



Falite Family Chiropractic

Drs. Dawn & Michael Falite
770-667-2232
 2910 Vaughan Dr, Cumming, GA 30041
 www.FaliteChiropractic.com

Accident Case History

Name: _____ Date: _____ Date of Accident: _____

Address: _____ City: _____ Zip: _____

Date of Birth: _____ Age: _____ Marital Status: M S D W

Phone (Home): _____ (Work): _____ (Cell): _____

SS #: _____ email: _____

Spouse's Name: _____ Spouse's Date of Birth: _____

Spouse's Employer: _____ Spouse's Work Phone: _____

Names & Ages of Children: _____

Who referred you to our office: _____ Relationship: _____

By signing below, I understand that I am ultimately responsible for the payment of the balance due for my care. Per the doctor's discretion, he/she may agree to wait for payment-in-full until my case has settled (credit card number to remain on file).

Patient's Signature: _____ Date: _____

Credit Card #: _____ EXP Date: _____ Billing Zip Code: _____

PLEASE DESCRIBE YOUR COMPLAINTS:

Involving neck and head: _____

Involving mid-back/shoulders/arms/hands: _____

Involving low back/hips/legs/feet: _____

What activities make your condition worse? _____

What activities make your condition better? _____

INDICATE THE ABILITY TO PERFORM THE FOLLOWING ACTIVITIES:

U - Unable P - Painful D - Difficult L - Limited N - Normal

<input type="checkbox"/> Coughing or sneezing	<input type="checkbox"/> Climbing	<input type="checkbox"/> Gripping
<input type="checkbox"/> Getting in/out of car	<input type="checkbox"/> Kneeling	<input type="checkbox"/> Pushing
<input type="checkbox"/> Bending forward to brush teeth	<input type="checkbox"/> Balancing	<input type="checkbox"/> Pulling
<input type="checkbox"/> Turning over in bed	<input type="checkbox"/> Dressing self	<input type="checkbox"/> Reaching
<input type="checkbox"/> Walking short distances	<input type="checkbox"/> Sleeping	<input type="checkbox"/> Bending forward
<input type="checkbox"/> Standing for more than one hour	<input type="checkbox"/> Stooping	<input type="checkbox"/> Sexual activity
<input type="checkbox"/> Lying on back	<input type="checkbox"/> Lying flat on stomach	<input type="checkbox"/> Sitting at a table
	<input type="checkbox"/> Lying on side w/knees bent	

Check symptoms of Nervous Stress:

<input type="checkbox"/> Blurring vision	<input type="checkbox"/> Headaches (How often? _____)	
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Fainting	<input type="checkbox"/> Confusion
<input type="checkbox"/> Buzzing/ringing of ears	<input type="checkbox"/> Numbness	<input type="checkbox"/> Convulsions
<input type="checkbox"/> Loss of sleep	<input type="checkbox"/> Muscle jerking	<input type="checkbox"/> Paralysis
<input type="checkbox"/> Depression or crying spells	<input type="checkbox"/> Low resistance	

Check proper space:

Symptoms are BETTER in: AM Midday PM
 Symptoms are WORSE in: AM Midday PM
 Symptoms do not change with time of day

Date of last x-rays: _____

Women Only: Are you (or could you be) pregnant? Yes No

Time of accident: _____ (AM/PM) Driver of Car: _____ Where were you seated? _____

Who owns the car? _____ Year and model of car: _____

What was the approximate damage done to your car? \$ _____

Where was your car struck? right left rear front side

Type of accident: head-on collision broad-side collision
 rear-end collision front impact, rear-ended car in front
 non-collision: _____

Describe in your own words what happened to you upon impact: _____

- a) Did you see the accident coming? yes no
 b) Did you brace for impact? yes no
 c) Were seat belts worn? yes no
 d) Were shoulder harnesses worn? yes no
 e) Does your car have headrests? yes no
 f) If yes, what was the position of those headrests compared to your head before the accident?
 top of headrest even with bottom of head
 top of headrest even with top of head
 top of headrest even with middle of neck
 g) Was your car breaking? yes no
 h) Was your car moving at the time of the accident? yes no
 i) If yes, how fast would you estimate you were going? _____ m.p.h.
 j) How fast was the other car traveling? _____ m.p.h.

Head/Body position at time of impact:

head turned left/right body straight in sitting position
 head looking back body rotated left/right
 head straight forward other: _____

a) At the time of impact, recall what parts of your head or body hit what parts on the inside of your car: _____

b) As a result of the accident you were:

rendered unconscious dazed/circumstances vague Other: _____

c) Could you move all parts of you body? yes no

If no, what parts and why? _____

d) Were you able to get out of the car and walk unaided? yes no

If no, why not? _____

Did you get bleeding cuts or bruises? yes no

If yes, explain: _____

Please describe how you felt. Please be specific.

a) Immediately after the accident: _____

b) Later that ___ day ___ night: _____

c) The next ___ day ___ night: _____

Check symptoms apparent since the accident:

<input type="checkbox"/> Headache	<input type="checkbox"/> Loss of smell	<input type="checkbox"/> Numbness in fingers
<input type="checkbox"/> Neck pain/stiffness	<input type="checkbox"/> Loss of taste	<input type="checkbox"/> Cold hands
<input type="checkbox"/> Mid back pain	<input type="checkbox"/> Loss of memory	<input type="checkbox"/> Cold feet
<input type="checkbox"/> Low back pain	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Diarrhea
<input type="checkbox"/> Eyes sensitive to light	<input type="checkbox"/> Tension	<input type="checkbox"/> Constipation
<input type="checkbox"/> Pain behind eyes	<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Chest pain
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Irritability	<input type="checkbox"/> Nervousness
<input type="checkbox"/> Fainting	<input type="checkbox"/> Depression	<input type="checkbox"/> Cold sweats
<input type="checkbox"/> Ringing/buzzing ears	<input type="checkbox"/> Sleeping problems	<input type="checkbox"/> Anxious
<input type="checkbox"/> Loss of balance	<input type="checkbox"/> Numbness in toes	<input type="checkbox"/> Other: _____

Occupation: _____ Employer: _____

Have you missed time from work? yes no

If yes, ___ full-time off work _____ to _____

 ___ part-time off work _____ to _____

 ___ been unable to work since accident

Did you seek medical help immediately/soon after the accident? yes no

If yes, how did you get there?

Someone else drove me Ambulance

Drove own car Police

Doctor/Hospital/Clinic seen: _____ Date of first visit: _____

Were you examined? yes no Were X-rays taken? yes no

Were you given treatment? yes no

If yes, what treatment was given to you? _____

What benefits did you receive from this treatment? _____

Date of last treatment: _____

Did you have any physical complaints just before the accident? ___yes ___no

If yes, please describe in detail: _____

Prior to this accident, have you ever had symptoms similar to what you're experiencing now? ___yes ___no

If yes, please explain: _____

Do you notice any activities of your home daily routines that are different now than from before the accident?
___yes ___no

If yes, list them: (Please be specific)

a) Those you are unable to do: _____

b) Those that are painful to do: _____

c) Those that are difficult to do: _____

On a scale from 1 to 10 with "1" being pain free and can function quite well and "10" being in pain all the time and cannot function at all, rate yourself. Circle one: 1 2 3 4 5 6 7 8 9 10

Automobile Accident - Insurance Data

Attorney Information:

Do you have an attorney on this case? ___yes ___no

Name: _____ Phone: _____

Address: _____ City: _____ Zip: _____

Patient's Car Insurance Information:

Company Name: _____ Phone: _____ Policy# _____

PO Box/Street #: _____ Adjuster's name: _____

City/State/Zip: _____

Insured's Car Insurance Information:

Insured's name if other than patient: _____ Phone: _____

Company Name: _____ Phone: _____ Policy# _____

PO Box/Street#: _____ Adjuster's name: _____

City/State/Zip: _____

Other Driver's Car Insurance Information:

Other Driver's name (if another car was involved): _____ Phone: _____

Company Name: _____ Phone: _____ Policy# _____

PO Box/Street: _____ Adjuster's name: _____

City/State/Zip: _____



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Notice of Doctor's Lien

I do hereby authorize **Falite Family Chiropractic** to furnish you, my attorney, with a full report of my examination, diagnosis, chiropractic care, prognosis, etc., in regard to the accident in which I was recently involved.

I hereby authorize and direct you, my attorney, to pay directly to Falite Family Chiropractic such sums as may be due for chiropractic services rendered me both by reason of the accident and by reason of any other bills that are due this office and to withhold such sums from any settlement, judgment, or verdict as may be necessary to adequately protect Falite Family Chiropractic. I hereby further give a lien on my case to Falite Family Chiropractic against any and all proceeds of my settlement, judgment, or verdict which may be paid to you, my attorney, or myself, as the result of the injuries for which I have been treated or injuries in connection therewith.

I agree never to rescind this document and that a rescission will not be honored by my attorney. I hereby instruct that in the event another attorney is substituted in this matter, the new attorney honor this lien as inherent to the settlement and enforceable upon the case as if it were executed by him/her.

I fully understand that I am directly and fully responsible to Falite Family Chiropractic for all chiropractic bills submitted by the office for service rendered me, and that this agreement is made solely for Falite Family Chiropractic's additional protection and in consideration of them awaiting payment. I further understand that such payment is not contingent on any settlement, judgment, or verdict by which I may eventually recover said fee.

Please acknowledge this letter by signing below and returning it to Falite Family Chiropractic. I have been advised that if my attorney does not wish to cooperate in protecting the doctors' interest, Falite Family Chiropractic will not await payment but may declare the entire balance due and payable.

Patient Name (print): _____

Patient's Signature: _____ Date: _____

The undersigned being attorney of record for the above patient does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment, or verdict as may be necessary to adequately protect Falite Family Chiropractic. Attorney further agrees that in the event this lien is litigated that the prevailing party will be awarded attorney fees and costs.

Attorney's Signature: _____ Date: _____

Please sign, date, and return one copy to Falite Family Chiropractic.



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(filed with Insurance Company)

I do hereby authorize **Falite Family Chiropractic** to furnish you, the insurance company, with a full report of my examination, diagnosis, chiropractic care, prognosis, etc., in regard to the accident in which I was recently involved.

I hereby authorize and direct you to pay directly to Falite Family Chiropractic such sums as may be due for chiropractic services rendered me both by reason of the accident and by reason of any other bills that are due this office and to withhold such sums from any settlement, judgment, or verdict as may be necessary to adequately protect Falite Family Chiropractic. I hereby further give a lien on my case to Falite Family Chiropractic against any and all proceeds of my settlement, judgment, or verdict which may be paid to you, or myself, as the result of the injuries for which I have been treated or injuries in connection therewith.

I agree never to rescind this document and that a rescission will not be honored by the insurance company. I hereby instruct that in the event another insurance company or an attorney is substituted in this matter, the new party honor this lien as inherent to the settlement and enforceable upon the case as if it were executed by him/her.

I fully understand that I am directly and fully responsible to Falite Family Chiropractic for all chiropractic bills submitted by the office for service rendered me, and that this agreement is made solely for Falite Family Chiropractic's additional protection and in consideration of them awaiting payment. I further understand that such payment is not contingent on any settlement, judgment, or verdict by which I may eventually recover said fee.

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Patient Name (print): _____

Patient's Signature: _____ Date: _____

HEALTH CARE AUTHORIZATION FORM

You are being provided with a copy of this Notice of Privacy Practices for Protected Health Information. The Notice of Privacy Practices describes the types of uses and disclosures of your Protected Health Information (PHI) that will occur during your treatment, payment of your bills or in the performance of health care operations of this chiropractic office. A copy of our notice is attached and we encourage you to read it and request your own copy if you would like one.

This Notice of Privacy Practices also describes your rights and the duties of the Chiropractor with respect to your protected health information. By signing below, you are giving permission to Falite Family Chiropractic (FFC) to use and/or disclose Protected Health Information in accordance with the following:

SPECIFIC AUTHORIZATIONS:

- I give permission to FFC to use my address, phone number, email and clinical records to contact me with appointment reminders, missed appointment notification, birthday cards, holiday related cards, newsletters, information about treatment alternatives and/or other health related information.
- If FFC contacts me by phone, I give them permission to leave a phone message on my answering machine or voice mail.
- I give permission to FFC to have my name on a sign-in sheet.
- I give permission to FFC to use my photograph on their patient picture bulletin board and/or other marketing materials such as their brochures, website and ads in print media.
- I give permission to FFC to use any testimonial written by me for marketing purposes such as, sharing with other patients or potential patients, in their brochures, on their website or in ads in print media.
- I give FFC permission to treat me in a semi-private room where other patients are also being treated. I am aware that other persons in the office may overhear some of my protected health information during the course of care. Should I need to speak with a doctor at any time in private, the doctor will provide a room for these conversations.

By signing this form you are giving FFC permission to use and disclose your protected health information in accordance with the directives listed above. The use of this format is intended to make your experience with our office more efficient and productive, as well as to enhance your access to quality health care and health information. This authorization will remain in effect for the duration of your care at Falite Family Chiropractic, plus 7 years or until revoked by yourself.

RIGHT TO REVOKE AUTHORIZATION:

You have the right to revoke this AUTHORIZATION, in writing, at any time. However, your written request to revoke this AUTHORIZATION is not effective to the extent that we have provided services or taken action in reliance on your authorization. You may revoke this AUTHORIZATION by mailing or hand delivering a written notice to the Privacy Official of FFC. The written notice must contain the following information: your name, Social Security number and date of birth; a clear statement of your intent to revoke this AUTHORIZATION; the date of your request; and your signature. The revocation is not effective until it is received by the Privacy Official. This AUTHORIZATION is requested by FFC for its own use/disclosure of PHI. (*Minimum necessary standards apply*)

I have the right to refuse to sign this AUTHORIZATION. If I refuse to sign this AUTHORIZATION, FFC will not refuse to provide treatment, however, it will not be possible for FFC to file third party billing on my behalf and I will be responsible for 1) payment in full at the time services are provided to me 2) scheduling my own appointments since FFC will be unable to contact me 3) all contact with FFC regarding my care. *Additionally, any collection activity as permitted by law is not waived by refusal to sign the authorization.* I have the right to inspect or copy, within boundaries, the protected health information to be used/disclosed. A reasonable fee for copying will apply. A copy of the signed authorization will be provided to me.

HEALTHCARE AUTHORIZATION

I have read and understand this Healthcare Authorization Form and acknowledge receipt of The Notice of Privacy Practices for Protected Health Information. My signature below represents agreement with these practices.

SSN: _____ DOB: _____ Today's Date: _____

Patient's name (please print): _____

Signature: _____ Relationship to Patient: _____