorize The Back Alley Chiropractic clinic/doctor/assistants to administer chiropractic treatment as deemed necessary to my son/daughter/legal dependent _____.

This authorization shall remain effective until _____ / _____ / _____, unless sooner revoked in writing.

Patient or Guardian Signature _____ Date _____

COVERAGE INFORMATION

☐ Self Pay ☐ Health Insurance ☐ Auto Insurance (MEDPAY) ☐ Third Party Auto Insurance ☐ Attorney

Health Insurance Company _____

Member ID # _____ Group # _____

Policy Holder Name _____ Date of Birth _____

Policy Holder Mailing Address _____

Your Auto Insurance Company _____

Policy # _____ Claim # _____

Adjustor Name _____ Phone # _____

Third Party Auto Insurance Company _____

Policy # _____ Claim # _____

Adjustor Name _____ Phone # _____

Attorney Name _____

Firm Name _____ Phone # _____

- *I authorize the release of any medical or other information necessary to process my claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.*
- *I authorize payment of medical benefits to The Back Alley Chiropractic and its physicians or supplier for services received.*

Print Patient Name _____

Patient or Guardian Signature _____ Date _____

INFORMED CONSENT FOR CHIROPRACTIC TREATMENT

I hereby request and consent to the performance of chiropractic treatment (also known as CMT, chiropractic adjustments or chiropractic manipulative treatment) and any other associated procedures; physical examination, tests, diagnostic x-rays, physiotherapy, physical medicine, physical therapy procedures, etc. on me by the doctor of chiropractic named and/or other assistants and/or licensed practitioners.

I understand, as with any health care procedure, that there are certain complications that may arise during CMT. Those complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, Horner's Syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to complications including stroke.

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 facts known, are in my best interest. I have had the opportunity to discuss nature, purpose and risks of chiropractic treatment and other recommended procedures with the doctor and/or with office staff and/or clinic personnel.

I have read, or have had read to me, the above explanation of the CMT. I state that I have been informed and weighed the risks involved in CMT. I have decided that it is in my best interest to receive CMT. I hereby give my consent to that treatment. I intend for this consent to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

Patient or Guardian Signature _____ Date _____

Arizona Revised Statute §20-263

(Patient information for personal injury regarding MEDPAY use)

Arizona Revised Statutes, Title 20 Insurance, Chapter 2 Transaction of Insurance Business, Article 2 Kinds of Insurance; Reinsurance; Limits of Risk, 20-263 vehicle insurance; prohibited act by insurer; hearing; penalty:

A. No insurer shall increase the motor vehicle insurance premium of an insured as a result of an accident not caused or significantly contributed to by the actions of the insured. Any insurer which increases the premium as a result of accident involvement shall notify the insured of the reason for such increase.

B. The director, after a hearing, shall order an insurer that has raised the premium of an insured in violation of subsection A to refund the amount attributable to such premium increase and shall impose a civil penalty not to exceed three hundred dollars. In determining whether an insurer has violated subsection A, the director may conduct such investigation as he deems necessary and the costs shall be paid by the insurer pursuant to section 20-159.

ACCIDENT INFORMATION

Date of Accident _____ Time _____ AM / PM (circle one)

Address/Intersection _____ City, State _____

In your own words, describe ***in detail*** how the accident occurred _____

_____

_____

Were you the ☐ Driver ☐ Front passenger ☐ Rear passenger ☐ Pedestrian

What direction were you traveling? ☐ North ☐ South ☐ East ☐ West

Did your car hit the other vehicle? ☐ Yes ☐ No Did the other vehicle hit your car? ☐ Yes ☐ No

If applicable, were you struck from ☐ Front ☐ Behind ☐ Driver side ☐ Passenger side

Were you ☐ Aware of the approaching impact ☐ Surprised by the impact

Is there a police/accident report? ☐ Yes ☐ No Were any traffic citations issued? ☐ Yes ☐ No

If applicable, citations were issued to ☐ You ☐ Driver of your car ☐ Driver of the other vehicle

Did you go to the hospital? ☐ Yes ☐ No -If yes, name of hospital _____

Have you lost time from work? ☐ Yes ☐ No -If yes, dates missed _____

Was your vehicle a rental car? ☐ Yes ☐ No Was your vehicle a work car? ☐ Yes ☐ No

Make/model of your car _____ Make/model of the other vehicle _____

Were you wearing your seatbelt? ☐ Yes ☐ No Did you lose consciousness? ☐ Yes ☐ No

Did your head hit anything? ☐ Yes ☐ No -If yes, what _____

Did your neck hit anything? ☐ Yes ☐ No -If yes, what _____

Did your chest hit anything? ☐ Yes ☐ No -If yes, what _____

Did your knees hit anything? ☐ Yes ☐ No -If yes, what _____

Did your feet hit anything? ☐ Yes ☐ No -If yes, what _____

How was your head positioned during the accident? _____

How was your torso positioned during the accident? _____

How were your hands positioned during the accident? _____

Please check any symptoms you have noticed since the accident

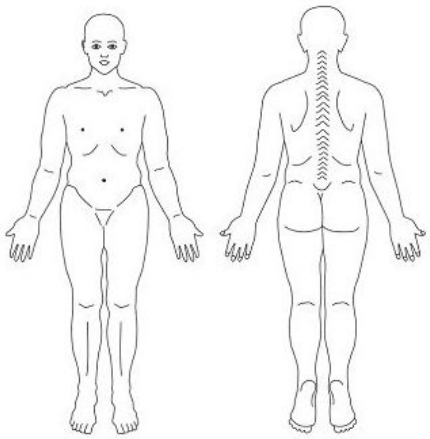
☐ Anxiety	☐ Back pain	☐ Blurred vision	☐ Chest pain	☐ Cold sweats
☐ Depression	☐ Dizziness	☐ Fainting	☐ Fatigue	☐ Fever
☐ Headache	☐ Hearing loss	☐ Irritability	☐ Loss of balance	☐ Loss of memory
☐ Loss of smell	☐ Loss of taste	☐ Neck Pain	☐ Neck stiff	☐ Nervousness
☐ Numbness	☐ Painful joints	☐ Pins and needles	☐ Ringing in ears	☐ Short of breathe
☐ Sleeping problems	☐ Tension	☐ Upset stomach		

Print Patient Name _____

Patient or Guardian Signature _____ Date _____

Height _____ Weight _____ Are you pregnant? ☐ Yes ☐ No

Use the following abbreviations to indicate your symptoms on the illustration to the right:



SS = Spasms
DP = Dull Pain
SH = Shooting Pain
NU = Numbness
ST = Stiffness
SP = Sharp Pain
TI = Tingling
O = Other

When did you first notice your symptoms? _____

How extreme are your symptoms? (circle one)

0 1 2 3 4 5 6 7 8 9 10
Absent Uncomfortable Agonizing

How often are your symptoms present? ☐ 0-25% ☐ 26-50% ☐ 51-75% ☐ 76-100%

What activities ***worsen*** the symptoms? _____

What tends to ***lessen*** the symptoms? _____

How does your ***current condition*** interfere with your:

Work career _____

Recreational activities _____

Household responsibilities _____

Personal relationships _____

Please list all prescription and over-the-counter medications you are **currently** using:

Prescription _____

Over-the-counter _____

Supplements/vitamins _____

To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern. Inaccurate information could be dangerous to my health. If there is any change in my medical status I will notify the chiropractor immediately. I authorize the chiropractor and staff to perform any necessary services needed during diagnosis and treatment.

Print Patient Name _____

Patient or Guardian Signature _____ Date _____

HEALTH HISTORY

Illnesses *Please check any illnesses that you've **had** OR currently **have***

☐ Alcoholism ☐ Allergies ☐ Cancer ☐ Chicken pox/shingles ☐ Diabetes

☐ Epilepsy ☐ Gout ☐ Heart disease ☐ Hepatitis ☐ HIV positive

☐ Multiple sclerosis ☐ Stroke ☐ Tuberculosis ☐ Typhoid fever

Review of Systems *Please check any condition that you've **had** OR currently **have***

☐ Angina ☐ Anorexia ☐ Anxiety ☐ Arthritis ☐ Asthma

☐ Back problems ☐ Blurred vision ☐ Chronic ear infection ☐ Constipation ☐ Depression

☐ Diarrhea ☐ Dizziness ☐ Elbow/wrist pain ☐ Emphysema ☐ Excessive bruising

☐ Fainting ☐ Fatigue ☐ Food sensitivities ☐ Foot/ankle pain ☐ Frequent infection

☐ Hair loss ☐ Hay fever ☐ Headache ☐ Hearing loss ☐ Heartburn

☐ High blood pressure ☐ High cholesterol ☐ Hip disorders ☐ Immune disorders ☐ Kidney stones

☐ Knee injury ☐ Loss of smell ☐ Loss of taste ☐ Low blood pressure ☐ Low energy

☐ Neck pain ☐ Numbness ☐ Osteoporosis ☐ Pins and needles ☐ Pneumonia

☐ Poor appetite ☐ Poor circulation ☐ Poor posture ☐ Prostate issues ☐ Ringing in ears

☐ Scoliosis ☐ Shoulder problems ☐ Skin cancer ☐ Swollen glands

☐ Thyroid issues ☐ TMJ issues

Operations *Please check any operations that you've ever **had***

☐ Appendix removal ☐ Bypass surgery ☐ Cosmetic surgery ☐ Elective surgery ☐ Eye surgery

☐ Hysterectomy ☐ Pacemaker ☐ Spine ☐ Tonsillectomy

Treatments *Please check the treatments you've received in the **past** OR are **currently** receiving*

☐ Acupuncture ☐ Antibiotics ☐ Birth control pills ☐ Blood transfusion ☐ Chemotherapy

☐ Chiropractic care ☐ Dialysis ☐ Dietary supplements ☐ Herbs ☐ Homeopathy

☐ Hormone replacement ☐ Inhaler ☐ Massage therapy ☐ Physical therapy ☐ Other _____

Social History *Please tell the doctor about your health habits*

Alcohol use ☐ Daily ☐ Weekly How much? _____

Coffee use ☐ Daily ☐ Weekly How much? _____

Exercise ☐ Daily ☐ Weekly How much? _____

Pain relievers ☐ Daily ☐ Weekly How much? _____

Soft drinks ☐ Daily ☐ Weekly How much? _____

Tobacco use ☐ Daily ☐ Weekly How much? _____

Water intake ☐ Daily ☐ Weekly How much? _____

To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern. Inaccurate information could be dangerous to my health. If there is any change in my medical status I will notify the chiropractor immediately. I authorize the chiropractor and staff to perform any necessary services needed during diagnosis and treatment.

Print Patient Name _____

Patient or Guardian Signature _____ Date _____

OFFICE POLICY

Appointments
We value the time we have set aside to see you. The Back Alley Chiropractic is a multiple provider office and we must often schedule overlapping appointments according to the service requested and depending on the treatment required.

Walk-ins are ***always*** welcome, however, appointments will be seen first.

If you are late for your appointment, we will do our best to accommodate you.

We strive to minimize wait time, however, emergencies do occur and will take priority over a scheduled visit. We appreciate your understanding.

If you have not been seen in our office in 6 months or longer, or if you have a new or different injury, a re-exam will be carried out and charged to you or your insurance carrier. If you have not been seen in our office in 3 years or longer, you are considered a new patient.

Self-Pay Patients
We welcome patients whose insurance companies are out-of-network, do not provide chiropractic benefits, or are uninsured.

All payments are to be paid in full at the time services are rendered.

Insurance ***cannot*** be used when opting for a pay-at-time-of-service discount.

FINANCIAL POLICY

Payment We accept cash, check, and debit, Visa, MasterCard and Discover. There is a minimum fee of $25 charged for returned checks.

Insured By request, as a courtesy to our patients, we will submit your medical claim to your insurance carrier. Patient balances are billed immediately upon receipt of your carriers EOB. Your remittance is due immediately upon receipt of our bill.

Self-Pay We offer a pay-at-time-of-service discount for all patients. If you fail to provide payment at the time services are rendered, you will be responsible for and billed for 100% of the professional fee.

Delinquent Accounts Unpaid balances are past due at 30 days. Balances left unpaid may receive a second and third notice prior to final notice, mailed at 30-day intervals. The Back Alley utilizes an outside collection agency. Balances over 120 days past due may be submitted to our collection agency.

Medicare We accept Medicare assignment. As a Medicare patient you are responsible for your deductible and co-insurance. If you have secondary or supplemental insurance we will bill it for you. Medicare non-covered services are due at the time of service.

Workers Compensation If you are here as a result of a work related injury; we will require information regarding your health insurance and your employers Workers Compensation insurance.

Personal Injury Claims We bill third party insurance carriers ***only*** on a lien basis. Please notify our staff of your personal injury immediately. You will be asked to complete forms specific to personal injury as well as a consent and notice for medical lien.

INSURANCE POLICY & PROCEDURES

The Back Alley Chiropractic fully complies with all our insurance contracts. It is not our custom to balance bill amounts not allowed by your insurance policy. It is your responsibility to update us with your current insurance information. **If you fail to notify us of a change in carrier, termination of coverage, and/or exceeded benefits, you will be 100% responsible for payment per your insurance policy's allowable amount.**

The Back Alley Chiropractic strives to contract with all local insurance plans. In special cases this may not be possible. Out-of-network coverage often requires a referral or pre-authorization by a Primary Care Physician (PCP). **It is your responsibility to know if a referral or pre-authorization is required to see specialists.** If a referral is required, it is up to you to arrange the submission per your insurance carrier by your PCP. If a referral is not received, you will be 100% responsible for payment.

The Back Alley Chiropractic does its best to verify and interpret your benefits and eligibility with regard to chiropractic and therapeutic procedures. Occasionally we are given incorrect information and can make mistakes. You are responsible for balances owed if your Explanation of Benefits (EOB) shows a different amount owed from your verification. **Any questions about balances owed should be directed to your insurance carrier's member services.**

According to your insurance carrier, you are responsible for co-pays, deductibles and/or co-insurances. **Co-pays, deductibles and/or co-insurances are fees that cannot be waived or discounted.** You will be responsible for your portion of the bill, which is due at the time of service, unless other arrangements have been requested in advance.

If your insurance carrier is to be billed prior to payment collection, once we receive an EOB from your insurance carrier an itemized bill will be sent to you with any balance owed per your insurance plan.

Any insurance you may have is an agreement between you and your insurance carrier and you are financially responsible for the payment of any services rendered. According to your insurance carrier, verification of benefits is not a guarantee of payment and final determination will be made for payment ***after*** a claim is received.

The Back Alley is committed to providing the best treatment for our patients. Our professional fees are usual and customary per local state and federal rate tables.

I have read and understand the above policies and agree to accept responsibility for any and all payment(s) due as outlined.

Print Patient Name _____

Patient or Guardian Signature _____ Date _____

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Chiropractic Physician

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PATIENT CONSENT FOR NOTICE AND CLAIM OF MEDICAL LIEN

Patient Full Name _____

Date of Accident _____ Claim # _____

State of Accident _____ Provider _____

I, _____ (Patient), the undersigned, hereby consent to examination, treatment, procedures and services performed by any and all providers at The Back Alley Chiropractic and Massage (Provider), including emergency treatment.

Patient hereby authorizes, _____(Attorney), (if applicable) to keep Provider advised of the progress of Patient's court case at reasonable intervals. Patient further authorizes and directs Attorney to pay Provider directly any sums due for medical services rendered to Patient. Patient directs Attorney to withhold such funds from any settlement, claim, judgment, verdict or result of said claim. Patient hereby notifies Attorney that Patient is giving Provider a lien on these benefits or settlement proceeds.

Patient understands that a copy of the Notice and Claim of Medical Lien will be filed with the Pima County recorder Office pursuant to A.R.S. §33-932. In consideration for Provider having agreed to treat me without payment at the time of service, this lien is irrevocable and can only be satisfied by full payment of all sums due for medical services rendered. Patient authorizes Provider to notify Attorney of this lien at Provider's discretion. Patient understands that any settlement, claim, judgment or verdict proceeds cannot be disbursed to Patient without first satisfying this lien.

Should a dispute arise regarding payment of Provider's charges, Patient authorizes and directs Attorney to hold in escrow all monies sufficient to satisfy this lien until the dispute can be resolved. Patient acknowledges that it would be a violation of Attorney's ethical duties to disburse the disputed funds prior to resolution of the lien dispute.

Patient understands and agrees that even though this lien has been given, Patient remains personally responsible for payment in full of Provider's fees for all services rendered. Patient is solely responsible to make appropriate arrangements for payment of such fees, including but not limited to insurance benefits. Patient acknowledges that this obligation to pay Provider's fees is not dependent on the outcome of Patient's court case.

I, the undersigned, understand that if the settlement, claim, judgment or verdict does not cover my entire bill at The Back Alley Chiropractic and Massage, I am still responsible for the remainder and payment of the charges. The bill is not contingent on any settlement, claim or judgment which I may eventually recover.

Patient or Guardian Signature _____ Date _____

---------- Attorney's Acceptance of Provider's Lien ----------

Being the attorney of record or authorized representative, I acknowledge receipt of my client's consent to Notice and Claim of Medical Lien and agree to honor the same.

Attorney Name _____

Attorney Signature _____ Date _____

Firm Name _____

Phone # _____ Fax # _____

Mailing Address _____