EAGLE TRACE
SPINE & SPORT
NECK • BACK • INJURY

Welcome! We are honored you chose use to evaluate your condition. So we may file your insurance forms for you, please fill out the information below. If you need assistance please ask the front desk person. Thank you.

VEHICLE ACCIDENT INFORMATION

PERSONAL INFORMATION

Patient name _____ Date _____

Date of birth _____ Age _____ Sex M ☐ F ☐

Address _____ City _____ State _____ Zip _____

Mobile phone # _____ Home phone # _____ Work phone # _____

E-mail _____ Social security # _____

Employer name _____ Occupation _____

Emergency contact _____ Relationship _____ Phone _____

REFERRAL INFORMATION

How did you find out about us? _____

Primary Care Physician (Name & Location) _____

ACCIDENT INFORMATION

Date and time of accident _____ am/pm How many people were in the accident vehicle? _____

Were you the? **Driver** ☐ **Front passenger** ☐ **Rear passenger** ☐ **Pedestrian/Bicyclist** ☐

Please describe the accident in your own words: _____

_____

_____

_____

IMPACT

Did your car impact another vehicle? **Yes** ☐ **No** ☐

Did your car impact a structure? **Yes** ☐ **No** ☐

Did any part of your body strike anything inside the car?

Yes ☐ **No** ☐ **If yes, explain** _____

Was the impact from: **Front** ☐ **Rear** ☐ **Left** ☐ **Right** ☐

Other _____

At the time of the impact were you:

Looking forward ☐ **Looking back** ☐

Looking to the left ☐ **Looking to the right** ☐

Looking down ☐ **Looking up** ☐

Were both hands on the steering wheel? **Yes** ☐ **No** ☐

If no, which hand was on the wheel? **Left** ☐ **Right** ☐

Was you foot on the brake? **Yes** ☐ **No** ☐

If yes, which foot was on the brake? **Left** ☐ **Right** ☐

Were you: **Surprised by impact** ☐ **Braced for impact** ☐

POLICE

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

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

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

Was a traffic violation issued? **Yes** ☐ **No** ☐

If yes, to whom? _____

ACCIDENT LOCATION

Road/Street Name _____

Nearest intersection with road/street _____

City/State _____

Driving conditions? **Dry** ☐ **Wet** ☐ **Icy** ☐ **Other** _____

What direction where you heading? _____

Speed you were traveling? _____

VEHICLE

Make/model of vehicle you were in _____

Were you wearing a seat belt? **Yes** ☐ **No** ☐

If yes, what type? **Lap** ☐ **Shoulder** ☐

Was vehicle equipped with airbags? **Yes** ☐ **No** ☐

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

Did your seat have a headrest? **Yes** ☐ **No** ☐

If yes, what position was it in? **Low** ☐ **Middle** ☐ **High** ☐

OTHER VEHICLE (IF APPLICABLE)

Make/model of other vehicle _____

What direction was other vehicle heading? _____

Speed other vehicle was traveling? _____

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VEHICLE ACCIDENT INFORMATION

PATIENT CONDITION

Were you unconscious immediately after the accident? **Yes** ☐ **No** ☐ If yes, how long? _____

Please describe how you felt immediately after the accident _____

_____

PREVIOUS TREATMENT

Did you go the hospital? **Yes** ☐ **No** ☐

When did you go? **Immediately after accident** ☐ **Next day** ☐ **2 days or more after the accident** ☐

How did you get to the hospital? **Private transportation** ☐ **Ambulance** ☐ **Where X-rays taken? Yes** ☐ **No** ☐

Name of hospital _____ Name of doctor _____

Treatment received _____

Diagnosis _____

Have you seen anyone else for this condition? **Medical doctor** ☐ **Physical therapist** ☐ **Chiropractor** ☐ **Other** _____

Have you had chiropractic care in the past? **Yes** ☐ **No** ☐ **If so, when?** _____

SYMPTOMS/INJURIES

Have you been able to work since this injury? **Yes** ☐ **No** ☐ If no, how many work days have you missed? _____

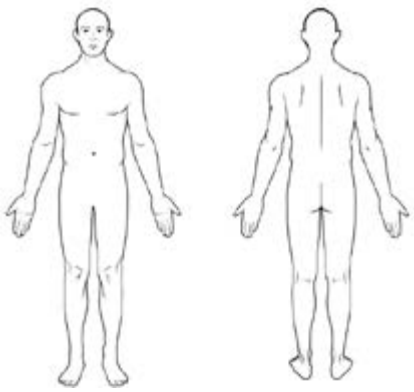
Prior to the injury were you able to work on an equal basis with others your age? **Yes** ☐ **No** ☐

If you have had any of the following symptoms since your injury, please check all that apply.

☐ **Arm/shoulder pain**	☐ **Ear buzzing**	☐ **Headaches**	☐ **Nausea**	☐ **Sleep difficulty**
☐ **Back pain**	☐ **Ear ringing**	☐ **Irritability**	☐ **Neck pain**	☐ **Stomach upset**
☐ **Back stiffness**	☐ **Fatigue**	☐ **Jaw problems**	☐ **Neck stiff**	☐ **Tension**
☐ **Chest pain**	☐ **Feet/toe numbness**	☐ **Leg pain**	☐ **Shortness of breath**	☐ **Vision blurred**
☐ **Dizziness**	☐ **Hand/finger numbness**	☐ **Memory loss**		

Is this condition getting progressively worse? **Yes** ☐ **No** ☐ **Unknown** ☐

Mark an X on the picture where you continue to have pain, numbness or tingling.



Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain): _____

How often do yo have this pain?_____ **Is it constant?** ☐ **Or does it come and go?** ☐

☐ **Sharp**	☐ **Dull**	☐ **Throbbing**	☐ **Numbness**
☐ **Aching**	☐ **Shooting**	☐ **Burning**	☐ **Tingling**
☐ **Cramps**	☐ **Stiffness**	☐ **Swelling**	☐ **Other**

Does in interfere with? **Work** ☐ **Sleep** ☐ **Daily Routine** ☐ **Recreation** ☐

Movements that are painful to perform: **Sitting** ☐ **Standing** ☐ **Walking** ☐ **Bending** ☐ **Lying down** ☐

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

Patient Name (please print) _____

Patient/Guardian Signature _____ **Date**_____

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VEHICLE ACCIDENT INFORMATION

PATIENTS AUTO INSURANCE INFORMATION

Auto Insurance Company Name _____ Claim #_____

Adjusters Name and Telephone # _____

Attorney Name and Telephone # _____

DOCTOR'S LIEN INSTRUCTION TO MY ATTORNEY

I do hereby authorize Eagle Trace Spine & Sport to furnish you, my attorney, with a full report of examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I was involved.

I hereby direct my attorney, to make directly to Eagle Trace Spine & Sport, such sums as may be due and owing for medical services rendered me both by reason of this accident existing at the time of settlement of my no-fault or liability awards. I instruct my attorney to withhold such sums from my settlement, judgment, or verdict as may be necessary to adequately protect the outstanding bill of Eagle Trace Spine & Sport.

By signing this document, I hereby authorize and give a lien on my injury case to Eagle Trace Spine & Sport the proceeds of my settlement, judgment or verdict which may be paid to you, my attorney, or myself as the result of injuries for which I have been treated or injuries in connection therewith up to the amount of any unpaid billings with Eagle Trace Spine & Sport.

Patient/Guardian Signature _____ **Date**_____

The undersigned, being attorney of record for the above patient, acknowledge receipt of these instructions and hereby agree to observe these instructions of my client and agree to withhold such sums from any settlement, judgment or verdict as may be necessary to protect Eagle Trace Spine & Sport.

Attorney's Signature_____ **Date**_____

Attorney, please sign and return one copy to Eagle Trace Spine & Sport. Keep one copy for your records. All parties agree to accept a photocopy of this document as valid as original copy.

ASSIGNMENT OF INSURANCE PROCEEDS

If you have insurance, please sign this assignment of benefits agreement. By agreeing to this assignment,we will direct your insurance company to make any payments for your chiropractic, physiotherapy, physical rehabilitation, x-rays, diagnostic testing or any other reimbursable treatment or evaluations you receive to our clinic directly. In exchange for services and supplies rendered, I assign to Eagle Trace Spine & Sport any insurance proceeds, including accident and health insurance, auto insurance benefits and bodily injury claim awards up to the amount of any unpaid balance on my account. In giving this assignment, I acknowledge that I am responsible for all charges to my account. **Initials**_____

RECORDS RELEASE AUTHORIZATION

Eagle Trace Spine & Sport is authorized to release any information contained in my file to any insurance company, attorney, adjuster or member of your office staff, including any contracted billing services representing Eagle Trace Spine & Sport or it's associated, in order to process any claim for reimbursement of charges incurred for supplies furnished to me or services rendered to me by your or another member of the clinic. I further authorize phone contact with the above listed third parties should phone contact be required for the purpose of obtaining payment for charges outstanding. **Initials**_____

COST OF COLLECTIONS (COLLECTION AGENCY OR ATTORNEY)

I understand that if I fail to pay my account as agreed, Eagle Trace Spine & Sport may, after reasonable attempts to obtain payment, place my account for collection. I understand that if my account is placed for collection with an agency, payments made after collection agency placement result in any agency service fee of 1/3 of any amount paid. If you account is place for collections, I agree to pay Eagle Trace Spine & Sport costs of a collection up to 1/3 of the amount recovered. **Initials**_____

I have read and agree with the clinic's policy regarding HIPPA, Assignment of Insurance, Release of Records and Costs of Collections.

Patient/Guardian Signature _____ **Date**_____

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PRIVACY AND INFORMED CONSENT

PRIVACY POLICY — HIPPA NOTICE

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA) and specifically its Privacy Rule, I have certain rights to privacy regarding my Protected Health Information (PHI). I understand that my PHI can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare provider that may be involved in my treatment directly or indirectly.
- Obtain payment or reimbursement from health coverage programs or others.
- Conduct normal healthcare business operation including routine aspects of operating a health related practice or business.

The privacy officer for Eagle Trace Spine may be contacted by mail by writing to 12002 County Road 11, Burnsville, MN 55337

INFORMED CONSENT — VEHICLE ACCIDENT

I hereby authorize physicians and staff at Eagle Trace Spine and Sport to treat my condition as deemed appropriate. The doctor will not be held responsible for any preexisting medically diagnosed conditions. I certify that the about information is correct to the best of my knowledge. I will not hold my doctor or any staff member at Eagle Trace Spine and Sport responsible for any errors or omissions that I may have made at completion of the form.

Chiropractic, as well as all other types of health care, is associated with potential risks in the delivery of treatment. Therefore, it is necessary to inform the patient of such risk prior to initiating care. While chiropractic treatment is remarkable safe, you need to be informed about potential risks related to your care to allow you be fully informed before consenting treatment.

Chiropractic is a system of health care delivery and therefore, as with any health care system, we cannot promise a cure for any symptoms, conditions or disease as a result of treatment in this office. An attempt to provide you with the very best is our goal, and if the results are not acceptable, we will refer you to another provider won we feel can further assist you.

Specific risk possibilities associated with chiropractic care:

- **Soreness** – Chiropractic adjustments and physical therapy procedures are sometime accompanied by post treatment soreness. This is normal and acceptable response to chiropractic care and physical therapy. While not generally dangerous, please advise your doctor if you experience soreness or discomfort.
- **Soft Tissue Injury** – Occasionally chiropractic treatment may aggravate a disc injury, or cause other minor join ligament, tendon, or other soft issue injury.
- **Rib Injury** – Manual adjustment to the thoracic spine, in rare cases, may cause rib injury or fracture. Precautions such as pre-adjustment x-rays are taken for preventative measures. Treatment is performed carefully to minimize such risk.
- **Physical Therapy Burns** – Heat generated by physically therapy modalities may cause minor burns to the skin. This rare, but it occurs, you should report it to your doctor or staff member.
- **Stroke** – Stroke is the most serious complication of chiropractic treatment. Most recent studies estimate that the incidence of this type of stroke is 1 in every 5 million upper cervical adjustments.
- **Other Problems** – There are occasionally other type of side effects associated with chiropractic, while these are rare, they should be reported to your doctor promptly. Please understand Eagle Trace Spine and Sport has a open room adjustment area, we do provide a private room for treatments – please inform your doctor if you prefer a private room.

If you have any questions concerning this form or above statements, please ask your doctor.

I have read and agree with the clinic's policy regarding HIPPA, Assignment of Insurance, Release of Records, Costs of Collections. And having carefully read above, I hereby give informed consent to have chiropractic treatment administration.

Patient Name (please print) _____

Patient/Guardian Signature _____ **Date**_____

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This is a summary of our clinic policies. We believe that a clear definitions allow us both to concentrate on the most important issue; regaining and maintaining your health. We are happy to answer any questions you have about your account.

OFFICE POLICY

PAYMENT POLICY FOR PATIENTS WITH INSURANCE

Eagle Trace Spine and Sport will file your insurance claim for you, and will attempt to verify coverage of services to be performed. We will review this information with you and explain what services (if any) are not covered that you will be responsible for. You are responsible for the balance on your account for any professional services rendered if you insurance denies coverage. Any balance billed from our office deemed 'Patient Responsibility' exceeding 90 days past due will be assessed at 10% interest charge. Payment plans are available,but you must contact our office to setup these plans. Additional notes about insurance coverage:

- Copays are due at the time of service
- You may be responsible for a Deductible Amount. This amount is deemed 'Patient Responsibility.' Our office will bill you for this amount following our offices receipt of an 'Explanation of Benefits' (EOB) from your insurance company.
- You may be responsible for the co-insurance amount (% responsibility). Our office will bill you for this amount following our offices receipt of an Explanation of Benefits (EOB) from your insurance company.
- You may choose to make payment in advance of receiving a bill from any amount considered patient responsibility.

PAYMENT POLICY FOR PATIENTS WITHOUT INSURANCE

You have the option of paying in full on the date of service, paying in advance for your services or receiving a bill from our office. Discounts apply for payment in advance and payment made on the same day. You are responsible for the balance on your account for any services rendered. Any balance billed from our office deemed 'Patient Responsibility' exceeding 90 days past due will be assessed a 10% interest charge.

APPOINTMENT POLICIES — CHIROPRACTIC

In order for us to better serve all patients, please call if you will be late or unable to keep your scheduled appointment.

APPOINTMENT POLICIES — MASSAGE

- **Cancellation Policy**: If you cannot make your appointment we ask you to please contact our office 24 hours in advance to cancel. If your appointment is not canceled 24 hours in advance it will be considered a 'No Show' and subject to our 'No Show' policy.
- **No Show Policy:** If you fail to cancel your appointment according to the cancellation policy you are considered a 'No Show' and will be unable to schedule your next appointment without providing payment in advance. If you fail to cancel this appointment according to the 'Cancellation Policy' you will surrender your payment for this appointment. The 'No Show' fee is $40 for every occurrence.
- **Refusal of Service Policy**: We reserve the right to refuse to provide services to any person at anytime. Should you be denied service, you will be reimbursed for any unused services that have been paid in advance.

By signing, I acknowledge having received and read the above 'Office Policy.' I hereby agree to the terms and conditions outlined.

Patient Name (please print) _____

Patient/Guardian Signature _____ **Date**_____

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