

# 1 one

# WELCOME

## ABOUT YOU

Today's Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ File #: \_\_\_\_\_

**Patient Name:** \_\_\_\_\_  
LAST FIRST MI

What You Prefer To Be Called: \_\_\_\_\_ ☐ Male ☐ Female

Birthdate: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age: \_\_\_\_ SS#: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

CITY STATE ZIP

Home Phone #: \_\_\_\_\_

Work Phone #: \_\_\_\_\_ Ext: \_\_\_\_\_

Other Phone #s: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_

**Employer:** \_\_\_\_\_ How Long? \_\_\_\_\_

Employer's Address: \_\_\_\_\_

CITY STATE ZIP

Occupation: \_\_\_\_\_

Status: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Spouse's Name: \_\_\_\_\_

Do you have children? ☐ Yes ☐ No How many? \_\_\_\_\_

# 2 two

## INSURANCE INFO

Co. Name: \_\_\_\_\_

Address: \_\_\_\_\_

CITY STATE ZIP

Phone #: \_\_\_\_\_

Insured's ID#: \_\_\_\_\_

Group # (Plan, Local, or Policy #): \_\_\_\_\_

Insured's Name: \_\_\_\_\_

Relation: \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Insured's Employer: \_\_\_\_\_

Please inform front desk of 2nd. Insurance source.

## REASON FOR VISIT

The reason for this visit is a result of (*Please circle*): work, sports, auto, trauma or chronic.

(*Explain what happened*): \_\_\_\_\_

Please describe the pain & its location: \_\_\_\_\_

When did condition begin? \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Is this condition getting worse? ☐ Yes ☐ No ☐ Constant ☐ Comes and goes

Is this condition interfering with your (*Please Circle*): work, sleep, or daily routine.

If so, please explain: \_\_\_\_\_

Have you had this or similar conditions in the past? ☐ Yes ☐ No

If so, please explain: \_\_\_\_\_

Have you been treated by a Medical Physician for this condition? ☐ Yes ☐ No

If so, where? \_\_\_\_\_

Have you ever been treated by a Chiropractor before? ☐ Yes ☐ No

If so, whom? \_\_\_\_\_ Phone#: \_\_\_\_\_

# 3 three

PLEASE CONTINUE ON BACK



4  
four

## IN EVENT OF EMERGENCY

Who should we contact? \_\_\_\_\_  
 Relation: \_\_\_\_\_  
 Home Phone #: \_\_\_\_\_ Work Phone #: \_\_\_\_\_  
 Who is your Medical Doctor? \_\_\_\_\_ Phone #: \_\_\_\_\_

## HEALTH HISTORY

## Are you taking any of the following medications?

☐ Nerve pills ☐ Pain killers (including aspirin) ☐ Muscle relaxers ☐ Stimulants  
☐ Blood Thinners ☐ Tranquilizers ☐ Insulin ☐ Other(s) \_\_\_\_\_

## Do you have or ever had any of the following diseases or conditions?

Y N Heart Attack / Stroke	Y N Heart Surg./Pacemaker	Y N Heart Murmur
Y N Congenital Heart Defect	Y N Mitral Valve Prolapse	Y N Artificial Valves
Y N Alcohol / Drug Abuse	Y N Venereal Disease	Y N Hepatitis
Y N HIV+ / Aids	Y N Shingles	Y N Cancer
Y N Frequent Neck Pain	Y N Emphysema / Glaucoma	Y N Anemia
Y N High/Low Blood Pressure	Y N Psychiatric Problems	Y N Rheumatic Fever
Y N Severe/Frequent Headaches	Y N Kidney Problems	Y N Ulcers / Colitis
Y N Fainting/Seizures/Epilepsy	Y N Sinus Problems	Y N Asthma
Y N Diabetes / Tuberculosis	Y N Difficulty Breathing	Y N Chemotherapy
Y N Lower Back Problems	Y N Artificial Bones / Joints	Y N Arthritis

Please list any other serious medical condition(s) you have or ever had: \_\_\_\_\_

Please list anything that you may be allergic to: \_\_\_\_\_

List previous surgeries/treatments with dates: \_\_\_\_\_

List any **past** serious accidents with dates: \_\_\_\_\_

Family Health History: \_\_\_\_\_

**Do you:** Take Supplements or Vitamins? ☐ Yes ☐ No / Exercise? ☐ Yes ☐ No

Are you on a special diet: ☐ Yes ☐ No / Since: \_\_\_\_/\_\_\_\_/\_\_\_\_

Do you smoke? ☐ No ☐ Yes / How Much? \_\_\_\_\_ How Long? \_\_\_\_\_

Are you wearing: ☐ Heel Lifts ☐ Sole lifts ☐ Inner soles ☐ Arch supports

What is the age of your mattress? \_\_\_\_ Is it comfortable? ☐ Yes ☐ No

**For women:** Are you taking Birth Control? ☐ Yes ☐ No

Are you Pregnant? ☐ No ☐ Yes/How long? \_\_\_\_ Nursing? ☐ Yes ☐ No

5  
five6  
six

## ACCOUNT INFO

## Person ultimately responsible for account

Name: \_\_\_\_\_

Relation: \_\_\_\_\_

Billing Address: \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

SSN: \_\_\_\_\_

D.L.#: \_\_\_\_\_

Work Phone#: \_\_\_\_\_

**Payment method:** ☐ CASH ☐ Check

☐ Credit Card - Enter card # above (if accepted)

I hereby authorize assignment of  
 my insurance rights and benefits  
 directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).

Initials \_\_\_\_\_

- We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider and or managed care organization, to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

☐ Adult Patient ☐ Parent or Guardian ☐ Spouse



# AUTO / WORK RELATED ACCIDENT

1  
one

2a  
twoa

## ABOUT YOU

Today's Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ File #: \_\_\_\_\_

Name: \_\_\_\_\_

2b  
twobb

## WORK RELATED ACCIDENT

Date & Time of Accident: \_\_\_\_\_ ☐ a.m. ☐ p.m.

Was your accident directly related to your work?  
☐ Yes ☐ No

Briefly describe the events that occurred just before and during your accident: \_\_\_\_\_  
\_\_\_\_\_

Give the address where accident occurred: (if other than employer's address) \_\_\_\_\_  
\_\_\_\_\_

Was anyone else present during your accident?  
☐ Yes ☐ No

Did you report your accident to your employer?  
☐ Yes ☐ No

What recommendations did your employer make just after your accident? \_\_\_\_\_  
\_\_\_\_\_

Has this type of accident happened to you before?  
☐ Yes ☐ No

To the best of your knowledge, has this accident occurred in your workplace before? ..... ☐ Yes ☐ No  
In general:

Is your job physically stressful? ..... ☐ Yes ☐ No

Is your job mentally stressful? ..... ☐ Yes ☐ No

Is your workplace noisy? ..... ☐ Yes ☐ No

Have you changed jobs in the last year? ☐ Yes ☐ No

## AUTO RELATED ACCIDENT

Date & Time of Accident: \_\_\_\_\_ ☐ a.m. ☐ p.m.

Were you the: ☐ Driver ☐ Front Passenger ☐ Rear Passenger

If a traffic violation was issued, to whom was it issued?  
\_\_\_\_\_

Number of people in accident vehicle? \_\_\_\_\_

Did the police come to the accident site? . . . ☐ Yes ☐ No

Was a police report filed? . . . . . ☐ Yes ☐ No

Were there any witnesses? . . . . . ☐ Yes ☐ No

Were you wearing your seat belt? . . . . . ☐ Yes ☐ No

Was this vehicle equipped with airbags? . . ☐ Yes ☐ No

If yes, did it/they inflate? . . . . . ☐ Yes ☐ No

In relation to the base of your skull, where was the headrest? . . . . . ☐ Above ☐ Below ☐ At base of skull

What did your vehicle impact? ☐ Another vehicle ☐ Other

If other, explain: \_\_\_\_\_

Did any part of your body strike anything in the vehicle? ☐ Yes ☐ No

If yes, please describe: \_\_\_\_\_

\_\_\_\_\_

Make & model of the vehicle you were occupying?

Name of the location/street on which you were traveling?

In which direction were you headed? ☐ N ☐ S ☐ E ☐ W

What was the approx. speed of your vehicle? \_\_\_\_\_

Did the impact to your vehicle come from the:

☐ Front ☐ Rear ☐ Right Side ☐ Left Side ☐ Other

During impact, were you facing: ☐ Right ☐ Left ☐ Forward

Were you ☐ aware or ☐ surprised by the impact?

If accident vehicle made impact with another vehicle...

Make and model of that other vehicle? \_\_\_\_\_

Direction other vehicle was headed? ☐ N ☐ S ☐ E ☐ W

Speed of the other vehicle? \_\_\_\_\_

In your words, please describe the accident: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

PLEASE CONTINUE ON BACK



# three

## AFTER INJURY

Did accident render you unconscious? . . . . ☐ Yes ☐ No

If yes, for how long? \_\_\_\_\_

Please describe how you felt immediately after the accident:

\_\_\_\_\_

Have you gone to a Hospital or seen any other Doctor? ☐ Yes ☐ No

When did you go? ☐ Just after accident ☐ The next day ☐ 2 days plus

How did you get there? ☐ Ambulance or ☐ Private transportation

Name of Hospital and/or Attending doctor: \_\_\_\_\_

Was he/she a: ☐ D.C. ☐ M.D. ☐ D.O. ☐ D.D.S.

Describe any treatment you received: \_\_\_\_\_

Were X-rays taken? . . . . . ☐ Yes ☐ No

Was medication prescribed? . . . . . ☐ Yes ☐ No

Have you been able to work since this injury? ☐ Yes ☐ No

Are your work activities restricted as a result of this injury?

☐ Yes ☐ No

Indicate ☒ the symptoms that are a result of this accident:

- |   |  |  |  |
|---|--|--|--|
| <input type="checkbox"/> Dizziness      | <input type="checkbox"/> Difficulty sleeping | <input type="checkbox"/> Jaw problems        | <input type="checkbox"/> Nausea          |
| <input type="checkbox"/> Memory loss    | <input type="checkbox"/> Irritability        | <input type="checkbox"/> Arms/Shoulder pain  | <input type="checkbox"/> Back pain       |
| <input type="checkbox"/> Headache(s)    | <input type="checkbox"/> Fatigue             | <input type="checkbox"/> Numb Hands/Fingers  | <input type="checkbox"/> Lower back pain |
| <input type="checkbox"/> Blurred vision | <input type="checkbox"/> Tension             | <input type="checkbox"/> Chest pain          | <input type="checkbox"/> Back stiffness  |
| <input type="checkbox"/> Buzzing in ear | <input type="checkbox"/> Neck pain           | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Leg pain        |
| <input type="checkbox"/> Ears ringing   | <input type="checkbox"/> Neck stiff          | <input type="checkbox"/> Stomach upset       | <input type="checkbox"/> Numb Feet/Toes  |
| <input type="checkbox"/> Other _____    |  |  |  |

Is your condition getting worse?

☐ Yes ☐ No ☐ Constant ☐ Comes & goes

Indicate your degree of comfort while performing the following activities:

	Comfortable	Uncomfortable <small>even if only sometimes</small>	Painful
Lying on back . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lying on side . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lying on stomach . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Standing . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stretching . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lovemaking . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Running . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sports . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Working . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lifting . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bending . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kneeling . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pulling . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reaching . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Have you retained an attorney: ☐ Yes ☐ No

If yes, whom: \_\_\_\_\_

His/Her Phone #: \_\_\_\_\_

# four

## RECOVERY

To evaluate the effect that continuing work will have on your recovery please complete the following:

How many hours are in your normal work day? \_\_\_\_\_

Please indicate ☒ your daily job duties and any activities which you are occasionally asked to perform.

- |                                   |                                   |  |
|-----------------------------------|-----------------------------------|--|
| <input type="checkbox"/> Standing | <input type="checkbox"/> Driving  | <input type="checkbox"/> Operating equipment       |
| <input type="checkbox"/> Sitting  | <input type="checkbox"/> Twisting | <input type="checkbox"/> Work with arms above head |
| <input type="checkbox"/> Walking  | <input type="checkbox"/> Crawling | <input type="checkbox"/> Typing                    |
| <input type="checkbox"/> Lifting  | <input type="checkbox"/> Bending  | <input type="checkbox"/> Stooping                  |

☐ Other \_\_\_\_\_

What positions can you work in with minimum physical

effort and for how long? \_\_\_\_\_ ☐ N/A

Prior to the injury were you capable of working on an equal basis with others your age? . . ☐ Yes ☐ No ☐ N/A

Do you work with others who can help you with any heavy lifting? . . . . . ☐ Yes ☐ No ☐ N/A

While in recovery, is there any light duty work you could request? . . . . . ☐ Yes ☐ No ☐ N/A

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## ADDITIONAL INSURANCE

### 2nd Insurance Source or Auto Insurance

Type of Insurance: \_\_\_\_\_

Co. Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone #: \_\_\_\_\_

Insured's Name: \_\_\_\_\_

Policy #: \_\_\_\_\_ Claim #: \_\_\_\_\_

Insured's SS #: \_\_\_\_\_ D.O.B. \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Insured's Employer: \_\_\_\_\_

Agent's Name: \_\_\_\_\_

If any of your medical or account information has changed, please inform our front desk personnel.

Please remember you are ultimately responsible for your account.

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
SIGNATURE DATE

OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY



PLEASE RECYCLE SO THAT WE MAY PRESERVE THE HEALTH OF OUR PLANET



# HIPAA COMPLIANT AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

TO:

\_\_\_\_\_  
Name of Healthcare Provider/Physician/Facility/Medicare Contractor

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City, State and Zip Code

RE:

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

To release my health care information to **Malek Chiropractic, 373 Golden State Blvd. Turlock, CA 95380**, for the purpose of reviewing my records.

## Information to be Released:

- ☐ All Medical Records  
☐ All Medical Billing Records  
☐ X-Ray and imaging reports

## Dates of Treatment:

- ☐ All Dates  
☐ Specific Dates: \_\_\_\_\_

Other: \_\_\_\_\_

1. I understand that my express consent is required to release any health care information relating to testing/diagnosis, and/or treatment for HIV (AIDS Virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use. If I have been tested, diagnosed, or treated for HIV (AIDS Virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use, you are specifically authorized to release all health care information relating to such diagnosis, testing or treatment.
2. I understand that authorizing the disclosure of this health information is voluntary and you have my consent to release medical records for all dates including all diagnostic tests of any type and reports, history, hospitalization, diagnosis, prognosis, treatment, medication and pharmacy records, correspondence, consults, statement of charges or expenses. Any and all reports of any type or character.
3. I understand I have the right to revoke this authorization in writing. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. To revoke an authorization I may fill out a revocation form available at the facility/Provider or write a letter to the facility/Provider.
4. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under Privacy laws.
5. I understand that the information authorized for release may include records which may indicate the presence of a communicable or non-communicable disease.
6. I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment, or enrollment).

This authorization will expire 90 days from the date signed. A copy or facsimile of this authorization shall be counted true and valid as original.

\_\_\_\_\_  
Signature of Patient or Legal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
If Signed by Legal Representative, Relationship to Patient

\_\_\_\_\_  
Signature of Attorney or witness



# Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an "arterial dissection" that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately a percentage of these patients will experience a stroke.

The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events/ per one million persons/year and risk of death has been estimated as 104 per one million users.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent or Guardian: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# **Malek Chiropractic**

## **Privacy Practices**

I have received or reviewed the privacy practice notice (4 pages) for Alternative Care Chiropractic, and understand the situations in which this practice may need to utilize or release my medical records. I also understand that I agreed to the use of those records when I initially applied for care at this office on my first visit, whenever that may have occurred.

I understand that this office will properly maintain my records, and will use all due means to protect my privacy as outlined in this privacy practices statement.

---

Patient Signature

---

Date

---

Print Patient Name



# ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO DOCTOR

Patient Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Employer: \_\_\_\_\_

Claim or Group # \_\_\_\_\_

SS# or ID# \_\_\_\_\_

I hereby instruct the above named Insurance Company to pay by check made out to and mailed directly to:

**CHIROPRACTIC REHABILITATION AND WELLNESS CENTER  
DR. SARGON MALEK D.C.  
373 S. Golden State Blvd.  
Turlock, CA. 95380  
(209) 664-1200**

If my current policy prohibits direct payment to the doctor, then I hereby instruct and direct you to make out the check to me and mail it as follows:

**CHIROPRACTIC REHABILITATION AND WELLNESS CENTER  
C/O DR. SARGON MALEK D.C.  
373 S. Golden State Blvd.  
Turlock, CA. 95380  
(209) 664-1200**

for professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional fees for non-covered services and/or fees, over and above the insurance payment or as required by my insurance policy.

A photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to insurance company, adjuster, or attorney for the purpose of securing payment under this policy of insurance.

Dated at \_\_\_\_\_ County, this \_\_\_\_\_ day of \_\_\_\_\_ 20\_\_\_\_

\_\_\_\_\_  
Signature of Policy Holder

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Signature of Claimant, if other than Policyholder



The Machine vs. Man video was shown to me by Dr. Malek, which demonstrated the occupant kinematics of the spinal column in:

☐ REAR IMPACT COLISION

☐ FRONTAL IMPACT COLISION

☐ LATERAL IMPACT COLISION

---

Patient Signature

Date



# FINANCIAL AGREEMENT PERSONAL INJURY

We would like to take a moment to welcome you to our office and to assure you that you will receive the very best care available for your injury. In order to familiarize you with the financial policy of our office, I would like to explain how your medical bills will be handled.

## ***PARTY RESPONSIBLE:***

If you were involved in an auto accident in your own vehicle, we will bill the medical payments portion or Personal Injury Protection portion of your insurance policy to cover the treatment charges incurred in our office.

**MED PAY:** If you were a passenger in another vehicle, the insurance company which insures the automobile may be billed for your medical services incurred.

**PIP:** If you were a passenger in another vehicle, and you own a car which has PIP coverage, the insurance company which carries your policy will be responsible to pay your medical bills.

**3rd PARTY:** If another vehicle has caused the accident, we will first bill your automobile MedPay or PIP policy for coverage PRIOR to submitting a claim to the insurance carrier of the party at fault.

It is also to your advantage for our office to bill your own health insurance policy for your medical services, providing your policy does not state otherwise. Any amount received above and beyond your total bill in this office will be refunded to you.

## ***ATTORNEY LIENS:***

If you hire an attorney to represent you in a law suit, it is our policy to have your attorney sign a Doctor's Lien. This will guarantee direct payment to our office for any undid balance upon the settlement of your law suit. We retain the right to first submit all charges to your private and/or auto insurance policy for payment. Further, this office does not discount or reduce the amount of your balance based upon the outcome of your settlement.

## ***RESPONSIBILITY FOR PAYMENT:***

As a courtesy to you, we will gladly submit your charges to your insurance company(ies) and/or your attorney; however, all services rendered by this office are charged directly to you, and ultimately, you are personally responsible for payment of these charges, regardless of any insurance reimbursement or settlement you may or may not receive.

Once again, we welcome you to our office. We hope that this has answered any questions that you might have about our financial arrangements. If, at any time, you have further questions about your care, please, don't hesitate to ask.

*I have read and agree to the above*

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date



**CHIROPRACTIC & WELLNESS CENTER**  
373 S. Golden State Blvd  
Turlock, CA 95380  
(209) 664-1200

**NOTICE OF DOCTOR'S LIEN**

Patient: \_\_\_\_\_ Date of Accident: \_\_\_\_\_

I do hereby authorize \_\_\_\_\_ to furnish you, my attorney, with a full report of his 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 him for the medical service rendered me both by reason of this accident and by reason of any other bills that are due his office and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect and fully compensate 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 him for service rendered me and that this agreement is made solely for said doctor's additional protection and in consideration of his 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.

I agree to promptly notify said doctor of any change or addition of attorney(s) used by me in connection with this accident, and I instruct my attorney to do the same and to promptly deliver a copy of this lien to any such substituted attorney(s).

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 and may declare the entire balance due and payable.

\_\_\_\_\_  
DATED

\_\_\_\_\_  
PATIENT'S 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 and fully compensate said doctor above-named. Attorney further agrees that in the event this lien is litigated, that the prevailing party will be awarded attorney fees and costs.

\_\_\_\_\_  
DATED

\_\_\_\_\_  
ATTORNEY SIGNATURE



# Back Index

ACN Group, Inc. Form BI-100

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

*This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.*

## Pain Intensity

- ① The pain comes and goes and is very mild.
- ② The pain is mild and does not vary much.
- ③ The pain comes and goes and is moderate.
- ④ The pain is moderate and does not vary much.
- ⑤ The pain comes and goes and is very severe.
- ⑥ The pain is very severe and does not vary much.

## Personal Care

- ① I do not have to change my way of washing or dressing in order to avoid pain.
- ② I do not normally change my way of washing or dressing even though it causes some pain.
- ③ Washing and dressing increases the pain but I manage not to change my way of doing it.
- ④ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
- ⑤ Because of the pain I am unable to do some washing and dressing without help.
- ⑥ Because of the pain I am unable to do any washing and dressing without help.

## Sleeping

- ① I get no pain in bed.
- ② I get pain in bed but it does not prevent me from sleeping well.
- ③ Because of pain my normal sleep is reduced by less than 25%.
- ④ Because of pain my normal sleep is reduced by less than 50%.
- ⑤ Because of pain my normal sleep is reduced by less than 75%.
- ⑥ Pain prevents me from sleeping at all.

## Lifting

- ① I can lift heavy weights without extra pain.
- ② I can lift heavy weights but it causes extra pain.
- ③ Pain prevents me from lifting heavy weights off the floor.
- ④ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
- ⑤ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
- ⑥ I can only lift very light weights.

## Sitting

- ① I can sit in any chair as long as I like.
- ② I can only sit in my favorite chair as long as I like.
- ③ Pain prevents me from sitting more than 1 hour.
- ④ Pain prevents me from sitting more than 1/2 hour.
- ⑤ Pain prevents me from sitting more than 10 minutes.
- ⑥ I avoid sitting because it increases pain immediately.

## Traveling

- ① I get no pain while traveling.
- ② I get some pain while traveling but none of my usual forms of travel make it worse.
- ③ I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
- ④ I get extra pain while traveling which causes me to seek alternate forms of travel.
- ⑤ Pain restricts all forms of travel except that done while lying down.
- ⑥ Pain restricts all forms of travel.

## Standing

- ① I can stand as long as I want without pain.
- ② I have some pain while standing but it does not increase with time.
- ③ I cannot stand for longer than 1 hour without increasing pain.
- ④ I cannot stand for longer than 1/2 hour without increasing pain.
- ⑤ I cannot stand for longer than 10 minutes without increasing pain.
- ⑥ I avoid standing because it increases pain immediately.

## Social Life

- ① My social life is normal and gives me no extra pain.
- ② My social life is normal but increases the degree of pain.
- ③ Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
- ④ Pain has restricted my social life and I do not go out very often.
- ⑤ Pain has restricted my social life to my home.
- ⑥ I have hardly any social life because of the pain.

## Walking

- ① I have no pain while walking.
- ② I have some pain while walking but it doesn't increase with distance.
- ③ I cannot walk more than 1 mile without increasing pain.
- ④ I cannot walk more than 1/2 mile without increasing pain.
- ⑤ I cannot walk more than 1/4 mile without increasing pain.
- ⑥ I cannot walk at all without increasing pain.

## Changing degree of pain

- ① My pain is rapidly getting better.
- ② My pain fluctuates but overall is definitely getting better.
- ③ My pain seems to be getting better but improvement is slow.
- ④ My pain is neither getting better or worse.
- ⑤ My pain is gradually worsening.
- ⑥ My pain is rapidly worsening.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Back  
Index  
Score

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# Neck Index

ACN Group, Inc. Form NI-100

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name \_\_\_\_\_

Date \_\_\_\_\_

*This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.*

## Pain Intensity

- ① I have no pain at the moment.
- ② The pain is very mild at the moment.
- ③ The pain comes and goes and is moderate.
- ④ The pain is fairly severe at the moment.
- ⑤ The pain is very severe at the moment.
- ⑥ The pain is the worst imaginable at the moment.

## Personal Care

- ① I can look after myself normally without causing extra pain.
- ② I can look after myself normally but it causes extra pain.
- ③ It is painful to look after myself and I am slow and careful.
- ④ I need some help but I manage most of my personal care.
- ⑤ I need help every day in most aspects of self care.
- ⑥ I do not get dressed, I wash with difficulty and stay in bed.

## Sleeping

- ① I have no trouble sleeping.
- ② My sleep is slightly disturbed (less than 1 hour sleepless).
- ③ My sleep is mildly disturbed (1-2 hours sleepless).
- ④ My sleep is moderately disturbed (2-3 hours sleepless).
- ⑤ My sleep is greatly disturbed (3-5 hours sleepless).
- ⑥ My sleep is completely disturbed (5-7 hours sleepless).

## Lifting

- ① I can lift heavy weights without extra pain.
- ② I can lift heavy weights but it causes extra pain.
- ③ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
- ④ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
- ⑤ I can only lift very light weights.
- ⑥ I cannot lift or carry anything at all.

## Reading

- ① I can read as much as I want with no neck pain.
- ② I can read as much as I want with slight neck pain.
- ③ I can read as much as I want with moderate neck pain.
- ④ I cannot read as much as I want because of moderate neck pain.
- ⑤ I can hardly read at all because of severe neck pain.
- ⑥ I cannot read at all because of neck pain.

## Driving

- ① I can drive my car without any neck pain.
- ② I can drive my car as long as I want with slight neck pain.
- ③ I can drive my car as long as I want with moderate neck pain.
- ④ I cannot drive my car as long as I want because of moderate neck pain.
- ⑤ I can hardly drive at all because of severe neck pain.
- ⑥ I cannot drive my car at all because of neck pain.

## Concentration

- ① I can concentrate fully when I want with no difficulty.
- ② I can concentrate fully when I want with slight difficulty.
- ③ I have a fair degree of difficulty concentrating when I want.
- ④ I have a lot of difficulty concentrating when I want.
- ⑤ I have a great deal of difficulty concentrating when I want.
- ⑥ I cannot concentrate at all.

## Recreation

- ① I am able to engage in all my recreation activities without neck pain.
- ② I am able to engage in all my usual recreation activities with some neck pain.
- ③ I am able to engage in most but not all my usual recreation activities because of neck pain.
- ④ I am only able to engage in a few of my usual recreation activities because of neck pain.
- ⑤ I can hardly do any recreation activities because of neck pain.
- ⑥ I cannot do any recreation activities at all.

## Work

- ① I can do as much work as I want.
- ② I can only do my usual work but no more.
- ③ I can only do most of my usual work but no more.
- ④ I cannot do my usual work.
- ⑤ I can hardly do any work at all.
- ⑥ I cannot do any work at all.

## Headaches

- ① I have no headaches at all.
- ② I have slight headaches which come infrequently.
- ③ I have moderate headaches which come infrequently.
- ④ I have moderate headaches which come frequently.
- ⑤ I have severe headaches which come frequently.
- ⑥ I have headaches almost all the time.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Neck  
Index  
Score

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