



Mosier/Timperley Chiropractic Clinic

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

Work 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? _____

What have you done for it? _____

What activities aggravate your condition? _____

Was your accident directly related to your work? (Yes / No) Did you fill out an accident report? (Yes / No)

Did you report the injury to your foreman or employer? (Yes / No) if yes, whom: _____

Does your employer know you are here today? (Yes / No) Was anyone present during your accident? (Yes / No)

What recommendations did your employer make just after your accident? _____

Did your employer ask who your primary doctor was? (Yes / No) Did your employer tell you what doctor you should see? (Yes / No)

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

Describe _____

Any previous surgeries/illnesses or accidents? _____

Any Prior Chiropractic Care? _____

What medications are you currently taking? _____

Did you require post-accident hospitalization? (Yes / No)

Have you lost any days of work? (Yes / No) If yes, from _____ through _____

Describe the circumstances of the accident: _____

Employer: _____ Phone: _____

Contact person: _____ Phone: _____

Claim #: _____ Insurance Adjuster: _____

Address: _____

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 _____