Charlotte Chiropractic Clinic, P.A.
537 West Sugar Creek Road, Suite 101
Charlotte, North Carolina 28213

Dr. Henry Rice
Dr. Ferzaan Ali

Date of Accident:
_____/_____/_____

New Personal Injury Case
(Please PRINT Clearly)

Today's Date: _____/_____/_____ Chart #: _____

Name: _____
First Middle Last Maiden

Address: _____ Apartment #:_____

City: _____ State _____ ZIP _____ Driver's License #: _____

Social Security #: _____ E-Mail Address: _____

Home Phone: (_____) _____-_____ Cell Phone: (_____) _____-_____

DOB: _____/_____/_____ Age: _____ Gender: Male___ Female___ Marital Status: _____

Employer: _____ Work Phone: (_____) _____-_____

Business Address: _____

Name of Spouse(parent): _____ Spouse's DOB: _____/_____/_____

Spouse's Employer: _____ Address: _____

Spouse's Work Phone: (_____) _____-_____ Spouse's SSN: _____

Previous Chiropractic Care? Yes ☐ No ☐ Doctor's Name: _____

Health Insurance Company: _____(please provide a copy of your insurance card)

Major Complaint: _____

Nearest Friend or relative that can be contacted in case of an emergency: _____

Relationship: _____ Phone #: (_____) _____-_____

<u>It is usual and customary to pay for services as rendered unless otherwise arranged.</u>

I do hereby authorize Charlotte Chiropractic Clinic, (Henry Rice D.C./Ferzaan A. Ali, D.C.) to furnish my Insurance Co. with a full report of physical examination, diagnosis, treatment, prognosis, etc. of myself in regard to my injury, if requested by them.

I hereby authorize and direct payment directly to said doctor such sums as may be due on owing him for chiropractic service rendered me. <u>I understand I am directly and fully responsible to said doctor for all medical bills submitted by him for service rendered me</u>. This agreement is made solely for said doctor's additional protection and in consideration of his awaiting payment.

I have read and agree to be bound by the terms of his assignment of benefits. I have also been advised that if my insurance company does not cooperate in protecting said doctor's interest, he will not await payment but may declare this entire balance due and payable; these assigned proceeds shall not exceed amounts due and payable to said doctor for services rendered.

Patient's Signature: _____ **Date:** _____

CHARLOTTE CHIROPRACTIC CLINIC, P.A.

Name: _____ Date: _____

Have you ever had chiropractic care before?

Yes: _____

No: _____

If Yes, did you receive treatment at our office? _____

If not out office, where? _____

How did you here about our practice? (Please name)

Relative _____

Friend _____

Doctor _____

Sign _____

Billboard _____

Yellow Pages _____

Other _____

In reference to your health insurance: (please choose one and initial on the line)

_____ I have health insurance and wish to have it filed if it includes chiropractic coverage. You will be responsible for paying your co-pay and/or deductible at each visit if you choose this option.

____ I am financially able to pay my copay at each visit

____ I am not financially able to pay my copay at each visit.

_____ I do <u>not</u> have health insurance.

_____ I have health insurance but choose <u>not to have it filed</u> at this time for this injury/illness.

Charlotte Chiropractic Clinic, P.A.
537 West Sugar Creek Road
Charlotte, North Carolina 28213
Phone: (704) 598-8040 FAX: (704) 509-0915

ASSIGNMENT OF BENEFITS, LIEN AND AUTHORIZATION

I hereby authorize and 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, provide, or distribute benefits to me for any medical conditions, accidents, injuries, or illness, past, present, or future ("condition") to pay directly and exclusively to Charlotte Chiropractic Clinic (CCC) or Office such sums as may be owing to CCC for charges incurred by me at the Office relating to my condition ("charges"), and with such payment to be made exclusively in the name of Charlotte Chiropractic Clinic. I further grant a lien to CCC with respect to my charges. This lien shall apply to all payers and to the full extent permitted by law. For the purposes of this document (herein "Assignment and Lien"), "benefits" shall include, but not be limited to, proceeds medical payment benefits, personal injury protection, no-fault coverage, uninsured and underinsured motorist coverage, third-party liability distribution, disability benefits, workers' compensation benefits, and any other benefits or proceeds payable to me for the purposes stated herein.

I authorize this Office CCC to release any information regarding my treatment or pertinent to my case(s) to all payers as defined above to facilitate collection under this Assignment and Lien. I further authorize and direct all payers to release to CCC any information regarding any coverage or benefits I may have including, but not limited to, the amount of coverage, the amount paid for thus far, and the amount of any outstanding claims. I hereby direct this Office, CCC to file a copy of this Assignment and Lien, together with any applicable charges, with any and all payers, regardless or whether a claim has been establish with said payers. I hereby grant CCC power of attorney 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 dependents.

I further authorize CCC to apply and credit balances on charges incurred by me to any other outstanding charges still owed by me, my spouse, or any of my dependents, regardless if these are related to my condition.

I understand that I remain personally responsible for the total amount due CCC for their services. This Assignment and Lien does not constitute any consideration for this Office to await payments and it may demand 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 CCC for all costs of such collection efforts, including, but not limited to, all court costs and attorney fees.

This Assignment and Lien shall not be modified or revoked without the mutual written consent of CCC 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 Assignment and Lien.

PATIENT NAME (please print): _____ Chart #: _____

PATIENT SIGNATURE: _____ Date: _____

CUSTODIAL PARENT/ LEGAL GUARDIAN (please print): _____

CUSTODIAL PARENT/ LEGAL GUARDIAN SIGNATURE: _____

Automobile Accident Questionnaire
Please answer all questions completely

Date: _____/_____/_____ Date of Accident: _____/_____/_____ Chart #: _______________

Patient Name:____

Occupation: ____

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Driver of vehicle you were in (self or other):_______________________________

Insurance Company: ____________________________ Phone: (_____) ______-__________

Policy Number: ________________________ Claim Number: _________________________

Name of person who has made contact with you: _______________________________

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Driver of other vehicle (if any):_______________________________________

Insurance Company: ____________________________ Phone: (_____) ______-__________

Policy Number: ________________________ Claim Number: _________________________

Name of person who has made contact with you: _________

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Have you retained an attorney: ☐ Yes ☐ No ☐ Not Yet

If so, his/her name & phone #: ____

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Please explain in detail how your accident happened: _________________________

____

____

Give date & time accident occurred: ______/______/______ @ _____________ ☐ AM ☐ PM

Direction you were heading: ☐ North ☐ South ☐ East ☐ West on _______________(street)

Number of people in your vehicle? ____________ Were the police notified? ☐ Yes ☐ No

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You were? ☐ Driver ☐ Front Middle ☐ Front Right ☐ Back Left ☐ Back Middle ☐ Back Right

Safety devices: ☐ Wearing Seat Belt ☐ Infant Car Seat ☐ Child Booster Seat ☐ Airbags deployed

Did you feel pain immediately after the accident? ☐ Yes ☐ No Where? ________________

Did your head strike the windshield or other object? ☐ Yes ☐ No What? ________________

Were you knocked unconscious? ☐ Yes ☐ No If so for how long? ____________________

Did you go to the hospital/urgent care/primary care doctor after the accident? ☐ Yes ☐ No

If so, where(name of facility)? ______________________ Were x-rays taken? ☐ Yes ☐ No

List any medications or treatments prescribed or taken for this injury: ____________________

____

Have you ever had any complaints in the involved area before? ☐ Yes ☐ No

Before the injury, were you able to work on an equal basis with others your age? ☐ Yes ☐ No
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Are your work activities restricted as a result of this accident? ☐ Yes ☐ No

Since the accident, are your symptoms ☐ Improving ☐ Getting Worse ☐ The Same

FILING YOUR **MEDPAY** and/or **HEALTH INSURANCE**

A lot of people have benefits (MEDPAY) included in their automobile policies and don't even realize it. Our office highly recommends that you use your Medpay coverage, if you have it, in the event that you've been injured in an automobile accident, regardless of who is at fault.

Here are 3 reasons why we recommend that we file your Medpay.

1) **Medpay is similar to Health Insurance** – Using it does not cause your rates to increase. If your rates increase, it's not because you filed your Medpay, it's most likely because: A) It was determined that you were partially at fault, B) you received the traffic citation or ticket, or C) you've been involved in numerous reported auto accidents within a brief period of time and therefore are now considered to be "high-risk".

2) **Filing your Medpay doesn't relieve the other party from having to pay in full for you loss.** On the contrary, by filing your Medpay, when you collect from the other driver's Liability insurance, a greater amount of the settlement will go directly to you because your bill at our office may be paid in part or in full. If the other driver's Liability insurance refuses to make payment to you for whatever reason, filing your Medpay will help to insure that you are not stuck with all the medical bills.

3) **If you have Medpay coverage and choose not to file it, then you are paying for an option or your own auto insurance, but choosing not receiving the benefit.**

For the same reasons, our office also recommends that you file your commercial Health Insurance (ex. Blue Cross/Blue Shield, United Healthcare, Aetna, Cigna, etc.). The important thing to remember is that you are not guaranteed to receive full payment from the other driver's Liability insurance company. Filing both your Medpay and your Health Insurance will help to insure that you are not left to pay the medical bills. If we receive overpayment on your account, we will be happy to refund you the difference.

By signing; you are stating that you have read this and agree to check your policy to see if you have medical payments coverage, and if you do, will discuss filing it with the doctor or your attorney.

Signature: _____ Date: _____

Date of Accident: _____ Chart #: _____

If you have any questions about filing your medpay and/or your health insurance, please do not hesitate to talk to the doctor and direct any questions that you have to him.

HIPAA Notice of Privacy Practices (page one)

Charlotte Chiropractic Clinic
537 West Sugar Creek Road
Charlotte, North Carolina 28213
(704) 598-8040

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

HIPAA Notice of Privacy Practices (page two)

Your Rights
Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected heath information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purpose of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to your family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure or your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003**.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have and objections to this form, please ask to speak with our HIPAA Compliances Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name: _____ Chart #: _____

Signature: _____ Date: _____