Mosier/Timperley Chiropractic Clinic

4645 Normal Blvd., Ste. 200 Lincoln, NE 68506
402-483-6633 * fax 402-483-6919 * www.MTchiro.net

Auto Related Injury

Date of Accident: ____/_____/_____

Name:_____ Time of Accident:_____ __a.m. __p.m.

Location of Accident:_____

Females are You Pregnant? (Yes / No) If yes, How far along? _____ Number of Children: _____

How may we help you today? _____

How long have you had this problem? _____ What have you done for it? _____

What activities aggravate your condition? _____

Have you been treated for any health conditions in the past year? (Yes / No)

Describe _____

Any previous surgeries/illnesses or accidents? (Yes / No)

Describe _____

Any Prior Chiropractic Care? (Yes / No) if yes, when were you last seen? _____

What medications are you currently taking? _____

What is you Auto Insurance?_____Phone:_____

Who is the primary cardholder?_____Phone:_____

Who is your claims adjuster? _____

Your Policy #:_____ Have you reported this to your Insurance Co.? (Yes / No)

Your Claim #:_____ Does your Insurance Co. know you are coming here? (Yes / No)

Other Parties Name:_____Address:_____

Other Parties Insurance Co.:_____Policy #:_____

Address:_____Phone:_____

Adjuster:_____Claim #:_____

Do you have an Attorney? (Yes / No) if yes, Who?_____Phone:_____

Please Mark when Appropriate:

Describe the circumstances of the accident:_____

_____

_____

_____

Is your condition getting any worse? ___Yes ___No ___Constant ___Comes & Goes

Did you require post-accident hospitalization? ___Yes ___No

Were you the ____Driver ____Passenger ____Pedestrian?

Were you using a seat belt? ___Yes ___No

Were you struck from ___Behind ___Right Side ___Left Side ___Front

Did your car strike the others involved ___Yes ___No

What speed was your vehicle going at the time of collision? _____mph

What speed was the other vehicle going at the time of collision? _____mph

Did any part of your body strike anything in the vehicle? ___Yes ___No

As a result of the accident, were traffic citations issued to you? ___Yes ___No

Did you feel pain immediately after the accident? __Yes __No __Later that day __Next day or when_____

Where did you feel pain immediately after the accident?_____

Were you aware of the approaching collision prior to impact? ___Yes ___No

Did you lose consciousness (black out) upon impact? ___Yes ___No, for how long? _____

Was the trunk of your body pointed straight forward at the time of impact? ___Yes ___No

if no, how was it turned? _____

Was your head pointed straightforward? ___Yes ___No

if no, what direction was it turned and how much?_____

Have you seen any other doctor for this injury? ___Yes ___No, if yes who?_____

Are you under any other doctor's care right now? ___Yes ___No, if yes who?_____

Have you ever had any complaints in the involved area prior to the accident? ___Yes ___No

if yes what were they?_____

Are your work activities restricted as a result of this accident? ___Yes __No

if so, how?_____

Have you lost any days of work? ___Yes ___No If yes, from_____ through_____

Signature_____ **Today's Date:**_____/_____/_____

Privacy Practices ~ HIPAA Form

I have received or reviewed the privacy practice notice for Chiropractic Care, and understand the situations in which this practice may need to utilize or release my medical records. I also understand that I agreed to the use of those records when I initially applied for care at this office on my first visit, whenever that may have occurred.

I understand that this office will properly maintain my records, and will use all due means to protect my privacy as outlined in this privacy practices statement.

_____ _____

Patient Signature Date

_____

Print the Patient Name

Informed Consent to Care

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctors of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future work at the Mosier/Timperley Chiropractic clinic.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I also understand that there are beneficial effects associated with these treatment procedures including decreased pain, improved mobility and function, and reduced muscle spasm. However, I appreciate there is no certainty that I will achieve these benefits.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

A wide variety of means for communication exists and continues to broaden and develop. By signing this Authorization, I agree that this office, and any third part used for treatment, billing, collection and other services, may use any means of communication with me. Thus, I understand and agree that any phone numbers and email addresses provided by myself to this office and to any of our service providers, now and in the future, may be used as a means to contact me, and that this office and our service may leave messages for me manually and by using automated systems such as by artificial or prerecorded voice. Specifically, if I provide a cellular phone number or place a cellular phone call to me or any of our service providers, I consent and agree to accept collection calls and other communications to my cellular phone from this office and from any of our service providers. For any landline and cellular phone calls this office or any service providers place to me, I consent and agree that those calls may be automatically dialed and that this office and our service providers may use recorded messages. I also agree that this office and any service providers may contact me by sending text messages and emails to any phone number or email address I provide to this office or service providers, and I consent to receive such text messages an email which may identify the name of this office or service provider sending the communication, and which may disclose the nature of the communication.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Dan Mosier, D.C., David Timperley, D.C., Timothy Maack, D.C.
Trenton Maly, D.C., Eric Timperley, D.C., Corey Dousharm, D.C.

Patient Signature_____ Date _____

Witness Signature _____ Date_____

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Medical Services Lien

I do hereby authorize the above doctor's office to furnish you, my attorney/insurance carrier, with a full report of his/her case history, examination, diagnosis, treatment, and prognosis of myself in regard to my accident/illness which occurred/began on _____.

I hereby give a lien to the Mosier/Timperley Chiropractic Clinic on any settlement, claim, judgment, or verdict as a result of said accident/illness, and authorize and direct you, my attorney/insurance carrier, to pay directly to said doctor such sums as may be due and owing him for service rendered me, and to **withhold such sums from such settlement**, claim, judgment, or verdict as may be necessary to protect said doctor adequately.

I fully understand that I am directly and fully responsible to said doctor for all chiropractic bills submitted by him/her for service rendered to 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, claim, judgment, or verdict by which I may eventually recover said fee.

Patient's Signature: _____ Date: _____

Assignment of Payment

Patient Name: _____
Address: _____
Attorney: _____
Insurance Company: _____

My attorney, my insurance company and/or any responsible insurance company are hereby commanded and authorized to pay direct to Mosier/Timperley Chiropractic Clinic any moneys due that office, this sum to be deducted from any settlement made on my behalf.

Further, I agree to pay Mosier/Timperley Chiropractic Clinic, the difference, if any, between the total amount of charges and the amount paid by the attorney and/or insurance company. It is further understood that I, the undersigned, agree to pay Mosier/Timperley Chiropractic Clinic the full amount of charges, should my condition be such that it is not covered by my policy or if for any reason, the insurance refuses to pay my claim.

In consideration of the doctor extending credit to the patient that above named patient herby agrees to pay the doctor the full amount, owed at the time of settlement.

Dated at Mosier/Timperley Chiropractic Clinic

Patient Signature: _____ Date: _____

Witness: _____ Date: _____