

AUTOMOBILE ACCIDENT QUESTIONNAIRE

PLEASE ANSWER ALL QUESTIONS COMPLETELY

Date _____
Patient _____ No. _____
Sex _____ Marital Status _____ Date of Birth _____ Home Phone _____
Address _____ City _____ State _____ Zip _____
Occupation _____
Who referred you to our office? _____
Social Sec. # _____ Business Phone _____ Company Name _____
Company Address _____
Please explain in detail how your accident happened? _____

Driver of other vehicle (if any) _____ Date of Birth _____
Insurance Company _____ Address _____ Phone No: _____
Policy No. _____
Claim No. _____
Name of person who has made contact with you _____
Name of driver of vehicle in which you were injured (self or other) _____
Insurance Company _____ Address _____ Phone No: _____
Policy No. _____
Claim No. _____
Name of Person who has made contact with you _____

Have you retained an attorney? Yes No Not Yet
If so, his/her name, address & phone # _____
Give time and date present injury occurred _____ AM PM ____/____/____
You were heading? North South East West on _____ (street or highway)
Number of people in your vehicle _____
Were police notified? Yes No Did head strike windshield or object? Yes No
Were you knocked unconscious Yes No If so, for how long _____
You were struck from? Behind Front Left Side Right Side
You were? Driver Passenger Front seat Back seat Using seat belts Other protective devices
Did you feel pain immediately after the accident? Yes No Later that day Next day When _____
Where did you feel pain immediately after the accident? _____
Where were you taken after the accident? _____
Was treatment given? _____
Was any doctor consulted after the accident? Yes No
If so, give doctor's name _____ D.C., M.D., D.O., D.D.S. _____
Doctor's Diagnosis _____
What treatment was given? _____
How often did you see the doctor? _____
How long did you see the doctor? _____
Have you ever had any complaints in the involved area before? Yes No
If so, what were the complaints? _____
Before the injury, were you capable of working on an equal basis with others your age? Yes No
Are your work activities restricted as a result of this accident? Yes No
Since the injury, are your symptoms Improving? Getting worse? The same?

HEALTH QUESTIONNAIRE

PLEASE CHECK MARK EACH OF THE CONDITIONS BELOW THAT YOU ARE CURRENTLY EXPERIENCING

Date: _____

Patient: _____ No.: _____

MUSCULO SKELETAL SYSTEM

- Low back pain
- Mid back pain
- Pain between shoulders
- Neck pain
- Arm problems
- Leg problems
- Swollen joints
- Painful joints
- Stiff joints
- Sore muscles
- Weak muscles
- Walking problems
- Spasms
- Broken bones
- Shoulder pain

GENITO-URINARY SYSTEM

- Bladder trouble
- Excessive urination
- Scanty urination
- Painful urination
- Discolored urine

FEMALE

- Vaginal discharge
- Vaginal bleeding
- Vaginal pain
- Breast pain
- Lumps on the breast

ARE YOU PREGNANT?
 YES NO

GASTRO-INTESTIONAL SYSTEM

- Poor appetite
- Excessive hunger
- Difficult chewing
- Difficult swallowing
- Excessive thirst
- Nausea
- Vomiting Blood
- Abdominal pain
- Diarrhea
- Constipation
- Black stool
- Bloody stool
- Hemorrhoids
- Liver trouble
- Gall bladder problems
- Weight trouble

CARDIO-VASCULAR RESPIRATORY

- Chest pain
- Pain over heart
- Difficult breathing
- Persistent cough
- Coughing phlegm
- Coughing blood
- Rapid heartbeat
- Blood pressure problems
- Heart problems
- Lung problems
- Varicose veins

EYE, EAR, NOSE AND THROAT

- Eye strain
- Eye inflammation
- Vision problems
- Ear pain
- Ear noises
- Ear discharge
- Hearing loss
- Nose pain
- Nose bleeding
- Nose discharge
- Difficult breathing through nose
- Sore gums
- Dental problems
- Sore mouth
- Sore throat
- Hoarseness
- Difficult speech
- Sinus
- Allergy
- Jaw Pain

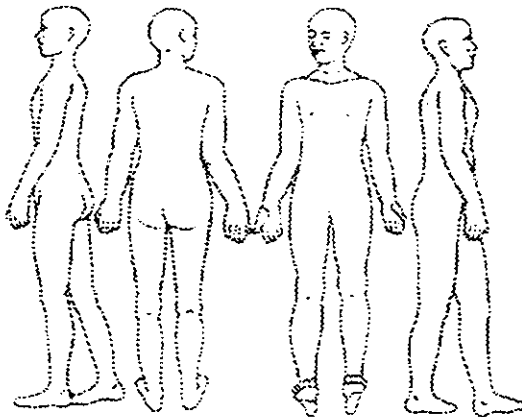
NERVOUS SYSTEM

- Numbness
- Loss of feeling
- Paralysis
- Dizziness
- Fainting
- Headaches
- Muscles jerking
- Convulsions
- Forgetfulness
- Confusion
- Depression
- Insomnia

HABITS

- Cigarettes
- Alcohol Abuse
- Coffee or Tea
- Drug Abuse
- _____

SYMPTOM LOCALIZATION



P ___ Pain T ___ Tender
 N ___ Numb H ___ Hypoesthesia
 S ___ Spasm

Pain Index

Least 1 2 3 4 5 6 7 8 9 10 Worst

 Patient's Signature

..... DO NOT WRITE BELOW THIS LINE

Patient Accepted? Yes No Doctor's Signature _____

ASSIGNMENT OF PROCEEDS, CONTRACTUAL LIEN, AND AUTHORIZATION

("Agreement")

I hereby direct any and all insurance carriers, attorneys, agencies, governmental departments, companies, individuals, and/or other legal entities ("payers"), which may elect or be obligated to pay benefits to me for any medical conditions, accidents, injuries, or illnesses, past or future ("condition"), to pay directly to, and exclusively in the name of, **Butler Chiropractic Clinic** (" **Butler Chiropractic** " or "Office") such sums as may be owing to **Butler Chiropractic** for charges incurred by me, including but not limited to, charges for treatment, narrative reports, depositions, testimony, and any other charges incurred by me at the Office ("charges"). I further grant a contractual lien to **Butler Chiropractic** with respect to my charges, applicable to all payers, however, I understand that nothing in this Agreement shall be construed as an election by **Butler Chiropractic** to claim protection under any statutory lien law. For the purposes of this Agreement, "benefits" shall include, but shall not be limited to, proceeds from any settlement, judgement, or verdict, as well as any proceeds relating to commercial health or group insurance, disability benefits, worker's compensation benefits, medical payments benefits, personal injury protection, lost wages benefits, lost services benefits, no-fault coverage, uninsured and underinsured motorist coverage, third-party liability distributions, malpractice proceeds, attorney retainer agreements, and any other benefits or proceeds payable to me for the purposes stated herein, regardless of whether such proceeds are related to my charges or not.

I further agree that, in the event a payer refuses to pay **Butler Chiropractic** I hereby assign to the Office, insofar as permitted by law, the following: all of my rights, remedies, and benefits to **Butler Chiropractic** as well as any and all causes of action that I might have against such payer to the extent of my charges, the right to prosecute such causes of action either in my name or in the Office's name, and the right to settle or otherwise resolve such causes of action as the Office sees fit.

In the event that I retain one or more attorneys to represent me in this matter, I hereby direct each attorney to issue a letter of protection to this office regarding my charges. Upon issuance, I hereby agree that such letter(s) of protection cannot be revoked or modified without the expressed written consent of this office. I further direct (and the Office hereby requests) each attorney to provide immediate notice to the Office regarding any funds received by the attorney relating to my accident, to promptly pay the Office out of such funds, and to provide a full accounting of such funds to the Office upon its request.

I hereby direct all payers to release to **Butler Chiropractic** any information regarding any coverage or benefits which I may have including, but not limited to, the amount of the coverage, the amount paid thus far, and the amount of any outstanding claims.

I authorize this Office to release any information regarding my treatment or pertinent to my case(s) to all payers as defined above to facilitate collection under this Agreement. I hereby direct this Office to file a copy of this Agreement, together with any applicable charges, with any or all payers, regardless of whether a claim has been established with said payers. I hereby authorize **Butler Chiropractic** to endorse/sign my name on any and all checks listing me as a payee which are presented to this Office for payment of an account relating to me, my spouse, or any of my dependents. I further authorize **Butler Chiropractic** to apply any credit balances on charges incurred by me to any other outstanding charges still owed by me, my spouse, or my dependents, regardless of whether these other charges are related to my condition.

I understand that I remain personally responsible for the total amounts due **Butler Chiropractic** for their services. This Agreement does not constitute any consideration for this Office to await payments and it may demand payments from me immediately upon rendering services at its option. If this Office must take any action to collect an outstanding balance on my account, I will be responsible for payment and will reimburse **Butler Chiropractic** for all costs of such collection efforts, including, but not limited to, all court costs and all attorney fees.

This Agreement shall not be modified or revoked without the mutual written consent of **Butler Chiropractic** and myself. I hereby revoke any previously signed authorizations, whether executed at this office or any other office to the extent that the terms of those authorizations conflict with the terms of this Agreement.

I agree that each and every provision of this Agreement is reasonably necessary for the protection of the rights and interests of **Butler Chiropractic** and myself. However, should any provision of this Agreement be found to be invalid, illegal or unenforceable, or for any reason cease to be binding on any party hereto, all other portions and provisions of this Agreement shall, nevertheless, remain in full force and effect.

Patient Name (please print): _____

Patient Signature: _____ Date: ___/___/___

Name of Custodial Parent or Legal Guardian (please print): _____

Parent/Guardian' Signature: _____ Date: ___/___/___

NOTICE OF PRIVACY PRACTICES

Randy W. Butler D.C.
1026 West Main Street # 100
Lewisville, Texas 75067
(972) 221-7533 (972) 219-6901

The health Insurance and Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

If you sign a Consent Form, we may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities and utilization review. An example of this would be sending a bill of your visit to your insurance company for payment.
- Health care operations including the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individual identifiable information.

We may, without prior consent, use or disclose protected health information to carry out treatment, payment, or health care operations in the following circumstances:

- In emergency treatment situations, if we attempt to obtain such a consent as soon as reasonably practicable after the delivery of such treatment:
- If we are required by law to treat you, and we attempt to obtain such consent but are unable to obtain such consent; or
- If we attempt to obtain your consent but are unable to do so due to substantial barriers to communicate with you, and we determine that, in our professional judgement, you consent to receive treatment is clearly inferred from circumstances.

We may contact you to provide appointment reminders, missed appointments or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we already have taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- **The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.**
- **The right to reasonable request to receive confidential communications of protected health information from us by alternative means or at alternative locations.**
- **The right to inspect and copy your protected health information.**
- **The right to amend your protected health information.**
- **The right to receive an accounting of disclosures of protected health information.**
- **The right to obtain a paper copy of this notice from us upon request.**

We are required by law to maintain the privacy of your protected health information and to provide you with a notice of our legal and privacy practices with respect to protected health information.

This notice is effective as of November 01, 2002 and we are required to abide by terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a formal written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information:

**Randy W. Butler D.C.
1026 West Main Street #100
Lewisville, Texas 75067
(972)221-7533
(972) 219-6901 Fax**

For more information about HIPAA or to file a complaint:

**The U.S. Department of Health
& Human Rights Services/
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257
Toll Free: 1 (877) 696-6775**

CONSENT FOR USE AND DISCLOSURE OF INFORMATION

I have reviewed the *"Notice of Privacy Practices"* of Randy W. Butler D.C. and have had all questions answered by this office.

I also consent to the use or disclosure of my protected health information for the following purposes:

TREATMENT

IT WILL BE NECESSARY TO SHARE PROTECTED HEALTH INFORMATION WITH ALL MEMBERS OF THE TREATMENT TEAM FOR TREATMENT PURPOSES. THIS CAN INCLUDE EMPLOYEES IN THIS OFFICE AS WELL AS OTHER PROVIDERS.

PAYMENT

NECESSARY INFORMATION WILL BE SHARED WITH THE APPROPRIATE PAYER SOURCES AND THEIR REPRESENTATIVES FOR PAYMENT PURPOSES INCLUDING, BUT NOT LIMITED TO ELIGIBILITY, BENEFIT DETERMINATION, AND UTILIZATION REVIEW. IT WILL ALSO BE NECESSARY FOR YOUR BILLING PERSONNEL INCLUDING BUT NOT LIMITED TO EMPLOYEES, CASE MANAGERS, CLAIM REPRESENTATIVES, THIRD PARTY BILLING SERVICES OR CLEARINGHOUSES TO HAVE ACCESS TO PROTECTED HEALTH INFORMATION TO CARRY OUT THEIR JOB FUNCTIONS.

HEALTHCARE OPERATIONS

NECESSARY INFORMATION WILL BE SHARED FOR THE CONTINUING OPERATIONS OF THIS OFFICE. SOME EXAMPLES INCLUDE, BUT NOT LIMITED TO PEER REVIEW, ACCREDITATION, CREDENTIALING PROCESSES, AND COMPLIANCE WITH THE FEDERAL AND STATE LAWS.

I release Randy W. Butler D.C. to discuss my case with my spouse, parent or gaurdian.

I understand that my treatment may be conditioned upon my consent. This consent is given freely and I understand that I can revoke this consent at any time in writing which will apply to disclosures and uses made subsequent to the revocation date.

Patients Name (Printed): _____

Date: _____

Patient Signature: _____