BLUE RIDGE
CHIROPRACTIC

Patient Information:

Name: _____ Phone: _____

Last 4 SSN: _____ Date of Birth: _____ ☐ Male ☐ Female

Address: _____ City: _____ State: _____

Zip:_____Email:_____

Occupation: _____ Date of accident: _____

_____	_____	_____
Patient's Printed Name	Signature of Patient (Guardian's signature if patient is under 18)	Date

Review of Systems

Have you had any of the following **pulmonary (lung-related)** issues?
□ Asthma/difficulty breathing □ COPD □ Emphysema □ Other _____ □ None of the above

Have you had any of the following **cardiovascular (heart-related)** issues or procedures?
□ Heart surgeries □ Congestive heart failure □ Murmurs or valvular disease □ Heart attacks/MIs
□ Heart disease/problems □ Hypertension □ Pacemaker □ Angina/chest pain □ Irregular heartbeat
□ Other _____ □ None of the above

Have you had any of the following **neurological (nerve-related)** issues?
□ Visual changes/loss of vision □ One-sided weakness of face or body □ History of seizures □ One-sided decreased feeling in the face or body □ Headaches □ Memory loss □ Tremors □ Vertigo
□ Loss of sense of smell □ Strokes/TIAs □ Other _____ □ None of the above

Have you had any of the following **endocrine (glandular/hormonal)** related issues or procedures?
□ Thyroid disease □ Hormone replacement therapy □ Injectable steroid replacements □ Diabetes
□ Other _____ □ None of the above

Have you had any of the following **renal (kidney-related)** issues or procedures?
□ Renal calculi/stones □ Hematuria (blood in the urine) □ Incontinence (can't control) □ Bladder Infections
□ Difficulty urinating □ Kidney disease □ Dialysis □ Other _____□ None of the above

Have you had any of the following **gastroenterological (stomach-related)** issues?
□ Nausea □ Difficulty swallowing □ Ulcerative disease □ Frequent abdominal pain □ Hiatal hernia
□ Constipation□ Pancreatic disease □ Irritable bowel/colitis □ Hepatitis or liver disease
□ Bloody or black tarry stools □ Vomiting blood □ Bowel incontinence □ Gastroesophageal reflux/heartburn
□ Other _____ □ None of the above

Have you had any of the following **hematological (blood-related)** issues?
□ Anemia □ Regular anti-inflammatory use (Motrin/Ibuprofen/Naproxen/Naprosyn/Aleve) □ HIV positive
□ Abnormal bleeding/bruising □ Sickle-cell anemia □ Enlarged lymph nodes □ Hemophilia
□ Hypercoagulation or deep venous thrombosis/history of blood clots □ Anticoagulant therapy
□ Regular aspirin use □ Other _____ □ None of the above

Have you had any of the following **oncological (cancer-related)** issues?
□ Fevers/chills/sweats/unexplained weight loss □ Abnormal bleeding/bruising
□ Current/past oncology disease _____□ None of the above

Have you had any of the following **dermatological (skin-related)** issues?
□ Significant burns □ Significant rashes □ Skin grafts □ Psoriatic disorders □ Other _____
□ None of the above

Have you had any of the following **musculoskeletal (bone/muscle-related)** issues?
□ Rheumatoid arthritis □ Gout □ Osteoarthritis □ Broken bones □ Spinal fracture □ Spinal surgery
□ Joint surgery□ Arthritis (unknown type) □ Scoliosis □ Metal implants □ Other _____
□ None of the above

Have you had any of the following **psychological** issues?
□ Psychiatric diagnosis □ Depression □ Suicidal ideations □ Bipolar disorder □ Homicidal ideations
□ Schizophrenia □ Psychiatric hospitalizations □ Other _____ □ None of the above

Is there anything else in your past medical history that you feel is important to your care here?

_____

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of chiropractic to provide me with chiropractic care, in accordance with this state's statutes. If my insurance will be billed, I authorize payment of medical benefits to **[Dr. Zachary Rushing]** for services performed.

Patient or Guardian Signature _____Date_____

BLUE RIDGE CHIROPRACTIC

Informed Consent for Chiropractic Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as “informed consent” and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, dislocations, strains, and sprains. In addition, the literature recognizes an association between strokes and chiropractic manipulation of the cervical spine. With respect to strokes, there is a rare but serious condition known as an “arterial dissection” that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Carotid and vertebral artery dissections are rare, with an annual incidence of 2.5 – 4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately, a percentage of these patients will experience a stroke.

The reported association between visits to a chiropractor or a primary care physician and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million visits.

It is also important that you understand there are treatment options available for you condition other than chiropractic procedures. Likely, you have tries many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its consent and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

_____	_____	_____
Patient’s Printed Name	Signature of Patient (Guardian’s signature if patient is under 18)	Date

BLUE RIDGE CHIROPRACTIC

HIPAA Consent Form

By signing below, I understand that some of my health information may be used and/or disclosed by Blue Ridge Chiropractic to carry out treatment, payment, or health care operations. For a more complete description of such uses and disclosures I should refer to Blue Ridge Chiropractic's privacy notice entitled "HIPAA Notice of Privacy Practices". I understand that I may review this notice any time prior to signing this form.

I understand that over time Blue Ridge Chiropractic's privacy practices may need to change in accordance with law and that if I wish to obtain a copy as revised, I can call Blue Ridge Chiropractic to request such copy.

I understand that for my protection, any requests made to amend my health information, request restrictions on how my information is used or disclosed to carry out treatment, payment, or health care operations, or to access my medical records must be made in writing.

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information with
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

In these cases, we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of chiropractic and treatment notes

Our responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share you information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

Check one:

☐ Blue Ridge Chiropractic does not have my permission to share my information.

☐ Blue Ridge Chiropractic can release my appointment, billing, and health records with: _____.
(name of individual)

Appointment Reminders

- Your health care provider or a staff member may disclose your health information to contact you to provide appointment reminders. If you are not at home to receive an appointment reminder, a message will be left on your voice mail, or with the person who answers the call. If you do not have a message left on a recording or someone other than yourself, please indicate below.

☐ I do agree to have messages left on a voicemail or whomever answers the call on the phone number I have provided

☐ I do not agree to have messages left on a voicemail or anyone other than myself.

- We also may send a text reminder of an appointment if you wish to not have this please indicate below

☐ I do not wish to have text reminders

You have the right to refuse us authorization to contact you to provide appointment reminders. If you refuse us authorization, it will not affect the treatment we provide to you.

_____	_____	_____
Patient's Printed Name	Signature of Patient (Guardian's signature if patient is under 18)	Date

BLUE RIDGE
CHIROPRACTIC

Financial Arrangements

Effective Jul. 2020

I do hereby acknowledge that I am receiving (or about to receive) health care services at Blue Ridge Chiropractic. My financial agreement is as follows:

Please initial one:

_____ CASH/CHECK/CREDIT CARD: I am responsible for services rendered to me at the time of service unless other arrangements have been made.

_____ INSURANCE PAYMENT: Upon verification, I may or may not have insurance coverage at this time, I am ultimately responsible for my chiropractic care. In the event my insurance does not cover my chiropractic services I understand I am still financially responsible for my services rendered. Deductibles or Copayments are due at each appointment. Medicare and many insurance deductibles and number of allowed visits reset January 1st of each new year.

_____ OTHER FINANCIAL AGREEMENT: _____

In the event my Other Financial Agreement does not cover my chiropractic services I understand I am still financially responsible for my services rendered.

I, _____ understand that no doctor can or should guarantee any “cure” for any course of treatment and that no spinal correction therefore can be guaranteed.

Any prepayment balance is refundable if treatment is discontinued at any time for any reason.

I fully understand the terms of this agreement and I may receive a copy of this agreement upon my request.

_____	_____	_____
Patient’s Printed Name	Signature of Patient (Guardian’s signature if patient is under 18)	Date

ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO DOCTOR
PRIVATE AND GROUP ACCIDENT AND HEALTH INSURANCE

Patient name: _____

Name of Insurance Company: _____

Claim Number: _____

Adjuster Name: _____Adjuster Phone Number: _____

I hereby instruct and direct the _____ Insurance Company to pay by check made out and mailed directly to:

Blue Ridge Chiropractic
673 Merchant Street, Suite A
Vacaville, CA 95688

OR

If my current policy prohibits direct payment to doctor, then I hereby also instruct and direct you to make out the check to me and mail it as follows:

For professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as a payment toward the total charges for 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 fees for non-covered services and/or fees over and above the insurance payment or as required by my insurance policy.

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 claim.

Dated at _____county, this _____ day of _____ 20___.

_____
Signature of Policy Holder

_____
Witness

_____
Signature of claimant, if other than Policy Holder

Blue Ridge Chiropractic
Zachary Rushing, DC
673 Merchant Street, Suite A
Vacaville, CA 95688
P: (707) 446-2225 F: (707) 724-8878

NOTICE OF DOCTOR'S LIEN

Patient: _____ Date of Accident: _____

I do hereby authorize **BLUE RIDGE CHIROPRACTIC** to furnish you, my attorney, with a full report of his examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I was recently involved.

I hereby authorize and direct you, my attorney, to pay directly to the doctor such sums as may be due and owing him for the medical service rendered me both by reason of this accident and by reason of any other bills that are due his office and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect and fully compensate said doctor. And I hereby further give a Lien on my case to said doctor against any and all proceeds of my settlement, judgment or verdict which may be paid to you, my attorney, or myself, as the result of the injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by him for service rendered me and that this agreement is made solely for said doctor's additional protection and in consideration of awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

I agree to promptly notify said doctor of any change or addition of attorney(s) used by me in connection with this accident, and I instruct my attorney to do the same and to promptly deliver a copy of this lien to any such substituted attorney(s).

Please acknowledge this letter by signing below and returning to the doctor's office. I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment and may declare the entire balance due and payable.

_____ _____

Date Patient Signature

The undersigned being attorney of record for the above patient does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect and fully compensate said doctor above-named. Attorney further agrees that in the event this lien is litigated, that the prevailing party will be awarded attorney fees and costs.

_____ _____

Date Attorney Signature

Please date, sign and return one copy to Blue Ridge Chiropractic. Also keep a copy for your records.

BLUE RIDGE CHIROPRACTIC

Auto Accident/Personal Injury Information & Acknowledgement

Blue Ridge Chiropractic wants you to be informed about your chiropractic care and payment of our services after an accident has occurred. We understand that after an accident it can take some time to work out all the details which now will also include receiving chiropractic care. Blue Ridge Chiropractic allows one week to submit & finalize your details and payment arrangements.

My financial agreement is as follows (**Please Initial One):**

_____1) Payment through your auto insurance:

If you have medical payments on *your* auto insurance, then we can directly bill *your* insurance carrier for payments related to your chiropractic care. You will need to submit a copy of your insurance declaration page or bill, which show your coverage. It *does not matter who is at fault*, your insurance will pay for your medical bills that are related to your auto accident. Blue Ridge Chiropractic can bill up to the medical payments limit. If your bill exceeds the limit or the insurance company does not pay, *you* will be responsible for the remaining balance, or you may retain an attorney to manage the remaining balance. *Your insurance rates will not go up as a result of using this option if you have the coverage in place.*

_____2) Retaining an attorney:

If you do not have medical payments on *your* auto insurance and you are *not at fault* for the accident, you can retain a personal injury attorney. If your case is accepted by an attorney, you will have no out of pocket costs. The attorney will represent you for a percentage of the final claim when your case is settled and will work on your behalf to manage your case. Per our Notice of Doctor's Lien, you as the patient are still responsible for our chiropractic bill if your case is dropped. If you need an attorney, we have a network of local attorneys and would be happy to provide you with their contact information.

_____3) Payment at the time of service:

We cannot bill a third-party insurance *no matter who is at fault.* If you do not have medical payments on your auto insurance and you choose not to retain an attorney, then you can pay at the time of service for your visits. You will incur the cost of the chiropractic care up front. Please understand that in this scenario *you* would be responsible for negotiating with the insurance company or responsible party for a settlement.

Please Initial:

_____I understand that I am ultimately responsible for my chiropractic bill. If in fact my insurance company does not pay, or my attorney drops my case for any reason, I am responsible and will pay for my services that were received.

_____ _____ _____

Printed Name Signature of Patient Date

_____Copy provided to patient. Yes / Patient declined

Frequently asked questions regarding Auto Accidents/Personal Injuries

Q: Someone hit me and admitted fault. Can't you bill their insurance?

A: The system is set up where we are not able to directly bill and interact with their insurance. (This is considered THIRD party) Their insurance company will only interact with you (the person who was involved in the accident). The other party's insurance may verbally agree to pay your medical bills now but then review them later and decide not to pay the full amount. Because patients in auto accidents are often not well versed in the negotiation process with insurance companies, we do not have that as an option. The problem comes in when insurance companies decide not to pay the full amount of our bill and then the patient is left to cover the remaining balance. Even though our bills are reasonable, insurance companies will sometimes fight paying them tooth and nail. Believe us when we say if this option was doable, and patients were happy with the outcome, we would be more than happy to go that route.

Q: Can you refer me to someone who will bill *their* insurance?

A: It is not a good business practice for a chiropractor to operate this way. Usually all parties involved are not satisfied with the process when it is done, including the patient. We are not aware of anyone that practices this way because it is such an undesirable process. If you would like to conduct your own search to find someone who does, you are free to do so.

Q: How much do I have to pay the attorney?

A: You do not have to directly pay the attorney. When your claim is settled, 3 payments will be dispersed by the other party's insurance: one to you, one to the attorney, and one to our office (and any other medical establishments you visited during the course of care). Attorneys are paid a percentage of your settlement, but also take on the responsibility of organizing your case and negotiating your settlement with the insurance company, so they earn that percentage.

Q: What are the odds an attorney will drop my case?

A: Very low. If you are not at fault for an accident and give truthful and timely information about your case, then the attorney will almost never drop your case and will work with you to settle your claim. If it has been determined that you are at fault for the accident, or you fall out of communication with the attorney and/or our office (don't return phone calls, give information that is later found to not be truthful, etc.) then the attorney has the option to drop your case. Once the attorney decides to not represent you, you would be financially responsible for your chiropractic care.

Q: How much time do I have to get an attorney or confirm my medical payments? Can I get treatments in the meantime?

A: We give you up to one week from your first visit to either confirm your medical payments on your insurance or retain a personal injury attorney. During the first week we will allow you up to 3 visits to start progress with your care plan. If after that first week you have not finalized either of these options, then you will have to pay directly for your care. We will give you our "payment at time of service discount" if you pay within 15 days of your first visit. If payment is not made in those first 15 days we will have to charge our full personal injury rates.

BLUE RIDGE CHIROPRACTIC

General Pain Index Questionnaire

Blue Ridge Chiropractic would like to know how much your pain **PRESENTLY** prevents you from doing what you would normally do. Please **CIRCLE ONE NUMBER** which best describes how your typical level of pain affects these six categories of activities. This will be completed about once a month during care.

1. AT-HOME RESPONSIBILITIES such as yard work, chores around the house, or driving the kids to school-

0 1 2 3 4 5 6 7 8 9 10
Causes No Pain — Pain Prevents All

2. RECREATION including hobbies, sports, or other leisure activities-

0 1 2 3 4 5 6 7 8 9 10
Causes No Pain — Pain Prevents All

3. SOCIAL ACTIVITIES including parties, theater, concerts, dining out and attending other social functions-

0 1 2 3 4 5 6 7 8 9 10
Causes No Pain — Pain Prevents All

4. EMPLOYMENT including work, volunteer work, and homemaking tasks-

0 1 2 3 4 5 6 7 8 9 10
Causes No Pain — Pain Prevents All

5. SELF-CARE such as taking a shower, driving, or getting dressed-

0 1 2 3 4 5 6 7 8 9 10
Causes No Pain — Pain Prevents All

6. LIFE-SUPPORT ACTIVITIES such as eating and sleeping-

0 1 2 3 4 5 6 7 8 9 10
Causes No Pain — Pain Prevents All

Patient Name:

Date:

Patient Signature:

Office Use Only:
Date:
Score:
Previous Score:
Doctor Initials: