

7100 Menaul Blvd. NE
Albuquerque, NM 87110

Phone: (505) 883-5858
Fax: (505) 883-0010

Acct #: _____ Case#: _____

Date: _____ Patient Name: _____

Address: _____

City _____ State _____ Zip _____

Home Phone: () _____ - _____ Work Phone: () _____ - _____ ext. _____

Cell Phone: () _____ - _____ e-mail address: _____

SS# _____ - _____ - _____ Birth Date _____ Age _____ Height _____ Weight _____

Occupation _____ Employer/ School _____

Name of Spouse/Nearest Relative _____ Phone: () _____ - _____

Emergency Contact: _____ Phone: () _____ - _____

Referred By/How did you hear about us: _____

HAVE YOU HAD ANY PREVIOUS CHIROPRACTIC CARE?

Yes ___ No ___ Date of last adjustment _____ Name of Chiropractor _____

What was the reason for your initial visit? _____

PRESENT REASON OF CONSULTING OUR OFFICE: _____

How long have you had this injury/symptom/condition? _____

Was/is this injury related to an accident? ___ Yes ___ No

If Yes, Auto Accident ___ Work Accident ___ Other: _____

Date of Accident/injury: _____

Have you had previous treatment for this injury? ___ Yes ___ No

If Yes, what/ where/with whom: _____

TYPE OF PAIN/DISCOMFORT:

Sharp Dull Throbbing Numbness Aching
Shooting Cramps Tingling Burning Stiffness
Swelling Other: _____

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your: Work Sleep Daily Routine Recreation

Activities or movements that are painful to perform: Sitting Standing Walking Bending Lying Down

LIST ALL MEDICATIONS YOU CURRENTLY TAKE (prescription and non-prescription):

What: _____

What: _____

What: _____

LIST ALL PREVIOUS ACCIDENTS AND/OR INJURIES:

Falls _____ Date: _____

Head Injuries _____ Date: _____

Broken bones _____ Date: _____

Dislocations _____ Date: _____

Auto Accidents _____ Date: _____

PLEASE LIST ALL SURGERIES YOU HAVE HAD:

Type _____ Date: _____

Type _____ Date: _____

Type _____ Date: _____

OCCUPATIONAL STRESSES (ex. repetitive motions, heavy lifting, standing on feet all day etc.):

Repetitive physical positions: _____

Heavy/Awkward lifting, explain: _____

Other: _____

How would you rate your current level of emotional stress: (lowest) 1 2 3 4 5 6 7 8 9 10 (highest)

Do you deal with stress easily or difficultly? _____

Do you smoke? Y / N How much? _____ How Long? _____

Do you consume alcohol? Y / N How much? _____ How Often? _____

PATIENT PRIVACY:

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information.

I HAVE BEEN GIVEN OR HAVE BEEN OFFERED A COPY A COPY OF CHIROPRACTIC ARTS **NOTICE OF PRIVACY PRACTICES** ("NOTICE"), WHICH DESCRIBES HOW MY HEALTH INFORMATION IS USED AND SHARED. I understand this acknowledgment will be used as authorization to use/disclose PHI for payment, treatment or healthcare operation purposes only. I understand that it may be updated and that I may obtain a current copy by contacting *Lesley Coren, Office Manager*.

_____ Patient Initial

ACKNOWLEDGEMENT OF SIGNED HIPAA PRIVACY AUTHORIZATION FOR RELEASE OF INFORMATION.

_____ Patient Initial

FINANCIAL POLICY:

We bill most health insurance carriers if proper information is provided to us. Co-payments and deductibles are due at time of service. Since your agreement with your insurance carrier is a private one, it is understood that you are fully responsible for all charges and balances regardless of insurance. If an insurance carrier has not paid within 60 days of billing, professional fees are due and payable in full from you. If you are insured by a PPO/POS/HMO plan, it is agreed that you have followed the plan guidelines for obtaining services from said doctor.

Many health insurance carriers will not pay for treatment of injuries sustained in an automobile collision as the automobile insurance carrier is the primary party responsible for medical bills resulting from an automobile collision. Furthermore, some therapeutic modalities necessary in proper treatment of collision related injuries are often not covered by many health insurance policies.

For treatment of injuries sustained in an automobile accident or personal injury accident, you are directly and fully responsible for all bills submitted. If you have insurance that provides medical payment coverage for auto-related or personal injuries, we will bill the insurance carrier directly. Since your agreement with your insurance carrier is a private one, it is understood that you are fully responsible for all charges and balances regardless of insurance. Payment is not contingent on any settlement, judgment or verdict by which a fee may be recovered.

I HAVE READ AND UNDERSTAND THE TERMS OF THE FINANCIAL POLICY. _____ Patient Initial

ASSIGNMENT OF BENEFITS:

I hereby assign/authorize all medical benefits to be paid directly to Scott M. DelPrete, D.C. This assignment will remain in affect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. **I understand that I am financially responsible for all charges whether or not they are paid by said insurance.** I hereby authorize said assignee to release all information necessary to secure the payment.

Patient Signature

Date

MOTOR VEHICLE CRASH:

Date of Crash: _____

Claim #: _____

Your Auto Insurance Company: _____

Policy #: _____

Adjuster's Name: _____ Phone: () _____ - _____

Name of Attorney: _____ Phone: () _____ - _____

You were: Driver Front seat passenger Rear seat passenger Motorcycle rider
 Motorcycle passenger Other: _____

Vehicle driven by: _____

Your vehicle (make, model, year): _____

Your estimated speed at moment of crash: Stopped Slowing Accelerating

Time of day: Daylight Dawn Dusk Dark

Road Conditions: Dry Damp Wet Snow Ice Other: _____

Head restraints: None Integral type Adjustable type (circle): Up / Down Don't know

If adjustable, was the position altered by the crash? Yes No

Was the seat back adjustment altered by the crash? Yes No

Was the seat broken? Yes No

Lap belt: Wearing Not wearing Don't know

Shoulder belt: None Wearing Not wearing

Did air bag deploy? Yes No If yes, were you struck? Yes No

Body position: Good Forward lean Other: _____

Head position: _____

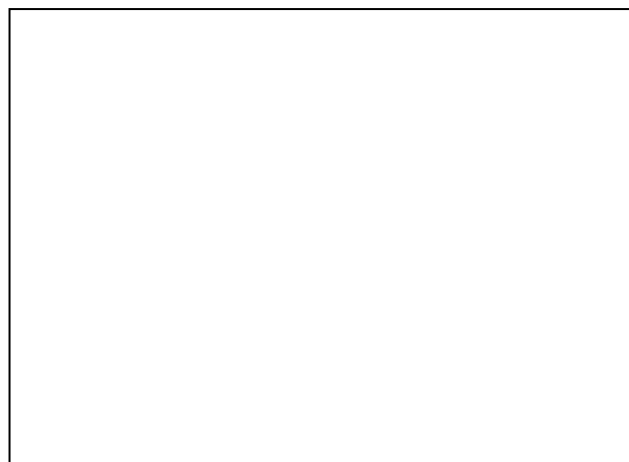
Hands: One hand on wheel Two hands on wheel N/A

Brakes applies? Yes No

Were you aware of impending crash? Yes No

Crash description:

Crash diagram:



During the crash:

Did you strike any parts of the vehicle? Yes No If yes, describe: _____

Did the vehicle strike any objects after the crash? Yes No If yes, describe: _____

Wearing hat or glasses? Yes No

If yes, still on after the crash? Yes No

Did you lose consciousness? Yes No If yes, for how long? _____

Estimated property damage to your vehicle: \$_____

Estimated damage to other vehicle(s): None Minimal Moderate Major

Were the police on-scene? Yes No

If yes, was a report made? Yes No

After the crash:

Where did you go after the crash? Home Work Hospital Other:_____

How did you get there:_____

Did you experience any of these Symptoms: Headache Dizziness Nausea Confusion/disorientation

Neck pain Back pain Paresthesia(s) if yes, where: _____

Extremity (ex. knee, elbow, arm, foot etc.) pain, where:_____

When did your symptoms first appear? Immediately after crash _____ hours after crash

_____ day(s) after crash

Complete ONLY if you went to the emergency room.

Were radiographs (i.e., x-rays) taken? Yes No

Body parts imaged: _____

Results: _____

Lab work: Yes No If yes, results: _____

Cervical collar Yes No

Medications: _____

Other: _____

Follow up instructions: Yes No If yes, describe: _____

PATIENT CONSENT TO CHIROPRACTIC TREATMENT

Please read the following carefully, then sign and date it. Thank You!

OUR RESPONSIBILITY

My responsibility to you is to provide the best chiropractic care possible and to educate you as to how to care for your health and how to keep it in top form, if you choose.

YOUR RESPONSIBILITY

Your responsibility is to learn, to ask questions, and make informed decisions about the recommendations I make for your chiropractic care. You are also responsible for keeping your schedule of care that you have decided to accept our recommendations and you are responsible for payment for your care. Payment is due at the time of service unless you have made specific previous financial arrangements with us. Please inform us if you have insurance that covers chiropractic care. If you have an accident, a surgery, a change of address or any other change in history please advise us on the visit following the change.

YOUR CARE

The chiropractic adjustment is a quick movement of the vertebrae of the spine, for the purpose of specifically realigning the bone(s) of your spine. Most patients say that the adjustment is comfortable, others may be sore the day after the adjustment(s). The risk of injury during an adjustment is minimal. These risks could include fracture, disk injury or in extremely rare instances, stroke (CVA) can occur. However, controversy exists within the scientific community regarding the chiropractic adjustments and the risk of stroke (CVA). Several studies cited against chiropractic often involve manipulation by other practitioners (PT/LMT/MD/DO) *not* chiropractors.¹ Some authors say that chiropractic care reduces the risk of stroke, others say that the risk is one in a million, to one in five million. The risk of having a subluxation and no care includes degeneration of the affected area and nerve compromise, which affects the health of your entire body. Research suggests that with early intervention, the vertebral subluxation complex can be eliminated. If degeneration occurs, the prognosis for full recovery decreases significantly.

TERMS OF ACCEPTANCE

When a person seeks chiropractic care and when a chiropractor accepts that person as a patient, essential to the successful relationship is that both parties seek the same goals. My sole intent and goal as a chiropractor is to find and correct the vertebral subluxation complex, to assist you in attaining your optimum health. I do not treat or cure any physical or emotional diseases nor diagnose or give advice about ailments or disease. Please consult with your physician or other appropriate medical provider regarding these medical concerns. I address subluxations and vertebral fixations because I know that your body is self-healing and self-regulating and that, when freed from the effects of the subluxation, it has the innate ability to heal itself. Your body functions at a much higher and more efficient level when I reduce the subluxation because the adjustment maximizes the function of your nerves allowing for freer communication between your brain and your body.

ACKNOWLEDGMENT:

I have read and understand this and I agree to its terms and intent.

Patient's Name: _____

DOB: _____

Patient's Signature _____

Date _____

Parent/Guardian Authorization for care of a minor child under the age of 18:

Printed Name: _____

Relationship: _____

Signature: _____

Date _____

1. Cohn, A. "A Review of Literature Regarding Stroke and Chiropractic." *Journal of Vertebral Subluxation Research*. 4, no. 3(2001):52-59.
Rome, P.L., "Perspectives: An overview of Comparative Considerations of Cerebrovascular Accidents." *Chiropractic Journal of Australia* 29, no.3(1999):87-102
Terret, A.G.J., "Misuse of the literature by Medical Authors in Discussing Spinal Manipulative Therapy Injury." *Journal of Manipulative and Physiological Therapies*. 18, n.4 (1995): 203-210.