Randolph Chiropractic Health Center

Authorization for Release of Information

Patient Information:

Name of Patient_____ Date of Birth_____

Street Address_____

City, State, Zip_____

Home Phone:_____ Office Phone:_____ Cell:_____

E-mail Address:_____

Name & Address of Covered Entity Authorized to release health and/or appointment information:

Randolph Chiropractic Health Center
2040-B Randolph Road
Charlotte, NC 28207
704-331-0100 Phone
704-331-0150 Fax

The above named entity is authorized to release health and/or appointment information to or with the following groups/individuals:

Entity to Receive Information. (Initial each that is subject to this authorization.)

_____ Insurance Companies that you have coverage with and any other entity that we receive written authorization from.

_____ Leave information on the voice mail of ____ home, ____ office, ____ cell numbers listed above.

_____ Leave information with my spouse.

_____ Leave information with the following persons: (i.e. other household members)

This authorization shall be in force and effect until revoked by the patient or representative signing the authorization.

Randolph Chiropractic Health Center

Authorization for Release of Information (Continued)

The permitted use of the information is to inform the patient.

I understand that I have the right to revoke this authorization at any time by sending a written notification to:

Randolph Chiropractic Health Center
Attn: Christine Aarne
2040 B Randolph Road
Charlotte, NC 28207

I understand that a revocation is not effective in cases where information has already been disclosed but will be effective going forward.
I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
I understand that I have the right to inspect or copy the protect health information to be used or disclosed as described in this document. I can do this by written notification to:

Randolph Chiropractic Health Center
Attn: Christine Aarne
2040 B Randolph Road
Charlotte, NC 28207

I understand that my treatment will not be conditioned on signing this authorization.
I understand that I have the right to refuse to sign this authorization.

I understand that this office's policy is to not release any of your personal information to anyone other than those listed above without your written authorization. We do not sell your name to anyone!

_____ _____

Signature of Patient or Personal Representative Date

_____

Print or Type Name of Patient or Personal Representative

_____

Description of Personal Representative's Authority (attach necessary documentation)

Randolph Chiropractic Health Center
Accident / Injury Questionnaire

Patient's Name:_____ **Date:**_____

A. Date and Time of Accident / Injury

Date: _____ Time: _____

B. Description of Accident / Injury

- ☐ Auto Accident **(skip to Item C)**
- ☐ Slip / Fall Accident
- ☐ Pedestrian Accident
- ☐ **Describe in your own words what happened:**

_____

_____

_____

_____

C. Immediately After the Accident / Injury

1. How did you feel?

- ☐ Confused
- ☐ Dizzy
- ☐ Dazed
- ☐ Other:_____
- ☐ Nervous
- ☐ Weak
- ☐ Unconscious

2. Where did the pain immediately develop?

☐	Head	R L	Shoulder	R L	Arms
☐	Neck	R L	Ankles	R L	Legs
☐	Upper Back	R L	Elbows	R L	Feet
☐	Mid Back	R L	Forearm		
☐	Low back	R L	Wrists		
☐	Pelvis	R L	Hands		
☐	Chest	R L	Buttocks		
☐	Rib Cage	R L	Hips		
☐	Abdomen	R L	Thighs		
☐	Other:_____				

3. Describe any other significant injury:

_____

_____

_____

4. Did you receive emergency care at accident site?

☐ Yes ☐ No

D. Hospital Visit After the Accident / Injury

1. Did you go to the hospital?

☐ Yes ☐ No

2. If you answered yes, when did you go?

Date:_____ Time:_____

Hospital Name:_____

Doctor's Name:_____

Were you admitted?

☐ Yes ☐ No

Release Date:_____

3. List any treatments and/or tests given:

_____

_____

_____

4. Were medications prescribed?

- ☐ Pain
- ☐ Antibiotic
- ☐ Other:_____
- ☐ Nervousness
- ☐ Anti-inflammatory

5. Instructions upon discharge:

_____

_____

_____

E. Following the Accident / Injury

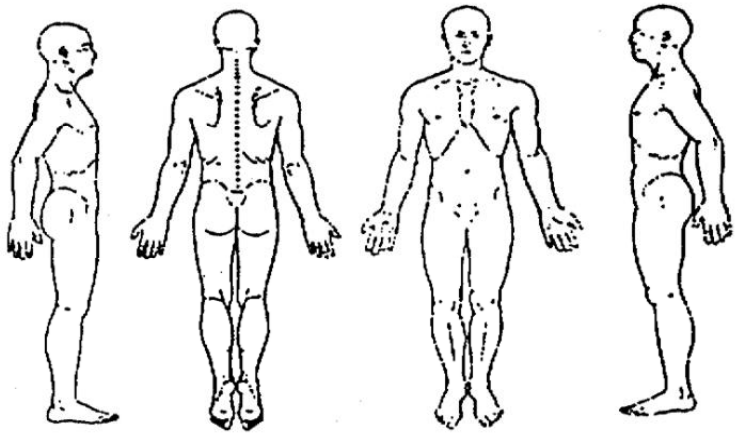
1. When did you notice additional symptoms?

- ☐ Immediately
- ☐ Hours
- ☐ Days
- ☐ Other:_____
- ☐ Months
- ☐ That Evening
- ☐ Next Morning

2. What additional symptoms developed?

Please mark the area(s) of injury or pain on the figures below using the following letters to describe the type o pain:

NNN: Numbness
BBB: Burning
SSS: Stabbing
PPP: Pins and Needles
AAA: Aching
RRR: Radiating



3. How bad are your symptoms at their best / wo

Best: 1(no pain) – 10(unbearable) _____

Worst: 1(no pain) – 10(unbearable) _____

Continued on back ⇨ ⇨ ⇨ ⇨

4. What if anything improves your condition?

_____

_____

5. What worsens your condition?

- ☐ Sitting
- ☐ Standing
- ☐ Walking
- ☐ Bending
- ☐ Reaching
- ☐ Lying Down
- ☐ Arising From A Seat
- ☐ Coughing/Sneezing
- ☐ Neck Movement
- ☐ Other: _____

6. When is the condition worse?

- ☐ Morning
- ☐ Evening
- ☐ Constant
- ☐ Afternoon
- ☐ Middle Of The Night

7. Since the accident have you suffered from:

- ☐ Blurred Vision
- ☐ Double Vision
- ☐ Reduced Vision
- ☐ Impaired Hearing
- ☐ Ringing in Ears
- ☐ Nausea
- ☐ Vomiting
- ☐ Anxiety
- ☐ Depression
- ☐ Tension
- ☐ Convulsions
- ☐ Dizziness
- ☐ Headaches
- ☐ Fainting
- ☐ Fatigue
- ☐ Weight Gain
- ☐ Difficulty Breathing
- ☐ Palpitations
- ☐ Constipation
- ☐ Frequent Urination
- ☐ Inability to Hold Urine
- ☐ Painful Urination
- ☐ Mood Swings
- ☐ Nervousness
- ☐ Poor Memory
- ☐ Loss of Balance
- ☐ Restlessness
- ☐ Insomnia
- ☐ Light Sensitivity
- ☐ Reduced Appetite
- ☐ Weakness
- ☐ Weight Loss
- ☐ Other: _____

8. How have you been restricted after the accident?

- ☐ Daily Life
- ☐ Recreation
- ☐ Occupational / Work
- ☐ Other: _____

9. Have you missed work due to the accident?

- ☐ No
- ☐ Out Of Work:

From: _____ To: _____

- ☐ Limited Work Activity
- ☐ Other: _____

10. Did you self treat your symptoms?

- ☐ Ice
- ☐ Bed Rest
- ☐ Heat
- ☐ Over The Counter Medicine
- ☐ Other: _____

11. Have you received medical care anywhere other than a hospital since the accident?

- ☐ Yes
- ☐ No

If you sought medical care elsewhere, list the doctors or other medical professionals as well as any procedures they performed on you:

_____

_____

_____

_____

_____

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_____

_____

F. Other Information

If you have any other information about your acciden you may provide it in the space below.

_____

_____

_____

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_____

_____

_____

_____

_____

_____

Patient's/Guardian's (if minor) Signature:

_____

Date:

_____

RANDOLPH CHIROPRACTIC HEALTH CENTER

Auto Accident Information

Only your car insurance (Med-Pay) will pay us directly. The other person's (at-fault) insurance company will only pay once you have been released and will not pay us directly unless you have an attorney. Therefore, unless you have an attorney or we are filing your personal health or car insurance, you will need to pay us directly.

Patient Name_____Prefer To Be Called_____Date___/___/_____
Sex: M F Age____D.O.B.___/___/____SS#____-____-_____Home Phone_____
Street Address:_____
City:_____State:_____Zip:_____
Marital Status: M S D W Spouse's Name_____Number Of Children_____
Occupation_____Employer_____Work/Other Phone_____
E-mail Address:_____
Date of Accident: _____Was the accident your fault?_____
Have you reported the accident to your insurance company? _____

Your Health Insurance Information:
Primary Company_____Policy/Contract#_____Group#_____
Phone_(___)_____Insured's Name_____D.O.B.____/____/_____
Insured's SS#____-____-_____Employer_____Phone_(___)_____
Insured's Address_____Relationship_____

Your Auto Insurance Information (Med-Pay):
Name of the Insured: _____
Your Insurance Company: _____
Address: _____
Your adjuster: _____ Phone: _____
Policy #: _____ **Claim #:** _____

Other Driver's Auto Insurance Information:
Driver of other vehicle: _____
Owner or insured of other vehicle: _____
Insurance Company: _____
Address: _____
Adjuster: _____ Phone: _____
Policy #: _____ **Claim #:**_____

Do you have an attorney who has agreed to represent you? _____
If yes, Name: _____ Phone: _____
Address: _____

Assignment of Benefits and Release:
I am requesting that all insurance companies and or my attorney pay directly to Randolph Chiropractic Health Center any medical benefits available on my behalf for treatments received. I am asking that this clinic file all insurance on my behalf. I understand that any and all unpaid balances not covered by the insurance settlement are my responsibility. In addition, I understand that I will be reimbursed directly if payments received by this clinic should exceed my charges.

Signature: _____ Date: _____
Witness: _____ Date: _____

Acct.#_____Diag._____Onset___/___/_____Faxed___/___/_____By_____

Randolph Chiropractic Health Center
Dr. Scott W. Firczak & Dr. David J. Greenberg
2040 B Randolph Road
Charlotte, NC 28207
704-331-0100

To any insurance company with coverage applicable to my claim(s) and to any attorney representing me:

ASSIGNMENT OF BENEFITS

IN CONSIDERATION of the willingness of Randolph Chiropractic Health Center to treat me on credit without demand for payment at the time services are rendered, I hereby agree and stipulate as follows:

I irrevocably assign Randolph Chiropractic Health Center any proceeds or compensation that I am or may become entitled to receive as a result of injuries that occurred on _____ to the extent of the chiropractic services rendered. I make this agreement without prejudice to any rights I may have to prosecute legal claims against any party who may be liable for my injuries, but I hereby authorize and instruct you to pay directly to Randolph Chiropractic Health Center, from any disability benefits, medical payment benefits, liability benefits, health and accident benefits, workers compensation benefits, judgments, settlements, or proceeds of any kind that would otherwise be payable to me, such sums as are due or may become due to Randolph Chiropractic Health Center for its services rendered.

I appoint Randolph Chiropractic Health Center as my attorney in fact to affix my name as an endorsement upon the reverse of any check or draft upon which I am named payee and to deposit said check or draft and apply the proceeds to any unpaid balance I may have with Randolph Chiropractic Health Center.

I authorize Randolph Chiropractic Health Center to release to any insurer with applicable coverage or to my attorney or successor attorney any information regarding my injuries, prior medical history, or treatment as may be necessary to facilitate collection of proceeds under this assignment.

I acknowledge that I remain personally liable for the total amount due to Randolph Chiropractic Health Center for services rendered, including any balance remaining after the application of insurance payments and settlement or judgment proceeds. If Randolph Chiropractic Health Center is required to take legal action against me to recover any unpaid balance on my account, I agree to reimburse Randolph Chiropractic Health Center for its costs of recovery, including reasonable attorney's fees.

_____
Patient

_____
Date

_____
Witness

NOTICE OF LIEN

Pursuant to N.C.G.S. 44-49 and 44-50, Randolph Chiropractic Health Center hereby asserts and gives notice of a lien upon any sums recovered in damages for personal injury in any civil action and also upon all funds paid to the above-named patient in compensation for or settlement of injuries sustained, whether in litigation or otherwise.

Randolph Chiropractic Health Center hereby requests that if its claim is not paid in full from foregoing proceeds, a full disclosure and accounting proceeds be provided in conformity with N.C.G.S. 44-50.1. Randolph Chiropractic Health Center agrees to be bound be any confidentiality agreements regarding the contents of the accounting.

RANDOLPH CHIROPRACTIC HEALTH CENTER

By:_____