

VEHICLE ACCIDENT INFORMATION

PATIENT INFORMATION

Date _____

Patient Name _____

Date of Accident _____ Time of Accident _____ a.m.

p.m.

Please describe the accident in your own words: _____

Were you the:

Driver

Front Passenger

How many people were

Rear Passenger

Pedestrian

in the accident vehicle? _____

ACCIDENT SITE

Road/Street Name _____

City/State _____

Nearest intersection with road/street _____

Driving conditions Dry Wet Icy Other _____

Which direction were you headed? _____

Speed you were traveling? _____

IMPACT

Did your car impact another vehicle? Yes No

Did your car impact a structure? Yes No

If yes, explain _____

Did any part of your body strike anything in the vehicle?

Yes No If yes, explain _____

Was impact from :

Front Rear Left Right Other _____

At the time of impact were you:

Looking straight ahead

Looking to the right

Looking to the left

Looking down

Looking up

Were both hands on the steering wheel? Yes No

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

Was your foot on the brake? Yes No

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

Were you: Surprised by impact Braced for impact

VEHICLE

Make and model of vehicle you were in:

Were you wearing a seatbelt? 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 was the position of the headrest?

Low Midposition High

OTHER VEHICLE

(If applicable)

Make and model of other vehicle _____

Which direction was other vehicle headed? _____

Speed other vehicle was traveling _____

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? _____

PATIENT CONDITION

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

Please describe how you felt immediately after the accident:

TREATMENT

Did you go to 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? Ambulance Private transportation

Name of hospital _____ Name of doctor _____

Diagnosis _____

Treatment received _____

X-rays taken _____

SYMPTOMS/INJURIES

Have you been able to work since this injury? Yes 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:

- | | | |
|--|---|--|
| <input type="checkbox"/> Arm/shoulder pain | <input type="checkbox"/> Feet/toe numbness | <input type="checkbox"/> Neck pain |
| <input type="checkbox"/> Back pain | <input type="checkbox"/> Hand/finger numbness | <input type="checkbox"/> Neck stiff |
| <input type="checkbox"/> Back stiffness | <input type="checkbox"/> Headaches | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Irritability | <input type="checkbox"/> Sleep difficulty |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Jaw problems | <input type="checkbox"/> Stomach upset |
| <input type="checkbox"/> Ear buzzing | <input type="checkbox"/> Leg pain | <input type="checkbox"/> Tension |
| <input type="checkbox"/> Ear ringing | <input type="checkbox"/> Memory loss | <input type="checkbox"/> Vision blurred |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Nausea | |

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) _____

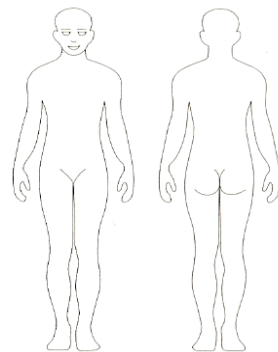
Type of pain: Sharp Dull Throbbing Numbness
 Aching Shooting Burning Tingling
 Cramps Stiffness Swelling Other _____

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your: 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.

Signature of Patient, Parent, Guardian or Personal Representative

Date

Please print name of Patient, Parent, Guardian or Personal Representative

Relationship to Patient

INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or the patient below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or serving as back-up doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic.

I understand and I am informed that in the practice of chiropractic, as in the practice of medicine, there are some risks to treatment. Including but not limited to fractures, disc injuries strokes, dislocations, and sprains. I do not expect the doctor to be able to anticipate or explain all risks and complications. I wish to rely on the doctor to exercise judgment based on the facts known at the time of service based on my best interests, during the course of treatment.

I have read or have had read to me, the above consent. I have also had an opportunity to ask questions about its content and by signing below, I agree to the above named procedures. I consent to this form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

To be completed by patient:

_____ Date: _____
Patient's Name (print) Patient's Signature

To be completed by patients representative If patient is a minor or incapacitated:

_____ Date: _____
Parent or Legal Guardian's Name Parent or Legal Guardian's Signature

Female Patient's Only:

This is to certify that to the best of my knowledge, I am **NOT** pregnant and that Dr. Kelly Lucas has my permission to take x-rays. (Please enter the first day of your last period): _____ / _____ / _____

_____ Date: _____
Patient's Signature

This is to certify that to the best of my knowledge, I **AM** pregnant and that Dr. Kelly Lucas does not have my permission to take x-rays. Please enter how many months/weeks pregnant you are: _____

_____ Date: _____
Estimated Due Date Patient's Signature

Name and Address of Clinic:
Coast Rehabilitation
1500 E. Katella Ave., Ste. G
Orange, CA 92867

Doctors Treating this Patient:
•Kelly K. Lucas, D.C.
Homa Bakhtar, D.C
John R. Kole, D.C

Financial Agreement

We would like you to take a moment to welcome you to our office and to assure you that you will be receiving the very best care available. In order to familiarize you with the financial policies of our office, we would like to explain how your medical bills will be handled. All patient portions of charges for treatment in this office are due and payable at the time the service is performed. The first visit is to be paid in full at the time of service for all patients with or without insurance benefits (except workman's compensation or personal injury). **Please Initial where it applies.**

Payment Plans

_____ **PRIVATE PAY:** I agree to pay for each visit at the time of service or I will agree to prepay for visits on a weekly/monthly basis. *Discounts are offered with prepaid visit plans. *

_____ **PRIVATE/GROUP INSURANCE:** I understand that the terms of my insurance policy are between the insurance company and myself. Should my insurance company deny any charges incurred, I will be personally responsible for payment for those services in full. I agree to pay my yearly deductible amount and my co-insurance amount at the time of service or prepay on a weekly/monthly basis. I will pay for the first visit in full at the time of service. That payment will be applied toward my yearly deductible, co-insurance amount or will be fully refunded if my insurance pays 100%. * As a courtesy our staff will verify your health insurance benefits but we cannot guarantee payment or the accuracy of benefits quoted.*

_____ **MEDICARE:** I understand that my Medicare insurance policy only covers 80% of allowed charges for spinal manipulation procedures performed by a chiropractor. Any and all other charges are considered not covered by Medicare. I agree to be personally responsible for payment of my deductible amount, my co-payment amount for covered services and for all non-covered services such as: x-rays, vitamins/supplements, pillows or supports.

_____ **PERSONAL INJURY:** I agree to allow Coast Rehabilitation to submit all charges incurred for this accident to my automobile medical payment policy. I further agree that if no medical coverage is available with my auto insurance or if I exhaust my benefits, that I will be personally responsible to pay for all charges incurred. If medical coverage is not available on my auto insurance policy my private health insurance may be billed.

ATTORNEY LIEN: I understand that Coast Rehabilitation has agreed to carry the balance of any unpaid charges on a lien with my attorney. I further understand that if I change attorneys or release this attorney prior to the settlement of my claim this agreement is void and I agree to pay the full balance due immediately.

3rd PARTY CLAIM (no attorney): I understand that I am making a claim against a 3rd party insurance policy and that this policy does not reimburse the doctor directly for any services incurred as a result of my claim. I agree that I am personally responsible to pay charges incurred on a daily/weekly/monthly basis or at the time of settlement of my claim.

_____ **WORKMAN'S COMPENSATION:** I understand that I am filing a worker's compensation claim. I also understand that if I do not follow the doctor's recommendations for care or if I miss appointments my claim may be denied. If my claim is denied because of my failure to follow the doctor's recommendation for treatment or because I miss appointments I understand I will be responsible and liable for the balance of the bill.

_____ **MISSED APPOINTMENT FEE:** I understand and Agree to pay a fee of \$25.00 upon a missed appointment that I did not cancelled within a 24 hr notice. I understand that this fee includes a massage appointment as well, if I did not cancel within the 24 hr period.

I further understand that if I suspend or terminate my care with this office, my balance will be immediately due and payable.

I have read and agree to the above:

_____ Date: _____

Patient's Signature

To be completed by patient's representative If patient is a minor or incapacitated:

_____ Date: _____

Parent or Legal Guardian's Signature

Dr. Kelly K. Lucas, DC
1500 East Katella Ave. Unit G
Orange, CA 92867
714-639-7654

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS 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 HEALTHCARE 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, AND FUTURE PHYSICAL OR MENTAL HEALTH OR CONDITION AND RELATED HEALTH CARE SERVICES.

1. 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 AMNAGE YOUR HEALTH CARE AND 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 HOME HEALTH AGENCY THAT PROVIDES CARE TO YOU, 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 BE 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, AND TRAINING OF MEDICAL STUDENTS, LICENSING, AND CONDUCTING OR ARRANGING FOR THE BUSINESS ACTIVITIES. FOR EXAMPLE, WE MAY DISCLOSE YOUR PROTECTED HEALTH INFORMATION TO MEDICAL SCHOOL 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 ANME 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 LA, 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, 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 SECTION 164.500.

