INJURY CHIROPRACTIC

INTAKE PG 1

Today's Date: _____

form 700 // updated 10/29/14

PATIENT INFORMATION: ☐ Male / *Masculino* / NAM
PASIENTE INFORMACION: ☐ Female / *Femenino* / NỮ
TÀI LIỆU CỦA BỆNH NHÂN:

First Name / *Nombre* / TÊN :_____

Last Name / *Apellido* / HỌ:_____

Date of Birth: (MM) _____/(DD)_____/(YY)_____ Age: _____

Fecha de Nacimiento: (*Mes*)_____/(*Día*)_____/(*Año*)_____ *Edad*: _____

NGÀY SANH: (THÁNG)_____/(NGÃY)_____/(NĂM)_____ TUỔI:_____

Address / *Dirección Domicilio* / ĐỊA CHỈ: _____

Apt # /A*partamento #* /CHUNG CỦ SỐ # : _____City / *Ciudad* /THÀNH PHỐ: _____

State / *Estado* /TIỂU BANG: _____ Zip Code / *Código Postal* / ZIP CODE: _____

Social Security # / *# de S.S.* / SỐ SOCIAL SECURITY:_____

Home Phone / *Teléfono de su casa* / ĐIỆN THỌAỈ NHÀ: (_____)_____

Cell Phone / *Teléfono celular* / ĐIỆN THỌAỈ DI ĐÔNG SỐ: (_____)_____

RESPONSIBLE PARTY: *If the patient is a minor under the age of 18 years, please complete this section.*
RESPONSABLE PARTY: *Si el paciente es menor de edad, por favor llene esta sección.*
NGỦỞI CHỊU TRÁCH NHỊỆM: NẾU BỆNH NHÂN DƯỚI 18 TUỔI, CHA MẸ HOẶC NGỦỞI THẤN CẬN ĐIỆN VÀO PHẦN NÀY.

Relationship / *Relación* / QUAN HỆ: _____

First Name / *Nombre* / TÊN :_____

Last Name / *Apellido* / HỌ:_____

Date of Birth: (MM) _____/(DD)_____/(YY)_____ Age: _____

Fecha de Nacimiento: (*Mes*)_____/(*Día*)_____/(*Año*)_____ *Edad*: _____

NGÀY SANH: (THÁNG)_____/(NGÃY)_____/(NĂM)_____ TUỔI:_____

Address / *Dirección Domicilio* / ĐỊA CHỈ: _____

Apt # /A*partamento #* /CHUNG CỦ SỐ # : _____City / *Ciudad* /THÀNH PHỐ: _____

State / *Estado* /TIỂU BANG: _____ Zip Code / *Código Postal* / ZIP CODE: _____

Social Security # / *# de S.S.* / SỐ SOCIAL SECURITY:_____

Home Phone / *Teléfono de su casa* / ĐIỆN THỌAỈ NHÀ: (_____)_____

Cell Phone / *Teléfono celular* / ĐIỆN THỌAỈ DI ĐÔNG SỐ: (_____)_____

HEALTH INSURANCE INFORMATION: ☐ YES / SI / CÓ
INFORMACION DE ASEGURANZA MEDICA: ☐ NONE / *Ninguna* / KHÔNG CÓ
QUÝ VỊ CÓ BẢO HIỂM SỦC KHỎE HAY KHÔNG?: ☐ AHCCCS

Insurance Company / *Compañía de aseguranza* / TÊN CỦA HÃNG BẢO HIỂM: _____

Insurance Phone # / *Teléfono de aseguranza* / ĐIỆN THỌAI CỬA HÃNG BẢO HIỂM: (_____)_____

Relationship to Insured*/ Relación* / QUAN HỆ VỚÍ BỆNH NHÂN**:** _____

Insured's ID# / *# de tarjeta* / SỐ ID#: _____

INJURY CHIROPRACTIC
5121 W Thunderbird Rd, Glendale, AZ 85306
Phone (623) 879-1015 ♦ FAX (623) 849-0406

STANDARD AUTHORIZATION OF USE & DISCLOSURE OF PROTECTED HEALTH INFORMATION: **I, the undersigned patient or patient representative, do hereby authorize Injury Chiropractic (the "Center") and its staff to furnish my legal representative with the following information. In addition, I authorize my legal representative to provide all the following information to the Center:**

•complete medical records •treatment status •insurance information •correspondence

This authorization is effective from today lasting for a period of five (5) years unless revoked or terminated by the party signing below. A written revocation to the attention of the HIPAA Compliance Officer to the above address is required to revoke or terminate this authorization. Information that is disclosed under this authorization may be disclosed again by the organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulations.

AGREEMENT ON PERSONAL INJURY RECOVERY: **I, the undersigned, hereby authorize and direct said Attorney to pay directly to the Center such sums as may be due and owing for services rendered to me and to withhold such sums from any settlement, judgment, or verdict as may be necessary to adequately protect and fully compensate the Center. Furthermore, I authorize this lien to the Center against all proceeds of any settlement, judgment or verdict that may be paid to me.**

I fully understand and acknowledge that I am directly and fully responsible to the Center for all services rendered to me and that this Agreement is made solely for the Center's additional protection and in consideration of the Center's agreement to postpone demand for payment. I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover all or any portion of the sums owed to the Center.

I agree never to rescind the Agreement portion of this document and that any attempt to rescind will not be honored by my Attorney. In the event of new legal representation, I authorize the new legal representative to honor this lien as inherent to the settlement and enforceable upon the case as if he/she originally executed it.

_____ _____

Dated **Responsible Party's Signature**

_____ _____

Patient's Name (if minor) **Printed Responsible Party's Name & Relationship to Patient**

The undersigned Attorney of record agrees to promptly notify the Center if Attorney ceases to represent or when any change in representation occurs. Attorney shall also promptly deliver a copy of this Agreement to any additional or substitute legal counsel. Furthermore, Attorney does hereby agree to observe all the terms of this Agreement stated above.

_____ _____

Dated **Attorney/Legal Representative**

A PHOTOCOPY OF THIS FORM SHALL BE DEEMED AS VALID AS THE ORIGINAL

Chart#: _____

AUTHORIZATION & ASSIGNMENT OF BENEFITS: I, the undersigned patient and/or responsible party, authorize Injury Chiropractic ("IC") to release any medical records and billing information to the health insurance, workers' compensation and/or auto insurance companies for services provided by IC. In addition, I authorize and assign appeal rights to IC as well as assignment of benefits and lien against any third party whose negligence may have caused me to seek treatment at IC. Finally, I authorize, assign and direct all insurance carriers to directly reimburse IC. **Medical payments carriers are authorized to pay IC directly. All payments should be mailed directly to:**

Injury Chiropractic, 5121 W Thunderbird, Glendale, AZ 85306.

CONSENT TO TREAT: Chiropractic care is a non-invasive approach with some of the safest outcomes in health care. I understand that IC cannot promise a complete recovery but will provide the best care possible and address any concerns. Furthermore, I have been advised treatment may result in temporary symptoms like soreness following manipulation or traction and skin irritation after ice, heat, ultrasound or EMS. I am aware that in rare instances, manipulation can cause aggravation to bulging/ herniated disc or cause a rib fracture, and even more rarely, cervical manipulation can be related to compromised vertebral artery and possible stroke symptomatology. Understanding the limitations and possible complications of receiving chiropractic care, I hereby authorize Injury Chiropractic and any associated doctor and /or staff member to examine, take x-rays and treat either me or my minor child (under age 18) named below. My signature below also verifies that I am either the parent or legal guardian of the below referenced minor patient and therefore have authority to grant this consent. **Revocation of this consent can only be made by sending a certified letter to our office to the attention of the treating IC doctor.**

HIPAA PRIVACY PRACTICES: My initialing of this section is only an acknowledgment that I have been informed I can request a copy of the posted HIPAA Notice of Privacy Practices. **Initials Here: _____**

FINANCIAL RESPONSIBILITY: I agree that health and accident insurance policies are an arrangement between the insurance carrier and the insured. Even though I authorize insurance carriers to assign benefits directly to Injury Chiropractic, I clearly understand and agree that all services rendered are charged directly to me and that by signing below I accept personal responsibility for payment of said services.

In the event that I receive any check, draft, or other payment for services provided by IC, I agree to act as the fiduciary agent for IC by IMMEDIATELY delivering said payment to IC. Additionally, I hereby assign Power of Attorney to IC and its assignee to endorse/sign my name on any and all checks and payments, for my indebtedness to IC. In addition, IC and I jointly agree to have a method of resolving disagreement, misunderstanding or disputes, should they occur, privately, quickly, economically and in a friendly, educational manner using the communication, negotiation, mediation and arbitration procedures set forth in the latest edition of the standard Law Forms Integrity Agreement.

Furthermore, I understand that if IC must employ collection counsel and/or legal counsel to obtain payment for my debt, that I will be responsible for any and all collection fees, interest fees and reasonable attorney's fees. I hereby waive the Statute of Limitations regarding IC's right to recover.

My signature below confirms that I understand and agree to comply with all parts of this document. I, the undersigned patient and/or responsible party, state that all information provided today is true and correct to the best of my knowledge.

_____ _____

Responsible Party Signature Date Signed

_____ _____

Print Responsible Party Name Print Patient's Name (if minor)

A PHOTOCOPY OF THIS FORM SHALL BE DEEMED AS VALID AS THE ORIGINAL