3025 N. Taft Avenue, Suite A
Loveland, Colorado 80538
Phone: 970.203.0621
Fax: 970.461.2462

Automobile Accident History Form

Patient Information

Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help. (Please Print)

Name: ____ Date: ____________________________

Address: ______________________________________ City: ____________________________

State: ________ Zip: _______________ Social Security Number: ______________________ Sex: M / F

Birth Date: __________________ Age: _________ Home Phone Number: _______________

What is your current weight? _________________________ Height? _________________________

Occupation: ________________________ Work #: __________________ Cell #: ____________________

How did you hear about us? ____

Contact in case of emergency: _____________________________ Phone Number: ___________________

The Accident

What was the date of the accident? _________________ Time of Accident: __________ ☐ AM ☐ PM

How many vehicles were involved in the accident? __________________

What was the estimated damage to the vehicle you were in? _________ ☐ Totaled ☐ Unknown

What street or intersection were you on when the accident occurred? ____________________________

What direction were you traveling in? ____

What city did the accident occur in? _________________What state did the accident occur in? _________

What type of impact was the auto accident? ____

Your position in the vehicle:

- ❑ Driver
- ❑ Front Passenger
- ❑ Rear Left Passenger
- ❑ Rear Right Passenger
- ❑ Other______________

Did you see the accident coming? ☐ Yes ☐ No Were you braced for the impact? ☐ Yes ☐ No

Describe the vehicle you were in: Make_______________________ Model_______________________

- ❑ Compact Car
- ❑ Mid-size Car
- ❑ Full size Car
- ❑ Mini Van
- ❑ Full Size Van
- ❑ Pick-up truck
- ❑ SUV
- ❑ Large Truck
- ❑ Other______________

What type of vehicle impacted yours: Make_______________________ Model_______________________

- ❑ Compact Car
- ❑ Mid-size Car
- ❑ Full size Car
- ❑ Mini Van
- ❑ Full Size Van
- ❑ Pick-up truck
- ❑ SUV
- ❑ Large Truck
- ❑ Other_____________

Your Vehicle Speed: __________mph Other Vehicle Speed: _________mph

Did you lose consciousness during the accident? ☐ Yes ☐ No

What was the direction of your head at the time of impact?

- ❑ Facing upward
- ❑ Facing forward
- ❑ Turned to the left
- ❑ Facing downward
- ❑ Turned to the right
- ❑ Other:______________

How were your hands positioned during the accident? ____

Did your head hit anything during the accident? ☐ Yes ☐ No If yes, describe: ______________

____

Did your face hit anything during the accident? ☐ Yes ☐ No If yes, describe: ______________

____

Did your chest hit anything during the accident? ☐ Yes ☐ No If yes, describe: ______________

____

Did your knees hit anything during the accident? ☐ Yes ☐ No If yes, describe: ______________

____

Did your feet hit anything during the accident? ☐ Yes ☐ No If yes, describe: _____________________

____

What kind of headrest was in your vehicle?

- ❑ Movable fixed headrest
- ❑ Non-movable fixed headrest
- ❑ No headrest

Where was the headrest positioned on your head? Choose one:

- ❑ Shoulder blade level
- ❑ Neck level
- ❑ Middle of head
- ❑ Bottom of head
- ❑ Top of head

Did you have a seat belt on? ☐ Yes ☐ No Did you have a shoulder harness on? ☐ Yes ☐ No

Did you slide out of your seatbelt during the accident? ☐ Yes ☐ No

What was damaged in your vehicle?

- ❑ Windshield
- ❑ Steering wheel
- ❑ Dashboard
- ❑ Seat frame
- ❑ Side window
- ❑ Rear window
- ❑ Mirror
- ❑ Knee bolster
- ❑ Rear bumper
- ❑ Front bumper
- ❑ Trunk
- ❑ Completely totaled
- ❑ Front left door
- ❑ Front right door
- ❑ Back left door
- ❑ Back right door

Where did you go after the accident?

- ❑ Home
- ❑ Work
- ❑ Hospital/ER
- ❑ Private Doctor

How did you get there?

- ❑ Drove Self
- ❑ Somebody Else Drove
- ❑ Ambulance
- ❑ Police

If you went to the hospital, how did get there? ____

What was the name of the hospital? ____

Were you hospitalized overnight? ☐ Yes ☐ No

Were you prescribed any of the following at the hospital?

- ❑ Pain medication
- ❑ Ice
- ❑ Muscle relaxers
- ❑ Neck brace
- ❑ Other: ____________

Medications: ____

Follow Up Instructions: ____

Did you receive any stitches for any cuts at the hospital? ☐ Yes ☐ No

Were x-rays taken? ☐ Yes ☐ No Body part x-rayed: ______________________________

Was an MRI or any other special imaging done? If yes, describe: ____________________

____

Check the location(s) of the problem(s) you are now experiencing:

- ❑ Headache
- ❑ Jaw
- ❑ Neck
- ❑ Upper back
- ❑ Shoulder
- ❑ Arm
- ❑ Elbow
- ❑ Wrist
- ❑ Hand
- ❑ Mid back
- ❑ Low back
- ❑ Hip
- ❑ Legs
- ❑ Knee
- ❑ Ankle
- ❑ Foot
- ❑ Other

Check the conditions that you or your immediate relatives have been diagnosed with:

- ❑ Rheumatoid Arthritis
- ❑ Heart problems
- ❑ Diabetes
- ❑ Cancer
- ❑ Lupus
- ❑ ALS
- ❑ Other: ________________

Check all conditions that **currently** apply to you:

- ❑ Headaches
- ❑ Neck pain
- ❑ Upper back pain
- ❑ Mid back pain
- ❑ Low back pain
- ❑ Shoulder pain
- ❑ Elbow/upper arm pain
- ❑ Wrist pain
- ❑ Hand pain
- ❑ Hip pain
- ❑ Upper leg pain
- ❑ Knee pain
- ❑ Ankle/foot pain
- ❑ Jaw pain
- ❑ Joint pain/stiffness
- ❑ Arthritis
- ❑ Rheumatoid arthritis
- ❑ Cancer
- ❑ Tumor
- ❑ Asthma
- ❑ Chronic sinusitis
- ❑ High blood pressure
- ❑ Heart attack
- ❑ Chest pains
- ❑ Stroke
- ❑ Angina
- ❑ Kidney stones
- ❑ Kidney disorders
- ❑ Bladder infection
- ❑ Painful urination
- ❑ Loss of bladder control
- ❑ Abnormal weight gain
- ❑ Loss of appetite
- ❑ Abdominal pain
- ❑ Ulcer
- ❑ Hepatitis
- ❑ Liver/gall bladder disorder
- ❑ General fatigue
- ❑ Muscular incoordination
- ❑ Visual disturbances
- ❑ Dizziness
- ❑ Diabetes
- ❑ Excessive thirst
- ❑ Frequent urination
- ❑ Smoking/tobacco use
- ❑ Drug/alcohol dependence
- ❑ Allergies
- ❑ Depression
- ❑ Systemic lupus
- ❑ Epilepsy
- ❑ Dermatitis/eczema or rash
- ❑ Hiv/aids

Females only:

- ❑ Birth control pills
- ❑ Hormone replacement
- ❑ Pregnancy

Check all conditions that have applied in the **past**:

- ❑ Headaches
- ❑ Neck pain
- ❑ Upper back pain
- ❑ Mid back pain
- ❑ Low back pain
- ❑ Shoulder pain
- ❑ Elbow/upper arm pain
- ❑ Wrist pain
- ❑ Hand pain
- ❑ Hip pain
- ❑ Upper leg pain
- ❑ Knee pain
- ❑ Ankle/foot pain
- ❑ Jaw pain
- ❑ Joint pain/stiffness
- ❑ Arthritis
- ❑ Rheumatoid arthritis
- ❑ Cancer
- ❑ Tumor
- ❑ Asthma
- ❑ Chronic sinusitis
- ❑ High blood pressure
- ❑ Heart attack
- ❑ Chest pains
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- ❑ Bladder infection
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- ❑ Smoking/tobacco use
- ❑ Drug/alcohol dependence
- ❑ Allergies
- ❑ Depression
- ❑ Systemic lupus
- ❑ Epilepsy
- ❑ Dermatitis/eczema or rash
- ❑ Hiv/aids

Females only:

- ❑ Birth control pills
- ❑ Hormone replacement
- ❑ Pregnancy

Before the accident, had you ever suffered significant trauma? If yes, describe: ______________

____

How do you rate your overall health?

- ❑ Excellent
- ❑ Very good
- ❑ Good
- ❑ Fair
- ❑ Poor

What type of regular exercise do you participate in?

- ❑ Strenuous
- ❑ Moderate
- ❑ Light
- ❑ None

List all supplements and medications you are currently taking: ______________________________

____

List any surgeries you've had: ____

____

Have you ever been hospitalized? If yes, describe: ______________________________

____

What is the primary activity you engage in at work?

- ❑ Computer
- ❑ Sitting
- ❑ Standing
- ❑ Driving
- ❑ Manual labor

What activities do you engage in outside of work? ____

____

Have you ever seen a chiropractor before? ☐ Yes ☐ No

Is there anything else you'd like us to know? ____

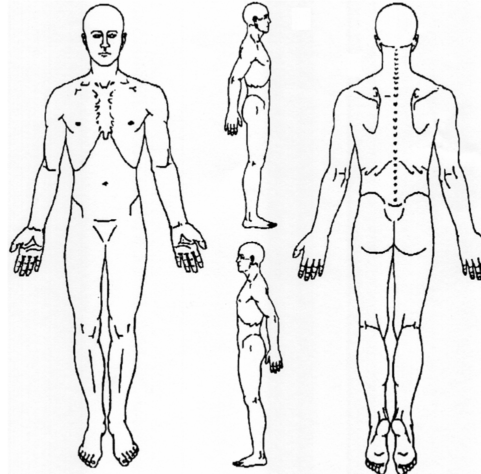
____

Please use the following letters to indicate TYPE and LOCATION of the symptoms you currently are experiencing.

A=Ache O=Other

B=Burning P=Pins and Needles

N=Numbness S=Stabbing



Insurance Company: ____________________________________ Claim Number: ___________________

Insurance Company Phone: ____

Who was found to be at fault for the accident (received the ticket):
☐ Me ☐ Other Driver ☐ Driver in my vehicle but I wasn't driving ☐ Other:___________________

Authorization

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I authorize the chiropractor to release any information. I agree to be responsible for payment of all services rendered on my behalf or on behalf of my dependents.

____ _____________________

Signature of Patient (or parent if a minor) Date

3025 N. Taft Avenue, Suite A
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Informed Consent for Chiropractic Care

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks, and alternatives.

Chiropractic is a science and art, which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may effect the restoration and preservation of health. **Health** is a state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

One disturbance to the nervous system is called a **vertebral subluxation**. This occurs when one or more of the 24 vertebras in the spinal column become misaligned and/or do not move properly. This causes alteration of nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by an **adjustment**. An adjustment is the specific application of forces to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine. Adjustments are usually done by hand but may be performed by handheld instruments. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included.

All health care procedures carry some risk. Risks associated with chiropractic care may include, but are not limited to, muscle or ligament injuries, nerve injuries, vascular injuries and fractures. Alternatives to chiropractic care may include medications, surgery and other alternative treatments.

If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks, and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

____

Print Name   Signature   Date

Consent to Evaluate and Adjust a Minor Child

I, ______________________________, being the parent or legal guardian of ____________________ have read and fully understand the above Informed Consent and herby grant permission for my child to receive chiropractic care.

Pregnancy Release

This is to certify that to the best of my knowledge, I am not pregnant and the above doctor and his associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child. Date of Last Menstrual Cycle: ____________________________

____

Print Name   Signature   Date

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Assignment of Benefits

I hereby instruct and direct _______________________________________ insurance company to pay by check made out and mailed to Coberly Chiropractic, Inc., 3025 N. Taft Avenue, Suite A, Loveland, CO 80538.

or

if my current policy prohibits direct payment to Dr. Coberly, I hereby also instruct and direct you to make out the check to me and direct payment to 3025 N. Taft Avenue, Suite A, Loveland, CO 80538 for the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

A photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

I authorize Doctor Coberly to initiate a complaint to the insurance commissioner for any reason on my behalf.

____

Print Name of Policy Holder Signature of Policy Holder Date

____

Print Name of Witness Signature of Witness Date

Thank You For Your Trust and Confidence

HIPPA HAPPENINGS

This notice describes how your health information may be used and how you can gain access to this information. Please review carefully.

Our Promise to you, our Valued Patient…

This is not meant to alarm you, quite the opposite. We want to assure you that we take the new Federal (HIPPA – Health Insurance Portability and Accountability Act) laws seriously. These laws were written to protect the confidentiality of your health information. We trust you will never delay treatment in our offices because of fear that your personal health information might be unnecessarily disclosed to others outside our office.

Why A Privacy Policy Now?

The most significant variable that has motivated the Federal government to legally enforce the privacy of health information is the rapid evolution of the use of electronic technology in the administration of health care business. The government has appropriately sought to standardize and protect the electronic exchange of your health information. This has challenged us to review not only how your information is used within our computers but also with the Internet, phones, fax machines and any device used to copy or transfer data.

We want to advise you that we have developed policies and procedures for our practice to assure that your personal or health information will be shared only as required and only for the purpose of administering your case. Our office is subject to State and Federal laws regarding the confidentiality of your health information and we will assure adherence to those laws and we want you to understand our procedures and your rights as a valued patient.

Your health information will be communicated only for the purpose of obtaining payment for services and conducting health care business. Be assured that without your written permission, your health information will not be used for any other purpose.

How Your Health Information May Be Used to Provide Treatment

Within our office, your health information will be used to provide you the best care and services possible. This may include administrative and clinical procedures designed to optimize scheduling and coordination between you and all office personnel. In addition, we may share this information with referring physicians, clinical pathology laboratories or other health care professionals providing you want treatment.

To Obtain Payment

Your health information may be included with an invoice for the purpose of collecting payment for services provided to you in our office. We may do this with insurance forms filed for you by mail or electronically. We will make all effort to work with companies with a similar commitment to the security of your health information.

To Conduct Health Care Operations

Your health information may be used during performance evaluations of our staff. Some of our best teaching opportunities use clinical situations experienced by patients receiving care in our office. As a result, your health information may be included in the training programs for students, interns, associates, as well as business and clinical employees. It is also possible that your health information will be disclosed during audits by insurance companies or government appointed agencies as part of their quality assurance and compliance reviews. Your health information may be reviewed during the routine process of certification, licensing, or credentialing activities.

In Patient Reminders

Because we believe regular care is very important to your general health, we will remind you of a scheduled appointment or that it is time for you to contact us and make an appointment. Additionally, we may contact you to follow up on your care and inform you of treatment options or services that may be of interest to you or members of your family. These communications are an important part of our philosophy of partnering with our patients to be sure they receive the best care chiropractic can provide. They may include postcards, newsletters, flyers, telephone or electronic reminders such as e-mail (unless you tell us that you prefer not to receive reminders).

Public Health and National Security

We may be required to disclose to Federal officials or military authorities health information necessary to complete an investigation related to public health and or national security.

For Law Enforcement

As permitted or required by state or Federal law, we may disclose your health information to a proper authorities for the purpose of law enforcement including, under certain circumstances, if you are a victim of a crime or in order to report a suspected crime.

Family, Friends and Caregivers

We may share your health information with those you tell us will be assisting you with your home hygiene, care, treatment or payment. We will be certain to obtain your permission prior to sharing your information. In the event of an emergency, were you unable to tell us what you want, we will use our very best judgment when sharing your health information with anyone participating in your care.

Medical Research

Advancing health care knowledge often involves learning from the careful study of health histories as a part of a research study will happen only under the ethical guidance, requirements and approval of an Institutional Review Board.

Authorization to Use or Disclose Health Information

Other than is stated above or where Federal, State or Local law requires us, we will not disclose your health information other than with your written authorization. *You may revoke that authorization in writing any time.*

Confidential Communications

You have the right to request that we communicate with you in a specific way. You may request that we only communicate your health information privately with or without other family members present or through sealed mail communications. We will make a reasonable effort to honor your request.

Inspect and Copy Your Health Information

You have the right to read, review and copy your health information including complete chart, x-rays and billing records. If you would like a copy of your health information, please let us know. We may need to charge you a reasonable fee to duplicate and assemble your copy.

Amend Your Health Information

You have the right to ask us to update or modify your records if you believe your health information is incorrect or incomplete. We will be happy to accommodate you as long as our office maintains this information. In order to standardize our process, please provide us with your request in writing and describe as completely as possible your reason for the request.

Your request may be denied if the health information record in question was not created by our office, is not a part of our records, or if the records containing your health information have been requested sealed and or delivered to any authority for review.

Documentation of Health Information

You have the right to request from us a description of how and where your health information was used by our office for any reason other than for treatment or payment, or health care operations. Our documentation procedures will enable us to provide information on your health information usage from April 14, 2003 and forward. Please let us know in writing the time period for which you are interested. We will greatly appreciate you limiting your request to no more than six years at a time. We may need to charge you a reasonable fee for your request.

Request a Paper Copy of this Notice

You have the right to request and obtain a copy of the Notice of Privacy Practices directly from our office at any time. Just let us know of your request. We are required by law to maintain the privacy of your health information and to provide to you and your representative this Notice of our Privacy Practices. We are required to practice the policies and procedures described in this notice, but we do reserve the right to change the terms of our notice. Patients would be notified of any such changes.

You have the right to express concerns or complaints to us or the Secretary of Health and Human Services if you believe your privacy rights have been compromised. We encourage you to express in writing, any concerns you may have regarding the privacy of your health information.

Patient Acknowledgement

Patient Name(s):

____

____

____

Thank you very much for taking time to review how we are carefully using your health information. If you have any questions, please let us know. If not, we would really appreciate your acknowledging by signature that you have received, thoroughly reviewed, and understood this policy.

_______________________________________ Date _____/_____/_____

Patient Signature

THIS AGREEMENT, entered into this date and between ______________________________"PATIENT" and **Coberly Chiropractic**

WHEREAS patient desires to receive chiropractic services from **Coberly Chiropractic** and desires to assign certain rights and benefits to **Coberly Chiropractic**] as consideration for **Coberly Chiropractic** awaiting payment of such benefits. Accordingly, it is hereby agreed:

A. Patient hereby authorizes **Coberly Chiropractic** to furnish a full report and records regarding case history, examination, diagnosis, treatment and prognosis, X-rays, laboratory reports and the results of all tests of any type or character of patients to such persons who present a signed HIPPA medical release.

B. Patient assigns to **Coberly Chiropractic** any and all benefits payable by patient's insurance or health care plan(s) as a result of charges incurred by patient(s) for services rendered by **Coberly Chiropractic**. Patient also assigns to **Coberly Chiropractic** any and all contractual rights patient has against insurance company, health care benefit plan, or any other party possibly liable to patient for payment of health care costs incurred by patient as a result of services rendered by **Coberly Chiropractic**.

C. Patient fully understands that patient is directly and fully responsible to **Coberly Chiropractic** for all bills submitted for services rendered and that this agreement is made solely for additional protection and consideration for awaiting payment. Patient(s) further understands that such payment is not contingent on any settlement, claim, judgment or verdict which patient may eventually recover. In the event of non-payment by any insurance company, health care benefit plan, or any other party possibly liable to patient for payment of health care costs incurred by patient as a result of services rendered by **Coberly Chiropractic**, Patient agrees to be responsible for any such outstanding balance, including interest at a rate of 18% per annum, reasonable attorney's fees and costs. In the event of any litigation arising from breach of this agreement, or the services provided under this agreement, the prevailing party shall be entitled to recover from the non-prevailing party all reasonable costs incurred including court costs, attorneys' fees, and all other related expenses incurred in such litigation.

D. Patient fully understands that the lien and assignment given to **Coberly Chiropractic** herein is irrevocable. Patient acknowledges that he/she alone, not his/her attorney, is responsible for his/her own outstanding balance with **Coberly Chiropractic.**

E. By executing this agreement, patient hereby instructs and directs any attorney representing patient to honor the above lien and assignment and make payment under the lien and assignment directly to **Coberly Chiropractic** Patient directs that attorney be bound by this lien and treat it, irrevocably, as an assignment due **Coberly Chiropractic**. **Coberly Chiropractic** is relying upon this lien, assignment and directive to any attorney, and as a result of such reliance, **Coberly Chiropractic** is providing care and treatment for which this lien, assignment and directive provides security for payment. Moreover, patient agrees **Coberly Chiropractic** is to be viewed as a third party beneficiary of this direction to patient's attorney and it is patient's intent to impose upon patient's attorney an obligation to comply with the terms of this directive, as well as Colorado Formal Ethics Opinion 94.

F. Patient hereby directs all insurers and other persons possibly responsible for patient's health care costs to make all payments for health care services rendered by **Coberly Chiropractic** directly to **Coberly Chiropractic.**

G. Patient agrees that in the event patient receives any check, draft, or other payment subject to this agreement, patient agrees to act as fiduciary agent for **Coberly Chiropractic** and will immediately deliver said check, draft, or payment **Coberly Chiropractic** to be applied to patient's debt for services rendered.

H. Patient hereby authorizes and directs his/her attorney to release information regarding the amount of any settlement, including the final disbursement sheet, to **Coberly Chiropractic** and releases attorney from any liability as a result of this action.

I. **Coberly Chiropractic** agrees to submit a copy of this agreement with the initial claim form(s) which **Coberly Chiropractic** submits to third party payor(s) as notice to the third party payor(s) of the assignment and other agreements contained herein. At the time each claim is submitted, a copy of the claim will be stored for safekeeping in patient's file and may be picked up by the patient, upon reasonable request and during normal business hours or upon written request by patient, be mailed to designated address.

J. Patient hereby authorizes and **Coberly Chiropractic** to receive a complete copy of patient's insurance policy including any endorsements, conditions, limitations or exclusions.

K. A copy of these documents shall be as binding as the document bearing the original signatures.

______________________ ___________________________
Date Patient Signature

______________________ ___________________________
Date [DR. SIGNATURE]

The undersigned, being attorney of record for the above patient, does hereby agree to withhold and pay such sums from the patient's portion of any settlement, judgment, or verdict as set forth above for the benefit of **Coberly Chiropractic**.

Date: ________________ ______________________________
Attorney

A PHOTOSTATIC COPY OF THIS AUTHORIZATION SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL.

References:

Valley State Bank v. Dean, 97 Colo. 151, 47 P.2nd 924 (1935)
Fort Lupton State Bank v. Murata, 626 P.2nd 757 (Colo. App. 1981)
Barcucas v. Bohemia Import Co., Inc., 518 P.2nd 850 (Colo. App. 1974)
Thomas v. Oken, 699 P.2d 7, 9 (Colo.App.1984)