AUTO NPT

CHIRO HEALTH

Caring For the Whole Person

Personal Info

Last Name: ______________________ First Name: ____________________ MI: _____ Suffix: _____

DOB: ____/____/______ Sex: M F Age: _____ SSN: ______/______/_______ Marital Status: M S D O

Weight: _________ Height: ___________ Employment: FT PT STUDENT Job: _____________________

Address: ________________________________ City: _______________ St: ______ Zip:__________

Home PH: (_____)____________ Cell PH: (_____)____________ Email:

Insurance

Your Auto Insurance Company: ____________________________ Insurance PH: _______________

Policy No: _____________________ Med Pay: Y N Claim No: ____________________

Third Party Insurance Company: ____________________________ Insurance PH: _______________

Attorney/Law firm: ___________________________________ PH No: ____________________

Accident Info

Date of Accident: _____/_____/_______ Time of Accident: ______ AM PM Weather: _______________

Location of Accident: ____

Describe how the accident occurred: ____

____

Were you heading: N S E W Speed of your vehicle: _______ Wearing your seatbelt: Y N

Other vehicle heading: N S E W Speed of other vehicle: _______ Were you the: Driver Passenger

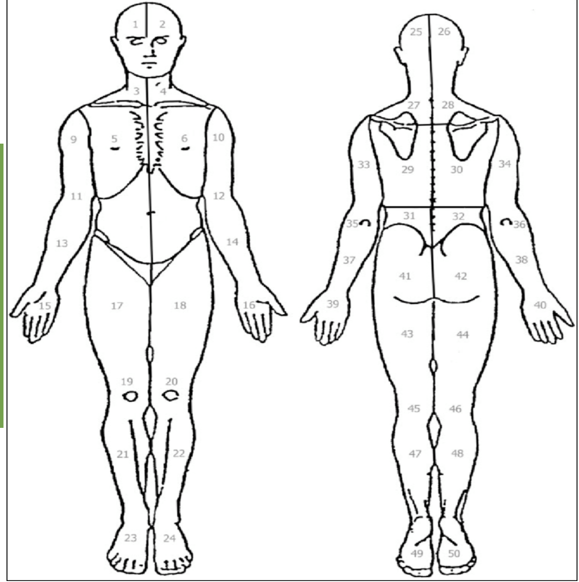
Were you hospitalized/taken to ER: Y N If so, what hospital: ______________________________

What care did you receive: ____

What imaging was done (if any): __________________________ Do you have the reports: Y N

About your Pain

Please mark areas of discomfort/pain below



Does it interfere with your: ☐ Work ☐ Sleep ☐ Hobbies ☐ Daily routine ☐ Exercising ☐ Driving

What makes it worse: _______________________________________

What makes it better: _______________________________________

How frequently do you feel your symptoms:

☐ Occasionally (0-25%) ☐ Intermittently (26-50%)

☐ Frequently (51-75%) ☐ Constantly (76-100%)

Have you lost work: Y N Are you back to work: Y N

If so, dates missed: ____________________________________

Women ONLY: Are you pregnant? Y N No of weeks: _______

Patient Signature: ____ **Date:** _____/_____/ ________

Office Use Only

Patient Category: ☐ Chiropractic ☐ Nutrition ☐ PI/Auto

Pay Type: ☐ Cash ☐ Insurance ☐ Medicare ☐ PI

# of Visits: _____ Co-pay Amt: $______ Prepaid: Y N

Addon Type: ☐ Standard Process ☐ Pure Trim ☐ Sombra ☐ Lifewave

Notes/Nutrition: ______________________________________

____

____

____

____

____

Revised 4/2024

(CONTINUE ON BACK)

Medications

Please list **ALL** medications and supplements you are taking with the reason for each

1. ______________________________ why: ______________________________
2. ______________________________ why: ______________________________
3. ______________________________ why: ______________________________
4. ______________________________ why: ______________________________
5. ______________________________ why: ______________________________
6. ______________________________ why: ______________________________
7. ______________________________ why: ______________________________
8. ______________________________ why: ______________________________
9. ______________________________ why: ______________________________
10. ______________________________ why: ______________________________

Informed Consent

Risk factors

Doctors of Chiropractic (DC), MD and DPT who use manual therapies such as spinal or extremity adjustments and/or therapies are required to advise patients that there may be some risk associated with such treatment. In particular, you should know that:

- While very rare, reports of fracture to bone, disk injuries, damage to muscles or ligaments have occurred following adjustments. In most of these cases, osteoporosis and/or serious degenerative diseases are a factor. ***Please let your doctor know of these conditions prior to any treatments***.
- While extremely rare, reported cases of stroke following a cervical adjustment have been noted. However, the possibility of a cervical related stroke has been estimated to occur in one to every million to five million adjustments.

You have choices. You may choose to receive the medical model of care, which could include drug therapy or surgery. Other therapists may be able to perform similar treatment protocols as well. The risk of such may be more, less, or equal to chiropractic.

Your treatment is designed to provide the optimum conditions to restore and maintain good health. Duration of treatment is based upon the nature of the problem. Treatment duration is only an approximation of time or a number of treatments based upon similar instances or the opinion of the doctor. This does not guarantee an outcome, nor is it a contract of an kind.

Please read and sign.

I acknowledge I have discussed or had the opportunity to discuss the nature of the information presented and therefore consent to chiropractic examination, adjusting and therapy.

Patient Signature: ______________________________ Date: ______/______/ ________

Expectations of Payment

Payment is due at the time of the visit. Financial arrangements can be made but must be done at the time of the FIRST VISIT. Every effort will be made to collect from your health, auto, or worker's compensation insurance companies, but ultimately ***you are responsible for the balance due***. We also will work with an attorney regarding personal injury claims; including waiting for settlement before being paid. (Medical payment benefits are billed and payment is expected upon receipt of reimbursement.) Please note that it is not the standard practice of this clinic to reduce balances due.

Point of Service discounts are available ***to all patients***. If you wish to pay a discounted fee, you must do so do so prior to leaving the clinic. Point of Service discounts cannot be used after the fact as this may be considered fraudulent. Please visit with the doctor or staff if you wish to have a discounted payment before leaving the clinic.

I authorize Dr. Mark E. Lee DC and Lee Family Chiropractic/Chiro Health to be paid in full for all serviced rendered. I expect my attorney, insurance company or any entity to do everything necessary to assure that no reductions are made without prior authorization from Dr. Mark E. Lee DC.

Patient Signature: ____ Date: ______/______/ ________

Authorization to Release Medical Information

I authorize Dr. Mark E. Lee DC, Lee Family Chiropractic/Chiro Health, and/or staff to release my personal healthcare information necessary to receive payment of services by any, or all parties associates with me and my healthcare treatment. I will not and do not hold Dr. Mark E. Lee DC or anyone associated with his clinic personally liable for the release of this information when deemed necessary to do so.

Patient Signature: ____ Date: ______/______/ ________

Protected Privacy

We are committed to do everything possible to protect your "non-public personal information". However, there are times when we must collect and send this information for and in your behalf, to be paid for services rendered. You have the right to inspect your personal healthcare information. You also have the right to amend any errors you may find in your record.

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CARING FOR THE WHOLE PERSON

Medical Reports & Doctor's Lien

I do hereby authorize Dr. Mark E. Lee, DC, (Lee Family Chiropractic/Chiro Health) to furnish you, my attorney, with a full report of his examination, diagnosis, treatments, prognosis, etc., of myself in regard to the accident in which I was involved.

I hereby authorize and direct you, my attorney, to pay directly to said doctor such sums as may be due and owing him for medical services rendered me both by reason of this accident and by reason of any other bills that are due his office and to withhold such sums from any settlement, judgement, 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 fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by him for services rendered me and that this agreement is made solely for said doctor's additional protection and in consideration of his awaiting payment. And I further understand that such payment is not contingent on any settlement, judgement, or verdict by which I may eventually recover said fees.

Patient Signature: ____ Date: ______/______/ ________

Attorney Section

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, judgement, or verdict as may be necessary to adequately protect said doctor named above.

Attorney Signature: ____ Date: ______/______/ ________

Please sign, date, and return one copy to the doctor's office listed below. Keep one copy for your records.

Dr. Mark E. Lee B.S, D.C, P.C
dr@drmlee.com

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Mesa, Arizona 85206

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