TYSONS CORNER CHIROPRACTIC

PATIENT NAME: (LAST)_____ (FISRT)_____

ADDRESS:_____

EMAIL:_____

SEX: M/F DOB:_____ PHONE:_____

AUTO ACCIDENT RELATED: Y/N DATE OF ACCIDENT:_____

ATTORNEY NAME:_____

ATTORNEY ADDRESS:_____

ATTORNEY EMAIL:_____ PHONE:_____

IF NO ATTORNEY, THEN:

INSURANCE COMPANY:_____

CLAIM NUMBER:_____

CLAIM ADJUSTER:_____ CLAIM PHONE:_____

AREAS OF PAIN:_____

SEVERITY OF PAIN (VAS):_____ PAIN GETTING: WORST / BETTER / NO CHANGE

TYPES OF PAIN: sharp dull throbbing numbness aching shooting
Burning tingling stiffness swelling

PAINFUL TO DO: sitting standing walking bending lying down ADLs

AUTO ACCIDENT QUESTIONNAIRE

PATIENT NAME:_____

WEIGHT:_____ **HEIGHT:**_____

DATE OF ACCIDENT:_____

YOU WERE THE: driver front seat passenger rear seat passenger

YOUR VEHICLE WAS STRUCK: rear right rear left rear

front right front left front

driver's side passenger's side

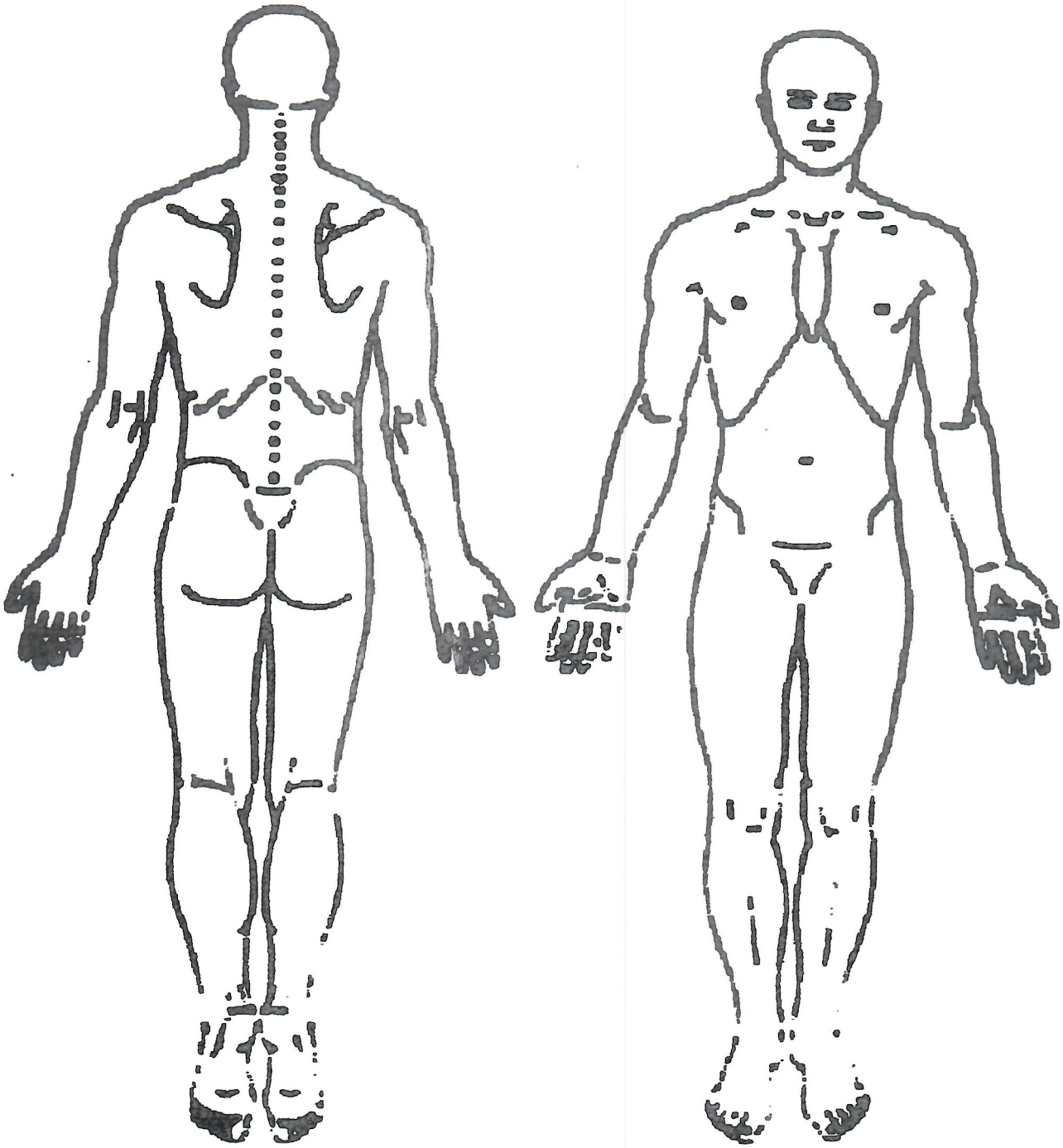
ADDITIONAL COMMENTS:_____

YOUR VEHICLE WAS: stopped slowing down making a turn moving

SEAT BELT: Y/N **AIR BAG DEPLOY: Y/N** **LOSS OF CONSCIOUSNESS: Y/N**

HOSPITAL: Y/N **IF YES, ANY IMAGING: Y/N** **IF YES, RESULTS?**

AMOUNT OF DAMAGE TO VEHICLE:_____



INFORMED CONSENT FOR EXAMINATION AND TREATMENT

I (We), hereby consent to the performance of examination and treatment on me or on _____, by the licensed doctors of chiropractic and/or physical therapists who may be employed by or engaged in practice in this clinic.

I have had an opportunity to discuss with the doctor(s) or other clinical personnel the nature and purpose of the different physical therapy procedures and chiropractic treatment (manipulation/adjustment). I understand that neither chiropractic or physical therapy treatment is an exact science and that my care may involve judgements based upon facts and information known to the doctor. The doctor uses this judgement to attempt to anticipate or explain risks and complications and an undesirable result does not necessarily indicate an error in judgement. No guarantee for results can be made or expected but rather I wish to rely on the doctor to choose and recommend a best course of treatment based upon facts known that is in my best interest.

I further understand that there are certain degrees of risk associated with chiropractic health care and physical therapy, which includes rarely, but not limited to fractures, disc injuries, strokes, and strain/sprains and am therefore willing to accept and consent to the risks associated with the care that I am about to receive.

I have read, or the information above has been explained regarding consent. I have had an opportunity to ask questions about my examination and treatment. By signing below, I agree and intend this consent form to cover the procedures prescribed for my condition and for any future conditions for which I seek treatment.

Female patients: By my signature on this form I do hereby state that to the best of my knowledge, I am not pregnant, nor is pregnancy suspected or confirmed at this particular time. Date of last menstrual period _____.

_____ _____

Patient's Name Patient's signature

_____ _____

Date Relationship or authority if not parent

_____

Witness

NOTICE OF INFORMATION PRACTICES

Protecting the privacy of your personal health information is important to us. This notice describes how information about you may be used and described and how you can get access to the information. Please review it carefully.

Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purpose of treatment, payment, practice operations will be made only after obtaining your consent. You may request restrictions on disclosures.

Disclosures of protected health information are limited to the minimum necessary for the purpose of the disclosure. This provision does not apply to the transfer of medical records for treatment.

You may inspect and receive copies of your records within 30 days a request to do so. There may be a reasonable cost-based fee for photocopying, postage, and preparation.

You may request changes to your records. Our practice has the right to accept or deny your request.

We maintain a history of protected health information disclosures that is accessible to you.

In the future, we may contact you for appointment reminders, announcements, and to inform you about our practice and its staff.

Our practice is required to abide by this notice. We have the right to change the notice in the future. Any revisions will be prominently displayed in a clearly visible location in our office.

You may file a complaint about privacy violations by contacting our office manager.

Name _____ Phone _____

The effective date of this Notice of Information Practice is _____

Thank you.

AGREEMENT OF NET SETTLEMENT OR JUDGMENT PROCEEDS

Attorney/Insurance_____ TYSONS CORNER CHIROPRACTIC

_____ 8230 Old Courthouse Rd #105B

_____ Vienna, VA 22182

Authorization and Assignment

For the consideration of providing any medical records, I _____, hereby authorize my physician, Dr. Amirreza Azad, to furnish to _____ and/or _____ insurance company any and all information, including bills and records, which my physician may have or which may be requested including but not limited to records pertaining to injuries sustained by me, my child or children on _____.

I further authorize and direct said attorneys or insurance company to pay from the proceeds of any recovery to Dr. Amirreza Azad, for professional services, health care and fees for preparation and testimony, as a result of any injury or condition sustained. I authorize and direct said attorney or insurance company to deduct and pay from the proceeds of any recovery in any case that I may have, from any monies, which they may now have or receive in connection with any claim for damages.

I understand that this in no way relieves me from any personal or primary responsibility to pay for said services. In the event that it is necessary to place this matter in collection, I hereby agree to pay all reasonable attorney's fee and costs of collection.

I hereby release Dr. Amirreza Azad, his employees and staff from any and all legal responsibility for the release of any information concerning my medical condition and/or treatment.

I hereby agree to waive defense of statute of limitations in the event that a claim is not filed against me by reason of any unpaid bills within the time period of the statute of limitations and I agree not to raise the defense of statute of limitations.

Dated_____ Patient's Signature:_____

I, the undersigned attorney, hereby agree to comply fully with the foregoing Assignment and Authorization, agree to advise Dr. Amirreza Azad in writing within (10) days of his request for information regarding the status of the claim and agree to notify the doctor of any changes in the status of the case, including any favorable or adverse results. I further agree to notify the doctor immediately in the event of a settlement.

Dated_____ Adjuster's/Attorney'sSignature:_____

A photocopy of this form shall be considered as valid as the original