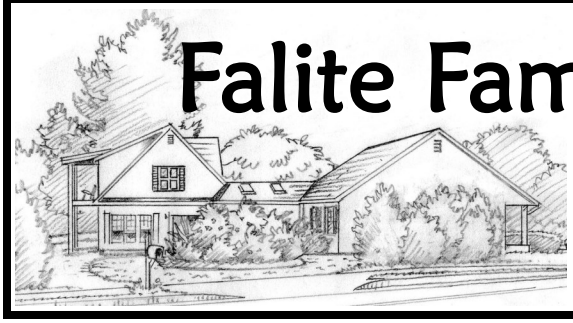


Falite Family Chiropractic

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

Accident Case History

Name:_____ Date:_____ Date of Accident:_____

Parent Name (if minor):_____

Address:_____ City:_____ Zip:_____

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

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

Occupation:_____ 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:_____

Have you received a Covid shot? Yes / No If Yes, when:_____
Please refrain from coming to the office within 2 weeks of receiving ANY vaccine due to shedding

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

_____Coughing or sneezing
_____Getting in/out of car
_____Bending forward to brush teeth
_____Turning over in bed
_____Walking short distances
_____Standing for more than one hour
_____Lying on back
_____Climbing
_____Kneeling
_____Balancing
_____Dressing self
_____Sleeping
_____Stooping
_____Lying flat on stomach
_____Lying on side w/knees bent
_____Gripping
_____Pushing
_____Pulling
_____Reaching
_____Bending forward
_____Sexual activity
_____Sitting at a table

Check symptoms of Nervous Stress:

_____Blurring vision
_____Dizziness
_____Buzzing/ringing of ears
_____Loss of sleep
_____Depression or crying spells
_____Headaches (How often?_____)
_____Fainting
_____Numbness
_____Muscle jerking
_____Low resistance
_____Confusion
_____Convulsions
_____Paralysis

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
___head looking back
___head straight forward
___body straight in sitting position
___body rotated left/right
___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:

___Headache	___Loss of smell	___Numbness in fingers
___Neck pain/stiffness	___Loss of taste	___Cold hands
___Mid back pain	___Loss of memory	___Cold feet
___Low back pain	___Fatigue	___Diarrhea
___Eyes sensitive to light	___Tension	___Constipation
___Pain behind eyes	___Shortness of breath	___Chest pain
___Dizziness	___Irritability	___Nervousness
___Fainting	___Depression	___Cold sweats
___Ringing/buzzing ears	___Sleeping problems	___Anxious
___Loss of balance	___Numbness in toes	___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:_____

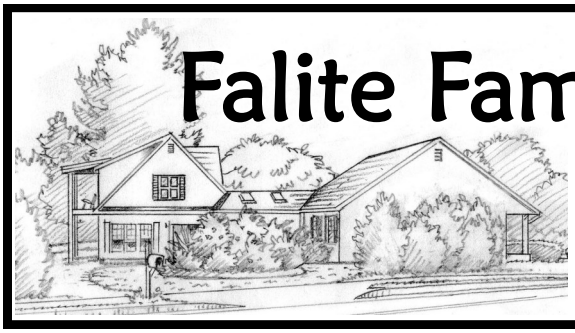
City/State/Zip:_____

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.

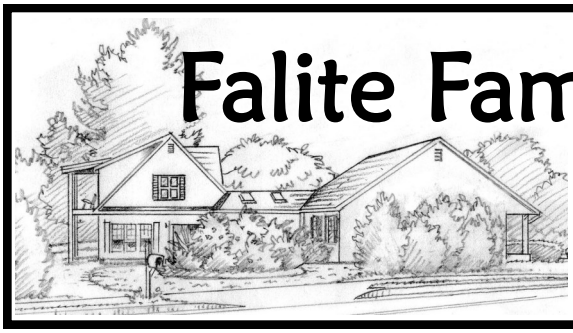
Patient Name (print):_____

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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Notice of Doctor's Lien

(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.

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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 texts, 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 or text, I give them permission to leave a voicemail or text message.
- 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 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, Google reviews, 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 an open 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 AUTHORIZAITON; 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.

Today's Date:_____

Patient's name (please print):_____ DOB:_____

Signature:_____ Relationship to Patient:_____