Patient Processing and Release Form

❑ Insurance ❑ Auto/Insurance ❑ WC ❑ Attorney Lien

Referring Physician: _____

Patient Name: _____ SS #: _____
Address: _____
Street / City / State / Zip: _____
Home Phone: _____ Work Phone: _____
DOB: _____ Sex: ❑M ❑F Marital Status: ❑ S ❑M ❑D ❑W
Employer: _____
Address: _____
Street / City / State / Zip: _____
Email: _____

Primary Insurance: _____
Insured Name (if not patient)_____ SS#: _____
Insured's DOB: _____
Mailing Address: _____
Telephone: _____
Policy: _____ Group #: _____
Date of Accident: _____ Claim#: _____
Secondary Insurance: _____
Mailing Address: _____
Telephone: _____
Policy: _____ Group #: _____

Acknowledgement of Notice of Privacy Practices

I understand that Delta Spine & Sportcare maintains a *Notice of Privacy Practices* that provides a more complete description of information uses and disclosures. The most recent version of this notice is displayed in the waiting room area. I understand that Delta Spine & Sportcare reserves the right to change this notice and its practices as needed and will make a reasonable attempt to inform me of any changes. I understand that I can request an additional copy of this notice at any time. I understand that I have the following rights and privileges:

The right to review the notice prior to signing this consent, and
The right to request restrictions as to how my health information may be used or disclosed.

I have had the opportunity to receive and review the *Notice of Privacy Practices* of Delta Spine & Sportcare

_____
Printed Name of Person Signing

_____
Patient Signature Date

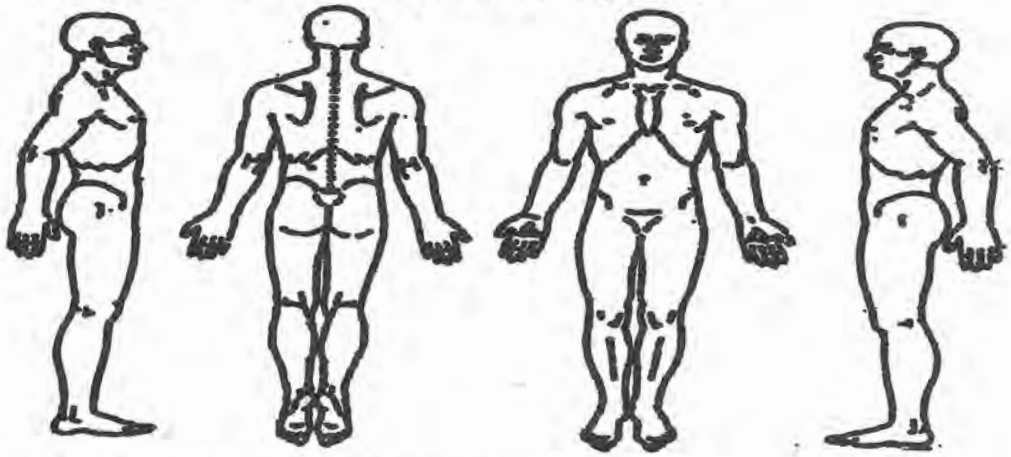
NOTE: Your health information will be kept strictly confidential. Any information that we collect about you on this form will be kept confidential in our offices. If a claim is submitted to Medicare, your health information on this form may be shared with Medicare. Your health information which Medicare sees will be kept confidential by Medicare.

PATIENT INTAKE FORM

Patient Name: _____ Date: _____

1. Is today's problem caused by: ◻ Auto Accident ◻ Workman's Compensation

2. Indicate on the drawings below where you have pain/symptoms



3. How often do you experience your symptoms?

◻ Constantly (76-100% of the time) ◻ Occasionally (26-50% of the time)
◻ Frequently (51-75% of the time) ◻ Intermittently (1-25% of the time)

4. How would you describe the type of pain?

◻ Sharp ◻ Numb
◻ Dull ◻ Tingly
◻ Diffuse ◻ Sharp with motion
◻ Achy ◻ Shooting with motion
◻ Burning ◻ Stabbing with motion
◻ Shooting ◻ Electric like with motion
◻ Stiff ◻ Other:_____

5. How are your symptoms changing with time?

◻ Getting Worse ◻ Staying the Same ◻ Getting Better

6. Using a scale from 0-10 (10 being the worst), how would you rate your problem?

0 1 2 3 4 5 6 7 8 9 10 (*Please circle*)

7. How much has the problem interfered with your work?

◻ Not at all ◻ A little bit ◻ Moderately ◻ Quite a bit ◻ Extremely

8. How much has the problem interfered with your social activities?

◻ Not at all ◻ A little bit ◻ Moderately Quite a bit ◻ Extremely

9. Who else have you seen for your problem?

◻ Chiropractor ◻ Neurologist ◻ Primary Care Physician
◻ ER physician ◻ Orthopedist ◻ Other:_____
◻ Massage Therapist ◻ Physical Therapist ◻ No one

10. How long have you had this problem? _____

11. How do you think your problem began?

_____

12. Do you consider this problem to be severe?

◻ Yes ◻ Yes, at times ◻ No

13. What aggravates your problem?

_____

14. What concerns you the most about your problem; what does it prevent you from doing?

_____

15. What is your: Height_____ Weight _____ Date of Birth _____
Occupation _____

16. How would you rate your overall Health?
□ Excellent □ Very Good □ Good □ Fair □ Poor

17. What type of exercise do you do?
□ Stenuous □ Moderate □ Light □ None

18. Indicate if you have any immediate family members with any of the following:
□ Rheumatoid Arthritis □ Diabetes □ Lupus
□ Heart Problems □ Cancer □ ALS

19. For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

Past	Present		Past	Present		Past	Present	
□	□	Headaches	□	□	High Blood Pressure	□	□	Diabetes
□	□	Neck Pain	□	□	Heart Attack	□	□	Excessive Thirst
□	□	Upper Back Pain	□	□	Chest Pains	□	□	Frequent Urination
□	□	Mid Back Pain	□	□	Stroke	□	□	Smoking/Tobacco Use
□	□	Low Back Pain	□	□	Angina	□	□	Drug/Alcohol Dependance
□	□	Shoulder Pain	□	□	Kidney Stones	□	□	Allergies
□	□	Elbow/Upper Arm Pain	□	□	Kidney Disorders	□	□	Depression
□	□	Wrist Pain	□	□	Bladder Infection	□	□	Systemic Lupus
□	□	Hand Pain	□	□	Painful Urination	□	□	Epilepsy
□	□	Hip Pain	□	□	Loss of Bladder Control	□	□	Dermatitis/Eczema/Rash
□	□	Upper Leg Pain	□	□	Prostate Problems	□	□	HIV/AIDS
□	□	Knee Pain	□	□	Abnormal Weight Gain/Loss			
□	□	Ankle/Foot Pain	□	□	Loss of Appetite		**For Females Only**	
□	□	Jaw Pain	□	□	Abdominal Pain	□	□	Birth Control Pills
□	□	Joint Pain/Stiffness	□	□	Ulcer	□	□	Hormonal Replacement
□	□	Arthritis	□	□	Hepatitis	□	□	Pregnancy
□	□	Rheumatoid Arthritis	□	□	Liver/Gall Bladder Disorder			
□	□	Cancer	□	□	General Fatigue			
□	□	Tumor	□	□	Muscular Incoordination			
□	□	Asthma	□	□	Visual Disturbances			
□	□	Chronic Sinusitis	□	□	Dizziness			
□	□	Other:_____						

20. List all prescription medications you are currently taking:
_____

21. List all of the over-the-counter medications you are currently taking:
_____

22. List all surgical procedures you have had:
_____

23. What activities do you do at work?

□ **Sit:**	□ Most of the day	□ Half the day	□ A little of the day
□ **Stand:**	□ Most of the day	□ Half the day	□ A little of the day
□ **Computer work:**	□ Most of the day	□ Half the day	□ A little of the day
□ **On the phone:**	□ Most of the day	□ Half of the day	□ A little of the day

24. What activities do you do outside of work?
_____

25. Have you ever been hospitalized? □ No □ Yes
if yes, why _____

26. Have you had significant past trauma? □ No □ Yes

27. Anything else pertinent to your visit today?_____

Patient Signature_____ **Date:**_____

POLICY FOR BILLING YOUR INSURANCE CARRIER

1.) We will need a copy of the front and back of your insurance card.

2.) You may have a deductible. If you have not met your deductible, we will bill you our regular office fee for the visits that are not covered.

3.) Co-payments are due at the time of your office visit.

4.) Many times health insurance companies need confirmation that your visit to the chiropractor is not related to a work or automobile injury. They may send you a questionnaire asking this information. Please fill it out and send it back to the insurance company as soon as you receive it. Payment for your treatment may be delayed by your insurance until this information is received.

5.) If your insurance is terminated or you change carriers, please notify us immediately or you may be charged our regular office visit fee. This is to insure continuous coverage and avoid billing mistakes.

6.) If you do not have chiropractic benefits on your insurance plan, payment for all services will be your responsibility.

7.) We maintain the philosophy that the office is a place of healing. If you have an insurance or billing question we will be happy to discuss it with you in private. Our medical billing and claims office can be reached by calling *925-634-5450*.

I, _____, have read and understand the above information to the best of my knowledge. I understand that I am financially responsible for all charges whether or not they are paid by my insurance carrier. I hereby authorize Wellens Chiropractic to release all information necessary to secure the payment of benefits. I authorize payment of medical benefits to be paid directly to my doctor at Wellens Chiropractic, Brentwood, California.

Patient Name (please print) _____

Patient Signature _____ Date _____

Automobile Accident History Form

Name: _____ Today's Date: _____

Date of Accident: _____ Time of Accident: _____ am / pm

City/State of Accident: _____

Did the police come to the accident scene? YES NO If yes, is there a report? YES NO

Did you go to a hospital? YES NO If yes, how did you get to the hospital? _____

What parts of your body were x-rayed at the hospital? _____

What did the hospital do for your injuries? _____

How long did you stay at the hospital? _____

Did the accident cause bleeding or cuts? YES NO If yes, where? _____

Did the accident cause any bruising? YES NO If yes, where? _____

Where were you seated in the vehicle? _____

Were you aware of the approaching collision prior to impact, or did the impact catch you by surprise?

AWARE SURPRISE

Did you lose consciousness or black out upon impact? YES NO If yes, for how long? _____

Do you remember the actual collision? YES NO

Did you experience a flash of light or explosion in your head? YES NO

Did you experience any of the following due to the accident? (circle all that apply)

CONFUSION DISORIENTATION LIGHT HEADEDNESS DIZZY NAUSEA

BLURRY VISION RINGING/BUZZING IN EARS

Do you still have any of the above symptoms? YES NO If yes, which ones do you still have? _____

_____

Are you currently suffering from any of the following? (circle all that apply)

RESTLESSNESS IRRITABILITY DIFFICULTY CONCENTRATING SLEEPLESSNESS

REDUCED TOLERANCE TO HEAT DIFFICULTY WITH MEMORY

Did you head go back over the top of your vehicle's headrest? YES NO

Were you wearing a seatbelt? YES NO If yes was it a lap seatbelt or a shoulder-lap seatbelt? _____

Does your vehicle have an airbag? YES NO If yes, did the airbag deploy? YES NO

Did you receive an injury from the airbag? YES NO If yes, please describe _____

_____

Write down the make, model, and year of the vehicle you were in: Make _____ Model _____ Year _____

Write down the make, model, and year of the other vehicle: Make _____ Model _____ Year _____

Was your car stopped at the time of impact? YES NO

If yes, was the driver's foot also on the brake? YES NO

If no, estimate the speed of the vehicle you were in: _____ mph

On what part of the automobile did your body parts hit?

Head hit the _____ Chest hit the _____

Right / Left shoulder hit the _____ Right / Left arm hit the _____

Right / Left hip hit the _____ Right / Left leg hit the _____

Right / Left knee hit the _____ Other _____

Did you receive any injury or bruise from the seatbelt? YES NO If yes, where? _____

Did the steering wheel break or bend during the accident? YES NO

Was your chest pointed straight forward at the time of collision? YES NO If no, what direction was your body in?

_____

Was your head pointed straight forward at the time of collision? YES NO If no, what direction was your head facing?

_____

ACCIDENT DIAGRAM

- Please draw out how the accident occurred.
- Make sure to note, as completely as possible, all of the involved vehicles and/or structures.
- Include city location, street names, and lane descriptions.
- Use arrows for direction markers to describe the direction of vehicle movement.
- Please note the exact location of the collision and the final resting position of your vehicle.

AUTO ACCIDENT INSURANCE POLICY

**You may pay for your care by using one of these three methods*

1) MED-PAY

Your auto insurance Med-Pay coverage will pay for your care in full, regardless of fault. Med-Pay is a set amount of funds, usually $1,000, $5,000, or $10,000, which is put aside to pay your medical bills in case of an accident. You pay extra for this benefit, so use it. Your insurance rates are not affected by the cost of the health expense, unless you were at fault. It is your responsibility to notify your claims office that you are being treated in this office and have them send any necessary paperwork directly to us.

In the event your auto insurance DENIES that you hold insurance, REFUSES payment, DOES NOT HAVE Med-Pay Coverage, or you have EXHAUSTED your Med-Pay Coverage, charges for services are due and payable.

2) GROUP HEALTH INSURANCE

Your group health insurance can be billed for your care. If you have an accident rider on your policy, it may be covered at 100%. You pay your deductible and co-payments as required and we will wait for the balance from the insurance company.

3) PATIENT PAYMENT

You can pay for your care as you go or we can arrange a convenient monthly payment plan for you. We will prepare billings for you to submit to your attorney, third party, etc.

****

You are considered a cash patient until all the required information is submitted to our billing office.

The only circumstance in which we will accept a lien is when all the above options are exhausted and you are making personal payments on your account. In this case, a lien may be accepted as a promise to pay the remaining portion of your bill.

We will bill your auto or health insurance and have you assign payment to us. In the event that your insurance company sends a check directly to you, be sure to send or bring it in, along with the attached stub, within three days. Otherwise, we may rebill in error, which will delay future payments.

If the insurance company fails to pay a portion of your bill after 90 days, that balance will be due and payable by you.

PLEASE NOTE THE INFORMATION BELOW IS YOUR AUTO INS.

Policyholder's Name: _____

Insurance Company's Name: _____

Policy #: _____ Claim #_____

Med-Pay Coverage?: (yes)_____ (no)_____ Amount: $_____

Adjuster's Name:_____ Phone #: (____)_____

Claims Office Address:_____