New Patient Car Accident Form

Date of Injury ___/___/___ Claim #_____

First Name_____MI_____Last Name_____ Sex M ____ F ____

Address_____ City_____ State_____ Zip_____

Home Phone_____ Cell Phone_____ Best contact □Cell □Home

Date of Birth_____ Age_____ Marital Status (Circle) M S D W

Social Security Number_____ E-mail Address_____

Occupation_____ Employer_____

Work Address_____ City,_____State ____Zip_____

Spouse's Name_____ # Children_____

Drivers License No. _____State:_____ Have you ever had Chiropractic before_____

All Charges are due when services are rendered. . . . . .

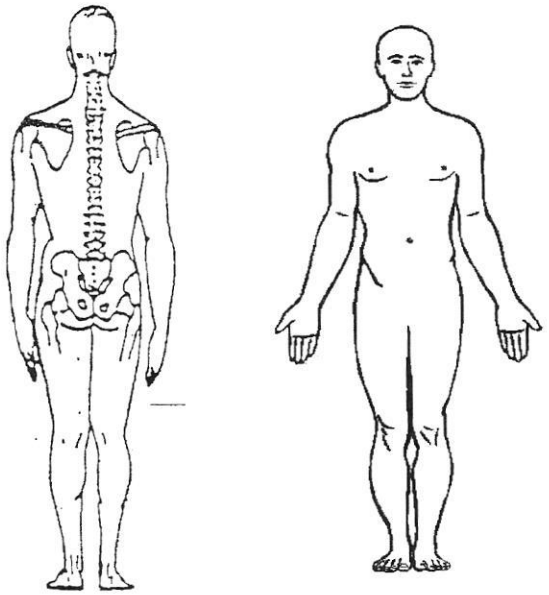
Method of payment ( ) Check ( ) Cash ( ) Credit Card ( ) Care Credit

---

Are you or do you think that you might be pregnant? 1) Yes 2) No 3) Not Sure

Cause of complaint: (circle) 1) Auto Accident 2) Work Injury 3) Other Accident 4) Illness 5) Congenital 6) Unknown

Please Mark an X on the diagram where your problems are →



List your major complaints in order of severity

1._____

2._____

3._____

4._____

5._____

6._____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. I authorize payment from my insurance carrier directly to this office with the understanding that all monies be credited to my account upon receipt. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I understand that if I suspend or terminate my care and treatment, all fees for professional services rendered me will be immediately due and payable. In the event of my default, I promise to pay legal interest on the indebtedness together with such collection costs and reasonable attorney fees as may be required to effect collection.

Patient Signature_____Date_____

Guardian or spouse's authorizing care_____

Thank You For Allowing Us To Serve You!

Vehicle Accident Report

Name_____

Date of Accident ___/___/___ Time of Accident ___:___ (AM /PM)

Were you at work when the accident occurred? _____

Have you been unable to work since injury? Yes___ No___ If yes, you were off work partially or completely

Please list date off work: _____ to _____. Are you working now? ( ) Yes, part time ( ) Yes, full time ( ) No

Were you: ( ) Driver ( ) Passenger (Front) ( ) Passenger (Rear) ( ) Pedestrian

Were you wearing seatbelts? ( ) Yes ( ) No Was your vehicle moving? ( ) Yes ( ) No Other vehicle moving? ( ) Yes ( ) No

Type of Vehicle: ( ) Auto ( ) Light Truck ( ) Truck ( ) Van ( ) Bus ( ) Motorcycle ( ) Motor Scooter ( ) Motor-home ( ) Bicycle

Other vehicle: ( ) Auto ( ) Light Truck ( ) Truck ( ) Van ( ) Bus ( ) Motorcycle ( ) Motor Scooter ( ) Motor-home ( ) Bicycle

---

How accident occurred: ( ) Struck by another vehicle ( ) Struck another vehicle ( ) Struck a stationary object ( ) Other

Where was your vehicle hit? ( ) Front ( ) Rear ( ) Rt. Side ( ) Lft. Side ( ) Rt. Front ( ) Lft. Front ( ) Rt. Rear ( ) Lft. Rear

Where was other vehicle hit? ( ) Front ( ) Rear ( ) Rt. Side ( ) Lft. Side ( ) Rt. Front ( ) Lft. Front ( ) Rt. Rear ( ) Lft. Rear

What occurred at the moment of impact? (Circle as many as apply)

Tensed body for impact	Neck whipped forward & back	Spine torque and twisted	Thrown over seat
Thrown from vehicle	Pinned in vehicle	Thrown from side to side	Cut and Bruised

---

Did you strike your: (Circle as many as apply)

Head	Against the: Dashboard	Windshield	Steering Wheel	Rt. Door	Lft. Door	Seat Frame	Unknown object
Shoulder	(Lft. /Rt.) Dashboard	Windshield	Steering Wheel	Rt. Door	Lft. Door	Seat Frame	Unknown object
Arm	(Lft. /Rt.) Dashboard	Windshield	Steering Wheel	Rt. Door	Lft. Door	Seat Frame	Unknown object
Upper Arm	(Lft. /Rt.) Dashboard	Windshield	Steering Wheel	Rt. Door	Lft. Door	Seat Frame	Unknown object
Forearm Arm	(Lft. /Rt.) Dashboard	Windshield	Steering Wheel	Rt. Door	Lft. Door	Seat Frame	Unknown object
Elbow	(Lft. /Rt.) Dashboard	Windshield	Steering Wheel	Rt. Door	Lft. Door	Seat Frame	Unknown object
Wrist	(Lft. /Rt.) Dashboard	Windshield	Steering Wheel	Rt. Door	Lft. Door	Seat Frame	Unknown object
Hip	(Lft. /Rt.) Dashboard	Windshield	Steering Wheel	Rt. Door	Lft. Door	Seat Frame	Unknown object
Knee	(Lft. /Rt.) Dashboard	Windshield	Steering Wheel	Rt. Door	Lft. Door	Seat Frame	Unknown object
Ankle	(Lft. /Rt.) Dashboard	Windshield	Steering Wheel	Rt. Door	Lft. Door	Seat Frame	Unknown object
Ribcage	(Lft. /Rt.) Dashboard	Windshield	Steering Wheel	Rt. Door	Lft. Door	Seat Frame	Unknown object
Thigh	(Lft. /Rt.) Dashboard	Windshield	Steering Wheel	Rt. Door	Lft. Door	Seat Frame	Unknown object
Shin	(Lft. /Rt.) Dashboard	Windshield	Steering Wheel	Rt. Door	Lft. Door	Seat Frame	Unknown object
Foot	(Lft. /Rt.) Dashboard	Windshield	Steering Wheel	Rt. Door	Lft. Door	Seat Frame	Unknown object
Low back	Dashboard	Windshield	Steering Wheel	Rt. Door	Lft. Door	Seat Frame	Unknown object
Upper back	Dashboard	Windshield	Steering Wheel	Rt. Door	Lft. Door	Seat Frame	Unknown object

---

Were you rendered unconscious? (Y/N) Did you receive medical attention at the scene of the accident? (Y/N)

Where did you go immediately following the accident? ( ) Hospital ( ) Home ( ) Personal Doctor ( ) To this office ( ) Resumed activities

Continued on back

Hospital Name_____ Hospital City/State_____

How did you get there? ( ) Ambulance ( ) Drove myself ( ) Someone drove me ( ) Walked

When did your symptoms develop? __ Immediately __Hours later __The next day

__Over the first few days __During first week __Over next few weeks __Over the next few months

Were you: (Circle as many as apply) Shaken Disoriented Nauseous Dizzy

Did you have any physical complaints before the accident? (Y/N) If "YES" please describe: _____

_____

_____

In your own words, please describe accident: _____

_____

_____

_____

_____

How did you feel immediately after the accident? _____

_____

_____

_____

If you were treated by another Doctor or Therapist for this condition, answer the following questions:

Name: _____ ( ) CA ( ) DC ( ) DDS ( ) DO ( ) DPM ( ) MD ( ) OD ( ) PT

Tests Performed: ( ) Examination ( ) X-Ray ( ) CAT scan ( ) EMG ( ) Thermography

( ) MRI ( ) EEG ( ) Lab ( ) Psychological

Prescription given: ( ) Pain Killers ( ) Muscle relaxants ( ) Antibiotics ( ) Sedatives ( ) Anti-inflammatory ( ) Other

Treatment given: ( ) Daily ( ) 1x/week ( ) 2x/week ( ) 3x/week ( ) 4x/week ( ) 1x/month ( ) 2x/month

Treatment duration: _____ ( ) Days ( ) Weeks ( ) Months

Date first appointment: ___/___/___ Date last appointment: ___/___/___ ( ) Ongoing

Did the treatment help? ( ) No, Aggravated the condition ( ) No ( ) Yes, a little ( ) Yes, a lot ( ) Cured the condition

---

Patient Signature_____ Date_____

Important: This form may be used in the determination of insurance benefits and/ or litigation for compensation. It is imperative that this from be filled out completely to protect your rights of compensation.

Patient Complaints

Name:_____ Date_____

Please check any of the symptoms you have recently experienced

GENERAL
- ☐ Anxiety
- ☐ Concentration
- ☐ Nervousness
- ☐ Irritability
- ☐ Fatigue
- ☐ Depression
- ☐ Memory Loss
- ☐ Loss of sleep
- ☐ Tension
- ☐ Fainting spells
- ☐ Dizzy spells
- ☐ PMS

NECK
- ☐ Neck pain
- ☐ Pain radiates
- ☐ Stiffness
- ☐ Grinding sounds
- ☐ Popping sounds
- ☐ Hoarseness

MIDBACK
- ☐ Pain
- ☐ Muscle spasm

LOWBACK
- ☐ Pain
- ☐ Stiffness
- ☐ Muscle spasm
- ☐ Pain radiates

URINARY TRACT
- ☐ Painful urination
- ☐ Frequent urination
- ☐ Unable to urinate
- ☐ Leakage of urine
- ☐ Blood in urine
- ☐ Bed wetting

HEAD
- ☐ Headaches
- ☐ Jaw Pain
- ☐ Jaw tension
- ☐ Pain in ears
- ☐ Ringing in ears
- ☐ Ear discharge
- ☐ Hearing loss
- ☐ Eye pain
- ☐ Decreased acuity
- ☐ Light sensitivity
- ☐ Floating lights
- ☐ Nose bleeds
- ☐ Nasal obstruction

SHOULDERS
- ☐ Pain with motion
- ☐ Pain at rest
- ☐ Muscle spasm
- ☐ Limited motion
- ☐ Muscle Weakness

THIGH
- ☐ Pain
- ☐ Pain radiates
- ☐ Numbness
- ☐ Pins & needles
- ☐ Knee pain
- ☐ Swollen knee
- ☐ Muscle weakness

CHEST
- ☐ Deep chest pain
- ☐ Pain around ribs
- ☐ Pain with exertion
- ☐ Shortness of breath
- ☐ Difficult breathing
- ☐ Irregular heartbeat
- ☐ Rapid heartbeat
- ☐ Night sweats
- ☐ Chronic cough

ARMS
- ☐ Upper Arm pain
- ☐ Pins & Needles
- ☐ Numbness
- ☐ Weakness
- ☐ Elbow pain
- ☐ Forearm pain

HANDS
- ☐ Wrist pain
- ☐ Hand pain
- ☐ Pins & Needles
- ☐ Numbness- Hand
- ☐ Thumb pain
- ☐ Index finger pain
- ☐ Middle finger pain
- ☐ Ring finger pain
- ☐ Little finger pain
- ☐ Numbness- Fingers
- ☐ Muscle weakness

PELVIS
- ☐ Hip joint pain
- ☐ Sacroiliac pain
- ☐ Buttock pain
- ☐ Groin pain
- ☐ Tail bone pain

CALVES
- ☐ Calf pain
- ☐ Pain radiates
- ☐ Numbness
- ☐ Pins & needles
- ☐ Cramps
- ☐ Muscle weakness

ANKLES
- ☐ Pain
- ☐ Swelling

Continued on Back

FEET	DIGESTIVE TRACT	WOMEN ONLY
☐ Pain	☐ Stomach pain	☐ Painful menstruation
☐ Numbness	☐ Indigestion	☐ Excess menstruation
☐ Pins & Needles	☐ Nausea	☐ Missed periods
☐ Swelling	☐ Gas	☐ Irregular periods
☐ Cramps	☐ Clay colored stool	
☐ Big toe pain	☐ Black tarry stool	
☐ 2nd toe pain	☐ Hemorrhoids	
☐ Mid toe pain	☐ Abnormal weight loss	
☐ 4th toe pain	☐ Diarrhea	
☐ Small toe pain	☐ Constipation	

Any other new symptoms since the accident that are not listed above_____

_____

Which is your most serious complaint? _____

Which is your next most serious complaint? _____

Approximate date of onset (if known): ____/____/____ **Onset was:** ☐ Sudden ☐ Gradual

Are the complaints? ☐ Improving ☐ Getting worse ☐ About the same ☐ Comes & Goes

When are the complaints most noticeable? ☐ Morning ☐ Afternoon ☐ Evening ☐ Night

What aggravates the complaint(s)? ☐ Standing ☐ Walking ☐ Sitting ☐ Bending ☐ Lying ☐ Lifting ☐ Twisting ☐ Coughing

What relieves the complaint(s)? ☐ Rest ☐ Sitting ☐ Lying ☐ Bending ☐ Stretching ☐ Exercise ☐ Lying knees bent

Lark Chiropractic

PERSONAL INJURY FORMS

Contact Information

Please print all information.

Patient Name (please print): _____

_____ **At Fault Insurance Information**

Insurance Company Name: _____

Claim #: _____

Adjuster Name: _____

Phone Number: _____

_____ **Your Auto Insurance Information**

Insurance Company Name: _____

Claim #: _____

Adjuster Name: _____

Phone Number: _____

_____ **Attorney Information**

Firm Name: _____

Attorney Name: _____

Phone Number: _____

_____ **Health Insurance Information**

Need copy of your insurance card.

_____ **Accident Report**

Need copy of Accident Report. Reports are typically released 48 hours after accident.

Signature below of patient/Guardian indicates that you have read and accept above provisions.

_____

Signature of Patient or Guardian Date

_____

Printed Name

Lark Chiropractic

PERSONAL INJURY FORMS

Office Policies

Personal Injury cases are accepted in our office. All personal injury cases, whether car or home accidents, must provide necessary information regarding your **personal car insurance**, the **"at fault" insurance**, your **commercial health insurance**, as well as the **accident report**, and **attorney name and contact information** if one has been retained.

The personal car insurance is needed because most individuals have medical benefits (usually called "Medpay" or" PIP") included in their automobile policies and some do not even realize it. If these benefits are available on your policy, our office requires that you use them in the event that your injuries are as a result of an automobile accident.

The following outlines why we require Medpay or PIP be filed:

1. **Medpay and PIP are exactly like health insurance – using either form of coverage does not cause your rates to go up.** However, if your rates are increased it is not because of the medpay was filed. It is most likely because: (a) the accident was determined by the insurance company to be your fault, (b) you received a police citation or ticket, and (c) you have been involved in numerous reported auto accidents within a brief period of time and are therefore considered "high risk".

2. **Filing your Medpay or PIP does not relieve the "at Fault" party from having to pay in full for your loss.** Filing Medpay or PIP does not relieve the other party from being held responsible for payment. If the "at fault" driver's liability insurance refuses to make payment on your medical bills for whatever reason, filing your Medpay/PIP will help ensure that you are not left to pay these expenses out of pocket.

3. **We do not charge for filing your Medpay or PIP.**

As long as Lark Chiropractic is filing my Medpay/PIP and, the insurance company is continuing to cover the charges accrued, collection of payment at time of service will be waived. If overpayment on my account is made, Lark Chiropractic will refund the difference. I clearly understand and agree that all services rendered to me are charged directly to me, thus, I am personally responsible for payment in full.

Signature below of patient/Guardian indicates that you have read and accept above provisions.

Signature of Patient or Guardian Date

Printed Name

Lark Chiropractic

PERSONAL INJURY FORMS

Contractual Lien

I hereby authorize and direct you, the insurance company, and/or my attorney, to pay directly to **Lark Chiropractic** such sums that may be due and owing this office for services rendered to me, both by reason of accident, of illness and by reason of any other bills that are due this office, and to withhold such sums from any disability benefits, medical payment benefits, liability benefits, health and accident benefits, workmens' compensation benefits, or any other insurance benefits obligated reimburse me or from any settlement, judgment or verdict on my behalf as may be necessary to adequately protect said office.

I hereby further give a lien to said office against any and all insurance named herein, and any and all proceeds of any settlement, judgment or verdict that may be paid to me as a result of the injuries or illness for which I have been treated by said office. This is to act as an assignment of my rights and benefits to the extent of the office's services provided.

I understand that I remain personally responsible for the total amounts due the office for their services. I further understand and agree that this assignment, lien and authorization does not contribute any consideration for the office to await payments and they may demand payment from me upon rendering services at their option. I authorize this office to release any information pertinent to my case to any insurance company or attorney to facilitate collection under this assignment, lien and authorization.

I agree that the above mentioned office be given power of attorney to endorse my name on any and all checks for payment of my doctor bill.

I further understand and agree, that if this office must take any action to collect an outstanding balance on my account, I will be responsible for payment of and reimburse this office for all costs of such collection efforts including but not limited to all court costs and attorney fees.

I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment, but will require me to make payments on my current balance.

By signing below, I acknowledge I have read, understand and agree to the above provisions.

Patient Name (please print): _____

Patient Signature: _____ Date: _____

Name of custodial parent or Legal Guardian (please print): _____

Parent/Guardian Signature: _____

Informed Consent for Chiropractic Care

We encourage and support a **shared decision making process** between us regarding your health needs. As a part of that process you have a right to be informed about the condition of your health and the recommended care and treatment to be provided to you so that you can make the decision whether or not to undergo such care with full knowledge of the known risks. This information is intended to make you better informed in order that you can knowledgably give or withhold your consent.

Prior to receiving chiropractic care in this Chiropractic office, a health history and physical examination will be completed. These procedures are performed to assess your specific condition, your overall health and, in particular, your spinal health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies are needed before treatment. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan to help you become informed prior to beginning care.

In addition to the benefits of chiropractic care and treatment, one should also be aware of the existence of some risks and limitations of this care. The risks are seldom high enough to contraindicate care and all health care procedures have some risk associated with them.

Risks associated with some chiropractic treatment may include soreness, musculoskeletal sprain/strain, and rarely, fracture. In addition, there are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence *does not* establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke; rather, recent studies indicate that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there may be a stroke already in process. However, you are being informed of this reported association because a stroke may cause serious neurological impairment. The possibility of such injuries occurring in association with upper cervical adjustment is extremely remote.

I understand and accept that there are risks associated with chiropractic care and give my consent to the examinations that the doctor deems necessary, and to the chiropractic care including spinal adjustments and other modalities, as reported following my assessment.

Patient Name or legal Guardian(printed)	Date
Patient or legal Guardian Signature	Relationship to patient
Witness Signature (office staff)	Date

Lark Chiropractic
Terms of Acceptance

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one primary goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic methods of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well being, not merely the absence of disease of infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission os mental impulses, resulting in a lessening of the body's innate ability to express it's maximum potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non- chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of health care provider who specializes in that area.

Regardless of what the disease is called , we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR PRIMARY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxation.

I _____have read and fully understand the above statements.

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

_____ _____

(Patient signature) (Date)

Patient Health Information Consent Form

We want you to know how your Patient Health Information (**PHI**) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this office to use their Patient Health Information (**PHI**) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment. The patient understands and agrees to allow this chiropractic office to contact them via electronic means such as through phone, fax, email, etc.

2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.

3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.

4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.

5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.

6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.

7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the healthcare provider has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

_____ _____

Name of Patient Date

NOTICE OF DOCTOR'S LIEN

I do hereby authorize **Dr. Sharon Lark** to furnish you, my attorney, with a full report of their examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I was recently involved.

I hereby authorize and direct you, my attorney, to pay directly to said doctor such sums as may be due and owing her for medical services rendered me both by reason of this accident and by reason of any other bills that are due their office and to withhold such sums from any settlement, judgment of verdict as may be necessary to adequately protect said doctor. And I hereby further give a Lien on my case to said doctor against any and all proceeds of my settlement, judgment or verdict which may be paid to you, my attorney or myself, as the result of the injuries for which I have been treated or injuries in connection therewith.

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

Please acknowledge this letter by signing below and returning to the doctor's office. I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment but may declare the entire balance due and payable. Patient further agrees that in the event this lien is litigated, patient agrees that the prevailing party will be awarded attorney fees and costs. In the event the sum disputed exceeds the jurisdiction of Small Claims Court, patient agrees to accept binding resolution through the American Arbitration Association.

RE: _____ **DOI:** _____

Dated_____ _____

Patients Signature

The undersigned being attorney of record for the above patient does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment, or verdict as may be necessary to adequately protect said doctor above named. Attorney further agrees that in the event this lien is litigated, attorney agrees that the prevailing party will be awarded attorney fees and costs. In the event the sum disputed exceeds the jurisdiction of Small Claims Court, attorney agrees to accept binding resolution through the American Arbitration Association.

Dated_____ _____

Attorney's Signature

Please date, sign and return one copy to doctor's office. Also keep one copy for your records.

Lark Chiropractic
125 E. Barstow Ave., Suite 150
Fresno, CA 93710