Wentzville Chiropractic and Acupuncture Center

Joan Brower D.C. ♦ Daryl Ridgeway D.C. ♦ Xephyr Day D.C. ♦ Leah Owens D.C. ♦ Jay Hauptman D.C.
1023 Main Plaza Dr.
Wentzville, MO 63385
636-639-8944 or 636-332-8944

Patient's Automobile Accident Information Sheet

_____ ___/___/___
Last Name First Name Middle Initial Birthday

_____
Address City/State Zip Code

Primary #(_____)_____ Mobile #(_____)_____

Email Address:_____

Gender: Male Female Marital Status: Single Married Widowed Other Employment: _____

Spouse's Name:_____ Phone #: (_____)_____

Injury Information:

Date of Injury: _____/_____/_____

Please write a brief description of how your injury occurred: _____

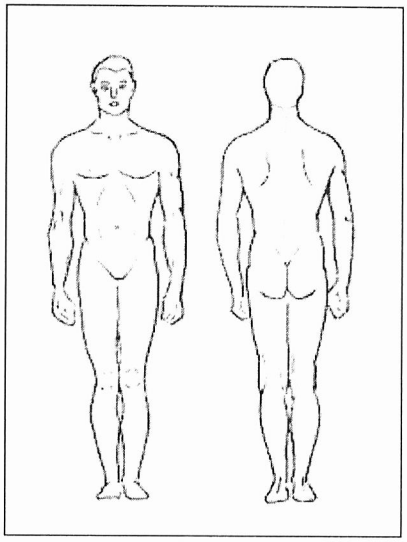
_____

_____

Please circle the following that apply to your auto accident:

Were you at a stop?	Yes	No	If no, approximate speed_____mph		
Was the other vehicle stopped?	Yes	No	If no, approximate speed_____mph		
At impact, was your body straight in your seat?	Yes	No	If no, turned to the left or the right_____		
Were you aware that you were about to be hit?	Yes	No	If no, position of head_____		
Were you wearing a seatbelt?	Yes	No	Did the Airbag deploy?	Yes	No
Did your chest or head hit the steering wheel?	Yes	No	Did your shoulder hit the door?	Yes	No
Did your head hit the windshield or side window?	Yes	No	Did the seat break?	Yes	No
Did your knees hit the dashboard?	Yes	No	If yes, where? _____		
Do you have any cuts or bruises from the accident?	Yes	No			
Was your car equipped with headrest?	Yes	No			
If yes, at what height was the top of the headrest?	Base of head		Mid Head	Top of Head	
Did you lose consciousness?	Yes	No	If so, how long? _____		

Area(s) of Complaint



Place an X on the area(s) in the diagram where you have pain and draw lines to where it radiates.

Did you have any of the above symptoms prior to the accident?
Yes No

Are you experiencing any of the following since your accident?
Please √ all that apply.

__Headaches	__Blurry Vision	__Dizziness/loss of balance	__Indigestion
__Neck Pain	__Rapid heartbeat	__Blood/Lymph disorders	__Shoulder Pain
__Anxiety	__Urinary difficulties	__Digestive Problems	__Elbow Pain
__Fatigue	__Skin Problems	__Breathing Problems	__Wrist/Hand Pain
__Sore Throat	__Memory lapses	__Hot/Cold Flashes	__Upper back pain
__Knee Pain	__Chest Pain	__Low back pain	__Weight Loss/Gain
__Hip Pain	__Mid back pain	__Ankle/Foot Pain	

Treatment Information

Did you go to the Emergency Room? Yes No If yes, when? _____

Name of Hospital Emergency Room_____

List any medications that you were given:_____

List any instructions that you were given: _____

From the following list, circle that treatment(s) that you received at the Emergency Room:

Exam X-Ray MRI CT Scan Back Brace Neck Brace Home Instructions Other: _____

List all the doctors along with their specialty, that you have seen as a result of your injuries (other that at the ER):

_____

_____

Do you have any future appointments with any doctor regarding your injuries? Yes No

If yes, when and with whom? _____

_____ _____

Patient and or Legal Guardian's Signature Date

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Doctor's Lien

To:

Re: Patient Records and Doctor's Lien

I do hereby authorize the above doctor to furnish you, my attorney/insurance carrier, with a full report of my case history, examination, diagnosis, treatment and prognosis of myself regarding my accident which occurred on:_____.

I hereby give a lien to said doctor on any settlement, claim, judgment, or verdict as a result of said accident, and authorize and direct you, my attorney/insurance carrier, to pay directly to said doctor such sums as maybe due and owing her/him for service rendered to me, and to withhold such sums from a settlement, claim, judgment or verdict as may be necessary to protest said doctor adequately.

I fully understand that I am directly and fully responsible to said doctor for all Chiropractic bills submitted by her/him for services rendered to me, and that this agreement is made solely for said doctor's additional protection and in consideration of her/him awaiting payment. I further understand that such payment is not contingent on any settlement, claim, judgment or verdict by which I may eventually recover said fee.

Date:_____ Patient Signature:_____

Patient Name:_____

The undersigned, being attorney of record or authorized representative of insurance carrier for the above patient does hereby acknowledge receipt of the above, lien and does agree to honor the same to protect adequately said above named doctor.

Date:_____ Claim Representative:_____

Date:_____ Physician Signature:_____

Notice: Please date, sign and return one copy to doctor's office at once. Keep one copy for your records. To mail send to address above or fax to 636-639-8922.

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CONSENT TO CHIROPRACTIC TREATMENT PLAN

THE MATERIAL RISKS INHERENT TO YOUR TREATMENT

Chiropractic care is a safe and effective approach for many health conditions, however as with any healthcare procedures, chiropractic treatments present the risks of complications or negative side effects. The list below includes the various treatments available in our clinic and the potential risks associated with these treatments.

CHIROPRACTIC EXAMINATION

Prior to establishing a treatment plan the doctor must perform a Chiropractic Examination in order to determine the exact cause of your complaint. During the examination the doctor will perform some procedures or maneuvers intended to reproduce your symptoms which will allow for a better understanding of your condition and for the development of an appropriate treatment regimen. There is a slight possibility that these maneuvers may temporarily aggravate your symptoms.

CHIROPRACTIC MANIPULATION THERAPY

The risk associated with chiropractic treatments include, but are not limited to, dislocations and sprains, disc injuries, fractures, and strokes. These negative effects are very rare and your doctor has done a careful screening for contraindications during the consultation and examination. Another more common side effect associated with chiropractic manipulation therapy is some soreness or stiffness following the treatment. Your doctor may recommend the use of ice packs to reduce the discomfort.

HOT AND COLD THERAPY

Application of a hot or cold pack can cause a local burn. We place a towel underneath the pack to minimize this risk, however if you have very sensitive skin you may experience a reaction. Please inform your doctor if the application is uncomfortable

ULTRASOUND

The therapeutic effect of ultrasound is produced by heat. The risk associated with ultrasound therapy is burning of tissues at the application site. Ultrasound should not be painful. If you experience pain from the treatment please inform your doctor. If you have a metallic implant in the area to be treated, inform your doctor, as the implant concentrates the heat.

ELECTROTHERAPY

The therapeutic electronic current is transmitted to your body via electrodes. A small defect in the electrode coating, not always detected by observation, may concentrate the current, causing a small burn to the skin. If you feel it sting where the electrode is placed, please inform your doctor. Electronic stimulation causes muscles to contract and in rare instances a muscle cramp may occur during such treatment. Inform your doctor if the procedure is uncomfortable.

GRASTON SOFT TISSUE TECHNIQUE

A metallic instrument is used to strip a muscle or tendon, softening adhesions and promoting healing of the injured or scared tissue. In some instances this procedure may cause bruising and some reactive swelling. This may be uncomfortable, but is not causing any harm to the patient and this reaction is part of the healing process. Please inform your doctor if you are taking blood thinner medication or if you bruise easily.

LABORATORY TESTS

Laboratory tests, including the collection of a blood sample may be ordered to help diagnosis your condition. Some patients may faint at the site of needles or blood. Patients with delicate veins may experience some bruising at the skin puncture site. In very rare instances the needle can touch a nerve causing pain for a few days or a few weeks.

ACUPUNCTURE TREATMENT

Acupuncture is a generally safe treatment, but may have some side effects including bruising, numbness, tingling, itching, and dizziness or fainting. Extremely rare risks of Acupuncture include spontaneous miscarriage, nerve damage, and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic using sterile disposable needles and maintains a clean and safe environment.

WATER TABLE THERAPY

Water table therapy uses warm, jetted water to help massage and relax your muscles. May cause redness and/or an itchy sensation to the back. Temperature can get hot, please inform your doctor if it becomes uncomfortable.

INFRARED

Laser light therapy used for intracellular healing. Infrared is great for injuries, rashes, and many other ailments. Infrared can be harmful if used incorrectly near the eyes.

HEAT LAMP THERAPY

Heat lamp therapy increases circulation, loosens fascia, and accelerates the natural healing process, mainly used in conjunction with acupuncture. May cause burning if used too close to the skin.

MASSAGE THERAPY

Massage therapy is used to relax the muscles and tendons. May cause some bruising, temporary muscle soreness, headaches and/or dizziness.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE. Please check the appropriate block and sign. I have read ( ) or have had read to me ( ) the above explanation of the chiropractic adjustment and related treatment. I have discussed it with the clinic and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risk involved in undergoing treatment and have decided that it is in my best interest (or, in the case of a minor, in the best interest of the patient) to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

_____	_____	_____/_____/_____
(Patient's Name Printed)	**(Patient or Guardian's Signature)**	**(Date Signed)**
_____	_____	_____/_____/_____
(Witness's Name Printed)	**(Witness's Signature)**	**(Date Signed)**

Wentzville Chiropractic and Acupuncture Center

Privacy Notice Acknowledgement

1. Wentzville Chiropractic and Acupuncture Center (WCAC):

   a. Is required by federal law to maintain the privacy of your PHI (Private Health Information) and to provide you with a Privacy Notice detailing the practices legal duties and privacy practices with respect to your PHI..

   b. Is required by state law to maintain a higher level of confidentially with respect to certain portions of your medical information that is provided for under federal law.

   c. Is required to abide by the terms of this privacy notice.

   d. Reserves the right to change the terms of this privacy notice and to make new privacy notice provisions affective for all of your PHI that it maintains. .

   e. Will not retaliate against you for filing a complaint.

2. Authorization: I authorize WCAC to use and or disclose information to the following person(s):

Name:	**Relationship:**
_____	_____
_____	_____
_____	_____

☐ **I do not want any medical information released except to myself**

3. Limitations: In addition to the above, the following criteria is restricted to be released:

_____

4. Messages related to PHI: When leaving messages, I give permission to WCAC to leave a detailed message on the requested number. Please √ one or all of the following:

☐ **Home Number** ☐ **Work Number** ☐ **Cell Phone Number**

5. Voluntary Act: WCAC acknowledges that this Authorization is voluntary.

6. Revocation: I understand that this Authorization may be revoked by me at any time, provided that I submit a signed revocation form to WCAC. However, any revocation shall not apply to the extent that WCAC has taken action in reliance on this Authorization.

7. Copy of Authorization: If WCAC has requested this Authorization from me, I understand that they will provide me with a copy of this Authorization once signed.

Name (Printed) Signature of Patient and or Guardian

Date: _____/_____/_____

Missed Appointment Policy

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Wentzville Chiropractic requests that you phone our office if you are going to miss an appointment so that your time can be reallocated to someone who is the need of treatment. If it is necessary to cancel your scheduled appointment we ask that you please call within 12 hours of your scheduled appointment time.

I hereby acknowledge that I will be charged a missed appointment fee if I do not call or cancel within 12 hours of my appointment time.

- Chiropractor Appointment: Fee of $25.00 for a missed appointment.
- Massage Appointment: Fee of half of the scheduled appointment time.

Signature of Patient: _____ Date: _____

Office Use Only:

Doctor Notes:	Staff Notes: