**Please make sure you fill out all pages of the 'Personal Injury Questionnaire' and that every question is filled out in *detail* (including the at fault driver's info, the at fault driver's insurance info, your auto insurance company info, and your attorney info).** We will also need a copy of the police report **regarding this accident, as well. Also, please sign the 'Professional Lien Letter'. If you have any questions, please don't hesitate to ask us. Thank you.**

Ancala CHIROPRACTIC

# *CONFIDENTIAL ADULT PATIENT INFORMATION*

***Please answer ALL the questions in detail to the best of your ability.*** *(All information you give is confidential)*

## PERSONAL INFORMATION

Today's Date: ____________________________

Name:___________________________________ ☐*Female* ☐*Male* Social Security No.__________/_________/___________
*(for insurance verification purposes)*

Address: ____________________________________________ City:_______________________ State:_________ Zip:___________

Home No. (____)__________________ Cell No. (_____)____________________ Work No. (____) ____________________

Date of Birth: .__________/_________/___________ Age:___________ Height: _____ft _______in Weight:_______________

☐ *Minor* ☐*Single* ☐*Married* ☐*Separated* ☐*Divorced* ☐*Widowed* ☐Partnered for ____ years Name of Spouse: ________________________

Number of children________Name:_____________ age:_____ / Name:_____________ age:_____ / Name:_____________age:_____

/ Name:_____________ age:_____ / Name:_____________ age:_____ / Name:_____________ age:_____

Occupation:_______________________________________________ Employed by:__________________________________________

Complete e-mail address: _______________________________________@ _______________________________ . ________

Have you ever been to a chiropractor before? ☐*Yes* ☐*No* *If yes*, when? _____________________________________

Whom may we thank for referring you? ☐*Dex Yellow Pages* ☐ *Online* ☐*Yellow Book* ☐*Health Insurance* ☐*Walk-by* ☐*Banner* ☐*Expo*

☐ *Talk/Screening by Dr. Mitch Borst* ☐Other __________________ ☐ *Friend (please give name so we can thank them with a gift!)*__________________

**IN CASE IF EMERGENCY, CONTACT**

Name___________________________________________________ Relationship ________________________________________________

Home No. (____)__________________ Cell No. (_____)____________________ Work No. (____) ____________________

## ACCIDENT INFORMATION

Who's at fault for the accident? ☐Myself ☐Driver of car I was in ☐Driver of other car ☐Undetermined

Do you have a police report? ☐Yes ☐No **If yes, we need to retain a copy ASAP**

Were any tickets issued? ☐Yes ☐No **If yes, to whom?** ________________________________________________________

Full name of driver at fault: ________________________________ Their Address: __________________________________________

At fault driver's Insurance company:______________________________ Address: __________________________________________

Phone # :___________________________ Policy #:_____________________________Claim #:________________________________

*****Note: The other party must report this accident to their insurance company to create a claim number*****

You **Auto Insurance** company:_____________________________ Address: _______________________________________________

Phone # :___________________________ Policy #:_____________________________

Have you reported this accident to your insurance company ☐ Yes ☐ No Claim #:________________________________

*****Note: It is your responsibility to report this accident to your insurance company. ***Your premiums will NOT increase by using your medical payments (MEDPAY) coverage*****

You **Health Insurance** company:____________________________________ Policy #:_________________________________________

*****Note: We need a copy of your Health Insurance Card and your Auto Insurance Card*****

Have you retained an attorney? ☐Yes ☐No _______________________________________________________________________
Attorney's Name Firm Name Phone #

### Nature of Accident

Date of Accident: __________________________________________ Time of day: ________________________☐am ☐pm

Location/ Cross Streets: ___________________________________________________________________________________________

Road conditions at the time of accident: ☐ Dry ☐Wet ☐Icy ☐Snow ☐Other: ________________________________

Where were you seated in the vehicle? ☐Driver ☐Front seat passenger ☐Back seat passenger

Was the accident report filed with the police? ☐Yes ☐No ➔➔➔➔➔➔➔➔➔➔ Did you brace for impact? ☐Yes ☐No

Did you lose consciousness (blackout) upon impact? ☐Yes ☐No *If yes, can you estimate how long*? ______________________

Was your headrest in the high or low position? ☐High ☐Low

Were you wearing your seat belt? ☐Yes ☐No ➔➔➔➔➔ *If so, what type*? ☐Lap belt only ☐Shoulder and lap belt

Is your car equipped with an airbag? ☐Yes ☐No ➔➔➔➔➔ *If yes, did the airbag activate*? ☐Yes ☐No

Were you struck from: ☐Behind ☐Front ☐Left side ☐Right side

Was your car stopped at the time of impact? ☐Yes ☐No Number of people in your vehicle? _________________

If your vehicle was moving at the time of the collision, was it… ☐Slowing down ☐Gaining speed ☐ Traveling at a steady speed

Please describe, to the best of your knowledge, what happened during this accident: ________________________________________

______________________________________________________________________________________________

______________________________________________________________________________________________

What type of care were you in? Year_____________ Make: ________________________ Model:__________________________

What type of car impacted with your vehicle? Year______________ Make: ____________________ Model:_____________________

Was the other vehicle moving at the time of the collision? ☐Yes ☐No ➔ *If yes, what was its approximate speed*: __________m.p.h.

What bruises or cuts did you get from the accident? __________________________________________________________________

Did any of your body strike any part of the car? ☐Yes ☐No *If yes, where?* ____________________________________________

What position was your head facing upon impact? ☐ Forward ☐Turned to the right ☐Turned to the left ☐Other______________

Was your vehicle pushed forward from the impact? ☐Yes ☐No

*If yes, how much?* ☐More than one car length ☐One car length ☐One-half car length ☐Less than one-half car length

Did your car hit anything else after it was hit? ☐Yes ☐No ➔ *If yes, what?* ____________________________________________

Describe the damage to your vehicle: ☐None ☐Minimal ☐Moderate ☐Major ☐Totaled

Which car parts broke during the accident?__________________________________________________________________________

Describe the damage to other vehicle(s): ☐None ☐Minimal ☐Moderate ☐Major ☐Totaled

Was anyone cited? ☐Yes ☐No ➔ *If yes, who?*_________________________________________________________________

**Emergency Care**

At the site of the accident, did you receive emergency care? ☐Yes ☐No

Please describe: ________________________________________________________________________________________

Where did you go after the accident? ☐This office ☐Emergency room ☐Physician's Office ☐Home ☐Other_________________

When did you receive care? ☐Immediately ☐Later that day ☐Next day ☐Days later, date:___________________________

By whom were you driven? ☐Ambulance ☐Self ☐Family Member ☐Friend

**Treatment**

Hospital Name: _____________________________________ (or) Other medical facility:_____________________________________

What type of treatment did you receive? ____________________________________________________________________________

X-Rays: _____________________________________ Medication prescribed: _____________________________________

What recommendations were you given? ____________________________________________________________________________

Have you been treated by any other doctor(s) for injuries related to this accident? ☐Yes ☐No

If yes, please list doctors and briefly describe treatment:

1. ____________________________________ Dates of care: ______________ Type of care:________________________

2. ____________________________________ Dates of care: ______________ Type of care:________________________

3. ____________________________________ Dates of care: ______________ Type of care:________________________

## CURRENT HEALTH CONDITION

Please list your current complaints in order of pain severity: ***(please circle one)***

(main complaint)________________________________________ How long have you had this problem? #_________ years / months/ days

( 2nd complaint)________________________________________ How long have you had this problem? #_________ years / months/ days

( 3rd complaint)________________________________________ How long have you had this problem? #_________ years / months/ days

Are you having any problems with the following? ☐ Jaw ☐ Shoulder ☐ Arm ☐ Elbow ☐ Wrist ☐ Hand ☐ Rib Cage

☐ Pelvis ☐ Thigh ☐ Hip ☐ Knee ☐ Lower Leg ☐ Ankle ☐Foot

Other Doctors / Professionals seen for these conditions: __________________________________________________________

Have you had similar conditions to these before? ☐*Yes* ☐*No* *If yes, when?* ____________________________________________

Does your condition ☐*Come and Go* **or is it** ☐*Constant* ? How did it start? ☐*Gradually* ☐*Suddenly*

What makes it feel ***better***? ☐*Rest* ☐*Heat/Ice* ☐*Lying* ☐*Chiropractic Adjustment* ☐*Massage* ☐*Standing* ☐*Sitting* ☐*Other*___________

What makes it feel ***worse***? ☐*Stress* ☐*Activity* ☐*Lifting* ☐*Standing* ☐*Sitting* ☐*Bending* ☐*Work* ☐*Turning* ☐*Other*_____________

How would ***describe*** the pain? ☐*Sharp* ☐*Dull* ☐*Achy* ☐*Burning* ☐*Stabbing* ☐*Deep* ☐*Shooting* ☐*Other*_____________________

Have you lost any days at work because of this condition? ☐*Yes* ☐*No* If yes, *how many?* ________________________________

**On the scale below, please circle the severity of your main complaint (*at it's worst*)**

*None* *Slight* *Mild* *Moderate* *Severe*

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|

**On the scale below, please circle the percentage of time you experience your main complaint (*at its worst*)**

*None* *Occasional* *Intermittent* *Frequent* *Constant*

| 10 | 20 | 30 | 40 | 50 | 60 | 70 | 80 | 90 | 100 |
|---|---|---|---|---|---|---|---|---|---|

**On the diagram below, please circle where you are experiencing ALL of your present complaints using the following letters:**

Do you have pain and/or difficulty performing any of the following activities (please check✓). **If none put a big N/A in the middle**

_____personal care _____lifting

_____reading _____concentrating

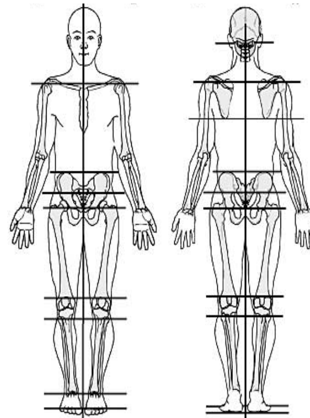
_____work _____driving

_____sleeping _____recreation

_____walking _____sitting

_____standing _____social life

**IMPORTANT…Please fill out! Circle where you hurt and put the letter of how you feel next to it.**



**A**: ache

**B**: burning pain

**C**: cramping

**D**: dull pain

**N**: numbness

**R**: throbbing pain

**T**: tingling

**O**: other_________

_______________

_______________

## PAST HISTORY

What operations have you had? __________________________________________________________________

Illness Current or Past? ______________________________

Broken / Fractured Bones? ☐ *Yes* ☐ *No* *Which ones?* ______________________________

Have you ever been hospitalized? ☐ *Yes* ☐ *No* *If yes, why?* ______________________________

Medical Doctor ____________ Date of last visit ____________ Purpose ____________

Females: Are you pregnant? ☐ *Yes* ☐ *No* ☐ *Unsure*

List any medication/drugs you are currently taking (both prescription and non-prescription): ______________________________

---

## PLEASE 'X' ANY OF THE FOLLOWING YOU HAVE HAD IN THE LAST 12 MONTHS

- ☐ Other accidents / falls
- ☐ Arthritis
- ☐ Convulsions, epilepsy
- ☐ Cancer
- ☐ Frequent colds/flu
- ☐ Depressed
- ☐ Anemia
- ☐ Allergy/sinus
- ☐ Stress
- ☐ Eating disorders
- ☐ Trouble sleeping
- ☐ Trouble concentrating
- ☐ Learning disability
- ☐ Mood changes
- ☐ Ringing in ears
  ___Right side ___Left side
- ☐ Pain when you cough or sneeze
- ☐ Headaches
- ☐ Chest pain / asthma
- ☐ Stroke
- ☐ Varicose veins
- ☐ Liver trouble
- ☐ Gall bladder trouble
- ☐ Hemorrhoids
- ☐ Impotence
- ☐ Kidney trouble
- ☐ Bedwetting
- ☐ AIDS, HIV

**Exercise**

- ☐ None
- ☐ Moderate
- ☐ Daily
- ☐ Heavy

**Work Activity**

- ☐ Sitting
- ☐ Standing
- ☐ Light Labor
- ☐ Heavy Labor

**Habits**

- ☐ Smoking — Packs/Day ____________
- ☐ Alcohol — Drinks/Week ____________
- ☐ Coffee/Caffeine Drinks — Cups/Day ____________
- ☐ High Stress Level — Reason ____________

## ASSIGN AND RELEASE & CONSENT FOR TREATMENT

I certify that if I, and/or my dependent(s), have insurance coverage I assign directly to Dr. Mitchell Borst, 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 understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I authorize the use of my signature on all insurance submissions.

Dr. Mitch Borst may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services determining insurance benefits or the benefits payable for related services.

I, the undersigned, a patient in this office, hereby authorize/consent Dr. Mitchell Borst, DC, Ancala Chiropractic, Desert Ridge Chiropractic, New Beginnings Chiropractic, their associates or interns (and whomever he may designate as his assistant(s) to administrator treatment as necessary). I also certify that no guarantees or assurances have been made to me as to the results that may be obtained.

I also authorize Dr. Mitchell Borst to give chiropractic in an "open-door", adjusting environment, and can use my name on welcome boards, referral boards, sign-in sheets, and travel file use. I understand it is the desire of this office to provide chiropractic care in an "open-door" adjusting environment. An open-door approach involves the doctor moving from patient-care area to patient-care area. As a result, patients and patient files with patient names are within sight of one another and some ongoing routine details of care are discussed within earshot of other patients and staff. This environment is used for ongoing care and is NOT the environment used for taking patient histories, performing examination of present reports and findings. These procedures are completed in a private, confidential setting. I also understand e-mail address will not be sold to anyone but used only from their office for their newsletter, office news or contact purposes. I also authorize this office to pre-approve me for payment arrangements through CareCredit® by the use of my name and address only, which will *not* affect my credit report or credit score.

I also understand that if I suspend or terminate my care and treatment, and fee for professional services rendered to me will be immediately due and payable to Ancala Chiropractic, Desert Ridge Chiropractic, and New Beginnings Chiropractic. If my account goes to collections I am responsible for any and all collection fees. I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize Ancala Chiropractic, Desert Ridge Chiropractic, and New Beginnings Chiropractic to do whatever is necessary in accordance with this state's statues, to provide me with chiropractic care.

Patient's Signature: ______________________________ Date: ____________

Guardian or Parent's Signature: ______________________________ Date: ____________

# HIPAA NOTICE OF PATIENT INFORMATION PRIVACY PRACTICES

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

## LEGAL DUTY

Ancala Chiropractic, Desert Ridge Chiropractic, and New Beginnings Chiropractic is required by law to protect the privacy of your personal health information, provide this notice about our information practices and follow the information practices that are described herein.

## USES AND DISCLOSURES OF HEALTH INFORMATION

Ancala Chiropractic, Desert Ridge Chiropractic, and New Beginnings Chiropractic uses your personal health information primarily for treatment; obtaining payment for treatment; conducting internal administrative activities and evaluating the quality of care that we provide. For example, Ancala Chiropractic, Desert Ridge Chiropractic, and New Beginnings Chiropractic may use your personal health information to contact you to provide appointment reminders, or information about treatment alternatives or other health related benefits that could be of interest to you.

Ancala Chiropractic, Desert Ridge Chiropractic, and New Beginnings Chiropractic may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, for research studies and for emergencies. We also provide information when required by law.

In any other situation, Ancala Chiropractic, Desert Ridge Chiropractic, and New Beginnings Chiropractic 's policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time.

Ancala Chiropractic, Desert Ridge Chiropractic, and New Beginnings Chiropractic may change its policy at any time. When changes are made, a new Notice of Information Practices will be posted in the waiting room and patient exam areas and will be provided to you on your next visit. You may also request an updated copy of our Notice of Information Practices at any time.

## PATIENT'S INDIVIDUAL RIGHTS

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment or other related administrative purposes.

You may also request in writing that we not use or disclose your personal health information for treatment, payment and administrative purposes except when specifically authorized by you, when required by law or in emergency circumstances. Ancala Chiropractic, Desert Ridge Chiropractic, and New Beginnings Chiropractic will consider all such requests on a case-by-case basis, but the practice is not legally required to accept them.

## CONCERNS AND COMPLAINTS

If you are concerned that Ancala Chiropractic, Desert Ridge Chiropractic, and New Beginnings Chiropractic may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our practice manager at 11259 E Via Linda, suite 108, Scottsdale, Arizona 85259. You may also send a written complaint to the US Department of Health and Human Services. For further information on Ancala Chiropractic, Desert Ridge Chiropractic, and New Beginnings Chiropractic's health information practices or if you have a complaint, please contact the following person:

# HIPAA PATIENT INFORMATION CONSENT FORM

I have read and fully understand Ancala Chiropractic, Desert Ridge Chiropractic, and New Beginnings Chiropractic's Notice of Information Practices. I understand that Ancala Chiropractic, Desert Ridge Chiropractic, and New Beginnings Chiropractic may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that ABC PT/OT will consider requests for restriction on a case-by-case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in Ancala Chiropractic, Desert Ridge Chiropractic, and New Beginnings Chiropractic's Notice of Information practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

______________________________________________
Patient Name

______________________________________________
Signature

______________________________________________
Date

# Notice of Professional Lien

**(office use only)**

To: ________________________________

Attn:_______________________________

___________________________________

___________________________________

(_______)_______________________ bus

(_______)_______________________ fax

Claim No. ___________________________


Mitchell Borst, D.C. /Ancala Chiropractic
11259 E Via Linda, suite 108
Scottsdale, Arizona 85259
(480) 661-6449 business
(480) 661-6737 fax


Re: Medical Lien

1. I do hereby authorize the above company, Mitchell Borst, D.C. / Ancala Chiropractic, to furnish you, my attorney, insurance company or company with whom the claim is through, with notes and final bill of myself in regard to the accident in which I was involved.

2. I hereby authorize and direct you, my attorney, insurance company or company with whom the claim is through, to pay directly to or include as payee to **Mitchell Borst, D.C.** such sums as may be due and owing them for any services or supplies rendered me by reason of this accident and by reason any other bills that are due their office and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect all proceeds of any settlement, judgment or verdict which may be paid to you my attorney, insurance company or company with whom the claim is through, or myself as the result of the injuries for which I have been treated of injuries in connection therewith.

3. I fully understand that I am directly and fully responsible to Mitchell Borst, D.C. / Ancala Chiropractic for all payments and fees submitted by them for service rendered me and that this agreement is made solely for Mitchell Borst, D.C. / Ancala Chiropractic's protection and in consideration of their awaiting payment. Also, I fully understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee. If this account is assigned for collection and/or sit, collection costs and/or interest, and/or attorney's fees, and/or court costs will be added to the total amount due. I also understand that Mitchell Borst, D.C. / Ancala Chiropractic may put a medical lien on my name through the Maricopa County Recorder, and I will receive a letter stating that has been done. When payment is received to Mitchell Borst, D.C. / Ancala Chiropractic that medical lien will be released.

Client Signature: ______________________________ Date: _____________________________

Client Name: _________________________________ Witnessed by ________________________