Motor Vehicle Accident Information

Last Name:

First Name:

Location of Accident:

Insurance Co.:

Insurance Agent:

Claim Number:

General Information

Date of Accident:

Location (circle one)	**Driver**		
	Passenger	Location (circle one)	Front / Middle / Rear
		Position (circle one)	Left / Middle / Right

Work from Left to Right and Circle One

Patients Vehicle	**Type :**	Car / Van / Pickup / Truck / Bus / SUV / M. Cycle / Other:
	Size :	Mini / Sub Comp / compact / Mid Size / Full Size
	Action :	Stopped / Slowing / Acceleration / Cruising
	Speed :	(MPH)
	Time of Accident:	Day Light / Dawn / Dusk / Dark
	Road Condition :	Dry / Damp / Wet / Snow / Ice
	Visibility :	Good / Fair / Poor

Enter impact Information for up to three Vehicles or Objects

Impact Information: Vehicle or Object (I)

(Select one)	**Name Object :**	
	Vehicle Type :	Car / Van / Pickup / Truck / Bus / SUV / M. Cycle / Other:
☐ **Vehicle**	**Size :**	Mini / Sub Comp / compact / Mid Size / Full Size
☐ **Object**	**Damage to Veh.:**	Minimal / Moderate / Extensive / Totaled / Unsure
Impact Location		

Impact Information: Vehicle or Object (II)

(Select one)	**Name Object :**	
	Vehicle Type :	Car / Van / Pickup / Truck / Bus / SUV / M. Cycle / Other:
☐ **Vehicle**	**Size :**	Mini / Sub Comp / compact / Mid Size / Full Size
☐ **Object**	**Damage to Veh.:**	Minimal / Moderate / Extensive / Totaled / Unsure
Impact Location		

Impact Information: Vehicle or Object (III)

(Select one)	**Name Object :**	
	Vehicle Type :	Car / Van / Pickup / Truck / Bus / SUV / M. Cycle / Other:
☐ **Vehicle**	**Size :**	Mini / Sub Comp / compact / Mid Size / Full Size
☐ **Object**	**Damage to Veh.:**	Minimal / Moderate / Extensive / Totaled / Unsure
Impact Location		

During Impact Information:

Seat Belt?	☐ Yes	☐ No	Brakes Applied ?	☐ Yes	☐ No
Air Bag Deployed?	☐ Yes	☐ No	Seat Broken ?	☐ Yes	☐ No
Seat Back position Changed?	☐ Yes	☐ No			

Head Rest : (Circle one)	Low / Mid / High / None
Prepare for Accident: (Circle One)	Un-expected / Expected / Expected and Braced
Body Position : (Circle one)	Straight / Rotated Left / Rotated Right / Unsure / Other:
Body Thrown?	☐ Yes / ☐ No
Direction of Throw :(Circle One)	Backwards / Forward / Outside / Unsure / Other:

(Circle One)

Head Position :	Straight / Rotated Left / Rotated Right / Forward / Unsure / Other:
Head Motion :	Forward Backwards / Backwards Forward / Right Left / Left Right / Unsure / Other:

Body Impact (Indicate any parts of your body that were struck during the impact)

☐ Head	☐ Upper Back	☐ Right hand	☐ Lower Back
☐ Left Shoulder	☐ Left Leg	☐ Mid Torso	☐ Right Foot
☐ Left Arm	☐ Right Leg	☐ Mid Back	☐ Left Foot
☐ Left Elbow	☐ Right Shoulder	☐ Right Knee	☐ Other :
☐ Left hand	☐ Right Arm	☐ Left Knee	
☐ Upper Front Torso	☐ Right Elbow	☐ Lower Front Torso	

After Accident Information:

Immediately After Accident:	☐ Dizzy/dazed ☐ Upset ☐ Weak ☐ Nervous ☐ Headache ☐ Disoriented ☐ Unconscious ☐/Other:

Pain (Indicate if you experienced any pain immediately following the accident)

☐ Head	☐ Left foot	☐ Right foot	☐ Left Knee
☐ Left Hand	☐ Left Shoulder	☐ Right Shoulder	☐ Right knee
☐ Right Arm	☐ Left Elbow	☐ Left Arm	☐ Other :
☐ Upper Front Torso	☐ Mid Torso	☐ Right elbow	
☐ Upper Back	☐ Mid back	☐ Lower Front Torso	
☐ Left Leg	☐ Right Leg	☐ Lower Back	

Numbness:	☐Left Hand ☐ Right Hand ☐ Left Leg ☐ Right Leg ☐ Left Upper Arm ☐ Right Upper Arm ☐ Left Foot ☐ Right Foot ☐ Other:

Medical Information (Did you get medical care for this accident before coming to our office)

Medical Care?	☐ Yes	☐ No

Time of care	Next day / At time of Accident / Later that Day / Days Later: (Specify)
Transported	Drove Self / Ambulance / Other
Went To	Orthopedic / Chiropractor / Neurologist / Family Doc / ER / Other:(Specify)
Admitted to Hospital?	☐ Yes ☐ No Days Spent in Hospita:
Test:	☐ X-ray ☐ Lab Work ☐ MRI ☐ CT Scan ☐ Other:(Specify)
Treatment:	☐ Ice Pack ☐ Hot Pack ☐ None ☐ Cervical Collar ☐ Medication ☐ Other:(Specify)

Previous Injuries

Previous Injuries / Accidents ☐ No ☐ Yes, Specify:

Residual pain from Previous Injuries/Accidents ☐ No ☐ Yes, Specify:

Later Symptoms (Please note any symptoms that started after the accident occurred)

Head
☐ Headache ☐ Dizziness ☐ Blurred Vision ☐ Light Headedness ☐ Loss of Vision
☐ Fainting ☐ Loss of Memory ☐ Pain in ear ☐ Double Vision
☐ Other Specify:

Neck (with Movement)
☐ Pain in Neck ☐ Forward ☐ Backward ☐ Turn Left ☐ Popping in Neck
☐ Muscle Spasms ☐ Turn Right ☐ Bend Left ☐ bend Right
☐ Other Specify:

Shoulders
☐ Pain in Shoulder joint ☐ Tension in shoulders ☐ Muscle Spasms in Shoulder
☐ Pain across shoulder ☐ Cant raise arms above [ ] Above shoulder level [ ] Over head
☐ Other Specify:

Arms and Hands
☐ Pain in Fingers ☐ Numbness in Left Arm ☐ Hands Cold
☐ Pin & needles in hands ☐ Numbness in Right Arm ☐ Loss of Grip Strength
☐ Pin & needles in fingers ☐ Swollen joints in Fingers
☐ Other Specify:

Chest
☐ Chest pain ☐ Pain Around Ribs ☐ Shortness of Breadth ☐ Breast Pain
☐ Other Specify:

Abdomen
☐ Nervous Stomach ☐ Nausea ☐ Diarrhea ☐ Gas ☐ Constipation
☐ Other Specify:

Mid back
☐ Sharp Stabbing ☐ Mid pain back ☐ Pain From front to back ☐ Dull Ache
☐ Pain in Kidney Area ☐ Muscle Spasms ☐ Pain between shoulders
☐ Other Specify:

Lower Back
☐ Low Back Pain

Low back pain is worse when
☐ Working ☐ Lifting ☐ Stooping ☐ Standing
☐ Sitting ☐ Bending ☐ Coughing ☐ Lying Down ☐ Muscle Spasms

☐ Other Specify:

Hips, Legs & Feet
☐ Pain in Buttocks ☐ Pain and needles in Legs ☐ Pain down leg
☐ Pain in hip joint ☐ Feet feel Cold ☐ Swollen Feet
☐ Numbness in Toes ☐ Numbness of Leg ☐ Knee pain
☐ Leg cramps ☐ Cramps in Feet

☐ Other Specify:

General
☐ Nervousness ☐ Fatigue
☐ Irritable ☐ Depressed
☐ Generally Feel Rundown ☐ Prostate Pain/Swelling
☐ Difficulty Urinating ☐ Night Urination
☐ Cramping ☐ Irregularity

Loss of Sleep : [_____] hrs per night

Loss of weight : [_____] lbs

Gain weight : [_____] lbs

Other:

All questions contained in this questionnaire are strictly confidential and will become part of your medical records with **Chiropractic Wellness Center, LLC.** 300 S Rodney Parham Ste 11, Little Rock, AR 72205 (501)663-4663.

Signature: _____ Date: _____

Chiropractic Wellness Center, LLC
300 S. Rodney Parham, Ste 11
Little Rock, AR 72205-4747

PATIENT INFORMATION

Date_____

Patient_____ Sex:____M____F Age_____
Address_____Apt._____ Birthdate_____
City_____ State_____ Zip_____
Single_____Married_____Widowed_____Separated_____Divorced_____
Patient SS#_____ Occupation_____
Employer_____
Employer Address_____
Spouse's Name_____ Occupation_____
Birthdate_____ SS#_____
Spouse's Employer_____
Referred By:_____

PHONE NUMBERS

Home_____ Work_____ext_____ Cell_____
Best time and place to reach you_____
Email Address_____
Preferred method of contact: Phone _____ Email_____ Text_____ Fax _____Mail_____
IN CASE OF EMERGENCY, CONTACT
Name_____ Relationship_____
Home Phone_____ Work Phone_____

INSURANCE

Who is responsible for this account? _____
Relationship to Patient_____
Insurance Co._____ Group #_____
Is patient covered by additional insurance? _____ _____Yes_____No
Subscriber's Name (for secondary insurance) _____
Birthdate _____ SS#_____
Relationship to Patient_____
Insurance Co._____ Group #_____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent)have insurance coverage with_____ and assign directly to Dr. Trudy L. Bennett all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____
Responsible Party Signature

_____ _____
Relationship Date

(over)

PATIENT CONDITION

Reason for visit? _____
When did your symptoms appear? _____
Is this condition getting progressively worse? _____Yes _____No _____Unknown
Rate the severity of your pain on a scale of 1(least pain) to 10(severe pain)_____

Type of pain: ____Sharp ____Dull ____Throbbing ____Numbness _____Aching
____ Shooting _____Burning ____Tingling ____Stiffness _____Swelling
____Other_____
How often do you have this pain? _____
Is it constant or does it come and go? _____
Does it interfere with ____Work ____Sleep ____Daily Routine ____Recreation
What activities or movements are difficult to perform?_____

Was this condition due to an accident? ____Yes ____No
If yes, Date of Accident_____
Type of Accident_____
Do you have an attorney? ____Yes ____No Name:_____

HEALTH HISTORY

What treatment have you received for this condition?_____
Other doctors seen for this condition_____
Date of Last: Spinal X-Ray_____
Spinal Exam_____ MRI, CT, Bone Scan_____
List any other conditions that we should be made aware of regarding you health.
_____
_____
_____

Have you seen a chiropractor before? _____Yes(last treatment)_____ _____No
If yes, did your last chiropractor create a schedule of spinal maintenance for optimum spinal function?
_____Yes _____No If yes what was that schedule? _____
What are your goals for care (mark all that apply) _____Temporary Pain Relief
_____ Maximum Chiropractic Improvement _____Wellness/health

_____Other_____

CHIROPRACTIC WELLNESS CENTER, LLC

Trudy L. Bennett, DC
Antoine J. de Ras, DC
(501)663-4663
300 S. Rodney Parham Ste 11
Little Rock, AR 72205

Electronic Health Records Intake Form

This form complies with CMS EHR incentive program requirements

First Name:_____ **Last Name:**_____

Email address: _____@_____

DOB: ___/___/_____ **Gender (Circle one):** Male / Female

Preferred Language: _____

Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail

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

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) / Native Hawaiian or Pacific Islander / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Medical Care Information			
Do You Have a Family Doctor?: ☐ No ☐ Yes, Name of Doctor:			
Doctor's Address:	City:	State:	ZIP Code:
Date of last Visit: / /	Date of last exam: / /		
Do You Have a Family Chiropractor?: ☐ No ☐ Yes, circle one: Dr. Trudy Bennett or Dr. Tony de Ras If other, name:			
Chiropractor's Address:	City:	State:	ZIP Code:
Date of last Visit: / /	Date of last exam: / /		
Have you had surgeries in the last 5 Years: ☐ Yes ☐ No	If yes, Last Surgery Date:		
Reason for Surgery:			

Present Illness / Conditions:				
☐ AIDS	☐ Cirrhosis/Hepatitis	☐ HIV/ARC	☐ Rheumatic fever	☐ Polio
☐ Allergies	☐ Diabetes	☐ Kidney Trouble	☐ Scoliosis	☐ STDs
☐ Anemia	☐ Dislocated Joints	☐ Low Blood Pressure	☐ Sinus trouble	☐ Epilepsy
☐ Arthritis	☐ Diverticulitis	☐ Mental/ Emotional Difficulty	☐ Spinal Disc Disease	☐
☐ Asthma	☐ Hay Fever	☐ Multiple Sclerosis	☐ Thyroid trouble	☐
☐ Bone Fracture	☐ Heart Problem	☐ Pacemaker	☐ Tuberculosis	☐
☐ Cancer	☐ High Blood Pressure	☐ Prostate trouble	☐ Ulcer	☐
Other:				
Type of Cancer: ☐ Breast ☐ Lung ☐ Other:				

Are you currently taking any medications? *(Include regularly used over the counter medications)*
Continue list on separate sheet if needed

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?
Continue list on separate sheet if needed

Medication Name	Reaction	Onset Date	Additional Comments

Family History of Illness: *(Record one diagnosis in your family history and the affected)*
Continue list on separate sheet if needed

Diagnosis (Write in below)	Father	Mother	Brother	Sister	Son	Daughter
Example: Heart Disease		X				

Social History:

Alcohol? ☐ Yes ☐ No Drinks per week?

Smoking Status (Check one): ☐ Never Smoked ☐ Former Smoker ☐ Occasional Smoker
☐ Current Every Day Smoker - Packs per day?
Smoking Start Date (Optional):

Caffeine? ☐ Yes ☐ No Drinks per day?

Exercise? (circle one) None / Light / Moderate / Strenuous Hours per week?

Misc.:

☐ **I choose to decline receipt of my clinical summary after every visit** *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

Patient Signature: _____ Date: _____

All questions contained in this questionnaire are strictly confidential and will become part of your medical record with **Chiropractic Wellness Center, LLC.** 300 S. Rodney Parham Ste. 11, Little Rock, AR 72205 (501) 663-4663

For office use only

Height: _____ Weight: _____ Blood Pressure: _____ / _____

Chiropractic Wellness Center, LLC

Trudy Bennett, D.C.
Antoine De Ras, D.C.

300 South Rodney Parham Road, Suite 11
Little Rock, AR 72205-4774
(501) 663-4663

Patient Privacy Act

May we have your permission for the following:

1. **May we leave messages regarding appointments on your voicemail (answering machine)?**

   At Home **Yes** **No**

   On Cell **Yes** **No**

   At Work **Yes** **No**

2. **May we leave a message with anyone who answers your phone?** **Yes** **No**

   Name of designated individuals Relationship to you

   _____ _____
   _____ _____
   _____ _____
   _____ _____
   _____ _____

3. **Do you want anyone to have access to your records?** **Yes** **No**

   Name of designated individuals Relationship to you Phone Number

   _____ _____ _____
   _____ _____ _____
   _____ _____ _____
   _____ _____ _____
   _____ _____ _____

I _____ have given Chiropractic Wellness Center, L.L.C. my answers on how I want my privacy to be protected.

_____ _____
Patient's (Legal Guardian's) Signature Date

Chiropractic Wellness Center, LLC

Trudy Bennett, D.C.
Antoine De Ras, D.C.

300 South Rodney Parham Road, Suite 11
Little Rock, AR 72205-4774
(501) 663-4663

Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name: _____ Patient ID #: _____

I hereby acknowledge that I have received a copy of Chiropractic Wellness Center L.L.C.'s Notice of Privacy Practices. I understand that I have the right to refuse to sign this acknowledgement if I so choose.

_____ _____
Signature of Patient or Legal Representative Date

_____
Printed Name of Patient's Representative (*if applicable*)

Relationship to Patient (*if applicable*)
- ☐ Parent or guardian of unemancipated minor
- ☐ Court appointed guardian
- ☐ Executor or administrator of decedent's estate
- ☐ Power of Attorney

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices on the following date, _____ but acknowledgment could not be obtained because:

- ☐ Patient/representative refused to sign
- ☐ Emergency situation prevented us from obtaining acknowledgement at this time (will attempt again at a later date)
- ☐ Communication barriers prohibited obtaining acknowledgement (Explain)

_____
_____
_____
_____
_____

- ☐ Other (Specify)

_____
_____
_____
_____

CHIROPRACTIC WELLNESS CENTER, LLC

300 S. Rodney Parham Rd. Ste 11
Little Rock, AR 72205-4774
(501) 663-4663

Trudy L. Bennett, DC

INFORMED CONSENT FOR CHIROPRACTIC CARE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective. 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. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks and alternatives.

Chiropractic is a science and art which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may affect the restoration and preservation of health. Health is a state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

One disturbance to the nervous system is called a vertebral subluxation. This occurs when one or more of the 24 vertebrae in the spinal column become misaligned and/or do not move properly. This causes alteration of nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by an adjustment. An adjustment is the specific application of forces to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine. Adjustments are usually done by hand but may be performed by handheld instruments. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included.

If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

_____	_____	_____
Print Name	**Signature**	**Date**

Consent to evaluate and adjust a minor child:
I _____ being the parent or legal guardian of _____ have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care.

Pregnancy Release:

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual cycle:_____

_____	_____
Signature	**Date**

CHIROPRACTIC WELLNESS CENTER, LLC
300 S. Rodney Parham Rd. Ste 11
Little Rock, AR 72205-4774

FINANCIAL ARRANGEMENT POLICY

Thank you for choosing us for your health care needs. We are committed to providing you with the best possible care. Your clear understanding of our financial policy is important to our professional relationship. We require you read and sign the following statement prior to any treatment.

1. All patients must complete our Patient Information form prior to seeing the doctor. To allow us to provide the highest quality care, please complete these forms as accurately as possible.
2. Payment of deductible, co-payment, co-insurance amount, and any non-covered services are **due at the time of service.**
3. Non-insured patients are expected to pay in full at the time of service.
4. Understand that payment of your bill is considered part of your treatment.

** We accept cash, personal checks, Visa, MasterCard, Discover and American Express.

Insurances
With the exception of Medicare, Medicaid and Managed Care Organizations with which we participate, your insurance coverage is a contract between you and your insurance company.
We are not a party to that contract, but we will help you to receive maximum benefits. We file claims as a courtesy to our patients, however, you are responsible for paying all deductibles, co-payments, co-insurance amounts and non-covered services at the time of service.

Usual and Customary Rates
Our practice is committed to providing the best treatment for patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. We will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, co-insurance, covered charges, secondary insurances, etc., other than to file and provide factual information as necessary. **YOU ARE RESPONSIBLE FOR TIMELY PAYMENT OF YOUR ACCOUNT.**

Below is a list of our most common fees. *This is not all-inclusive.

*New Patient Exam EM, Level 2 - $40
*Comprehensive Spinal Exam, EM Level 3 - $65
*Re-exam - $20
*Adjustment - 1-2 regions $35 or 3-4 regions $40
*Cervical X-ray Series - $80
*Lumbar X-ray Series - $100
*Full Spine X-ray Series - $180
*Therapy - $20

Patients with a 3rd party Auto Accident Claim require a Medical Lien or payment at time of service.
Patients without insurance coverage are expected to pay at the time of service.
Patients with insurance coverage are expected to pay any deductibles, co-payments, co-insurance amounts and non-covered services at the time of service.

_____ _____
SIGN (Patient, or parent/guardian if minor) **DATE**