YOUR ACCIDENT CENTER

Patient _____
(First) (Middle) (Last)

Address _____

City _____ State _____ Zip _____

E-mail address _____

Home Phone # _____ Cell Phone # _____

Would you like an appointment reminder? No( ) Text( ) Call: Cell( ) Home( )

Date of Birth _____ Age _____
(Month) (Day) (Year)

Social Security # _____

Single( ) Married( ) Spouse's Name _____

Patient's Employer _____

Work Phone # _____

Hobbies _____

Complaint _____

Is complaint accident related? Yes( ) No( ) Date accident occurred _____

Work related( ) Auto related( ) Other( ) _____

**Payment Is Expected At Time Of Visit Unless Other Arrangements Are Made In Advance**

_____ _____
Date Patient's Signature

# Insurance Information

Auto Insurance: _____ Policy #: _____

Insured Name: _____ Group #: _____

Claim #: _____

Patient is the ☐ Spouse ☐ Child ☐ Self ☐ _____ to the insured.

Date of Birth of Insured: ____/___/_____

Insured Address (If Different From The Patient):

Address: _____

City:_____ State: ____ Zip Code: _____

I understand that I am ultimately responsible for all payments for services rendered to me at YOUR Accident Center and that with my permission every effort will be made to collect from the provided insurance on my behalf.

Patient Signature: _____ Date: _____

# Accident Report

**Patient Name:** _____ **Date:** _____

**Date of Auto Accident** _____

Have you been a patient here before? ☐ YES ☐ NO

In the auto accident, were you the: ☐ Driver ☐ Passenger ☐ Pedestrian

If you are a passenger please **locate** your position in the vehicle:

☐ Front Seat ☐ Back Seat Passenger side ☐ Back Seat Driver Side

**Were you aware of the impending crash?** ☐ YES ☐ NO

**Please check the accident details during impact:**

☐ Stopped ☐ Front-end impact ☐ RIGHT side impact ☐ Multiple impacts

☐ Moving ☐ Rear-end impact ☐ LEFT side impact ☐ Don't remember

**Were you wearing a seat belt?** ☐ YES ☐ NO

**Did the air bag deploy?** ☐ YES ☐ NO

**Upon impact which way was your head turned?**

☐ To Left ☐ To Right ☐ Straight Ahead ☐ Looking Down ☐ Don't Remember

**Were your hands on the steering wheel?** ☐ Left hand ☐ Right hand ☐ Both hands

**Did you strike any portion of your body?** ☐ YES ☐ NO

**If yes, which portion of your body did you strike?**

☐ Head ☐ Knee ☐ Arms ☐ Hands ☐ Shoulders ☐ Other _____

**What objects did you strike?**

☐ Steering Wheel ☐ Dash Board ☐ Rearview Mirror ☐ Center Console

☐ Side Window ☐ Windshield ☐ Headrest ☐ Side Door ☐ Other_____

**After the accident were you?**

☐ Dazed ☐ Unconscious ☐ Cut ☐ Bruised ☐ Abrasions/Scrapes

**Did you experience?**

☐ Momentary Deafness ☐ Loss of Balance ☐ Ringing in ears ☐ Blurred Vision

☐ Immediate Pain ☐ Gradual Pain ☐ Nausea ☐ Dizziness

**Were any of the listed symptoms present before the accident?** ☐ YES ☐ NO

If **YES**, please describe? _____

**Did you go to the Emergency Room, Urgent Care or Doctor?** ☐ YES ☐ NO ☐ When _____

If **YES**, where? _____

**How did you get there?** ☐ Ambulance ☐ Drove myself ☐ Friend/Relative

**What procedures were done in the Emergency Room/Urgent Care?**

☐ Examination ☐ Stitches ☐ X-rays ☐ Collar ☐ Muscle Relaxers

☐ Pain Pills ☐ Brace ☐ Other_____

**Did you stay the night in the Emergency Room/Urgent Care?** ☐ YES ☐ NO

**Have you seen any other Physicians for this problem?** ☐ YES ☐ NO

**Are you taking any medications?** ☐ YES ☐ NO

**Are you pregnant?** ☐ YES ☐ NO **If yes, Due Date** _____

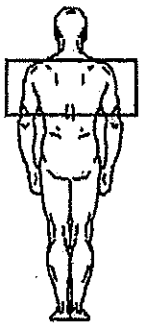
**Do you have a pacemaker or any metal in your body?** ☐ YES ☐ NO

# CHECK SYMPTOMS YOU HAVE NOTICED SINCE ACCIDENT

## HEAD & NECK

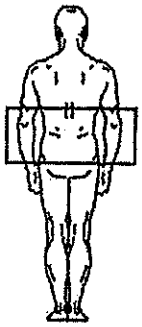
- ☐ Neck pain
- ☐ Neck stiffness
- ☐ Neck spasms
- ☐ Arm Pain
- ☐ Headaches
- ☐ Dizziness
- ☐ Hands Cold
- ☐ Fatigue
- ☐ Loss of memory
- ☐ Loss of balance
- ☐ Numbness in fingers
- ☐ Head seems to heavy
- ☐ Grinding sensation in neck
- ☐ Sleeping problems
- ☐ Eyes sensitive to light

## MID BACK



- ☐ Mid back pain
- ☐ Mid back stiffness
- ☐ Mid back spasms
- ☐ Rib/side Pain
- ☐ Chest Pain
- ☐ Shortness of Breath
- ☐ Sneezing increases pain
- ☐ Breathing increases pain
- ☐ Coughing increases pain

## LOW BACK



- ☐ Low back pain
- ☐ Low back stiffness
- ☐ Low back spasms
- ☐ Leg Pain
- ☐ Hip Pain
- ☐ Numbness in toes
- ☐ Sneezing increases pain
- ☐ Breathing increases pain
- ☐ Coughing increases pain
- ☐ Pins/Needles in legs

**Review & Consent**

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. I understand that it is my responsibility to bring to the attention of the providing physician ANY new information regarding my health and well-being or any changes in health status that would be pertinent to my case management.

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. Some patients will feel some stiffness and soreness following the first few days of treatment. The doctor will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to our attention, it is your responsibility to inform us.

Patient Signature _____ Date_____

Parent or Guardian Signature _____ Date_____

YOUR ACCIDENT CENTER

**Patient's Name:** _____

**Date of Accident:** _____

**Please provide us with a *detailed* description of what happened in your accident:**

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

**Current Medications:** _____
_____
_____

**Allergies:** _____
_____
_____

**Patient's Signature** _____
**Date** _____

## TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards 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.

Here are important terms that are used in this clinic:
**Adjustment:** An adjustment is the specific application of forces to aid in the body's correction of subluxations. Our chiropractic method of correction will be by specific adjustment of your spine and extremities.

**Support Therapy:** balancing of muscles and supporting tissue structures to give strength and stability to the adjustment, through massage, exercise, stretching, instructed home therapy life style modifications and education to help you regain your health.

**Health:** A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

**Misalignment:** if one or more of the 24 vertebrae in your spinal column, your skull placement, sacrum and hips, and also the joints in the extremities become misaligned, it can cause an alteration of nerve function and interfere with the proper transmission of nerve communication, resulting in a weakening of the body's ability to express its maximum health potential.

**Appointment:** Your health recovery is very important to us. We ask that you also make it a priority. Be on time! This is a very busy clinic, and reschedules and cancellations cause unwanted disruption to the quality and outcome of care for yourself and others. Scheduling changes will result in a diminished level of care due to the unavailability of certain procedures and services which are being provided to other patients. This clinic schedules therapy tailored to your needs, therefore, PLEASE BE ON TIME!

If during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings we will advise you. If you desire advice, diagnosis or treatment for those findings we will provide you with recommendations for care in this office or through the services of another health care provider.

Our objective is to eliminate major interferences to the recovery of your health. Our methods include specific adjusting to correct biomechanical dysfunctions, provide massage therapy, exercise and physical therapy, nutritional and homeopathic supplements and Biopuncture. Additional services may be added from time to time as determined by our clinic director.

**Patient Agreement:**
I understand that the clinic will provide a designated appointment time for me and I agree that I will respect the importance of that time and I will make every reasonable effort to keep my appointment and to be on time. Any cancellations or reschedules that are not given a 24 hour notice may be personally charged an administration fee of $15.00 per occurrence, which is not billable to my insurance. I agree to contact this office as soon as possible to reschedule my appointment.

I agree to have the clinic contact a qualified attorney and share my contact information regarding my accident, if the doctor feels it's important that I have representation.

I, _____ have read, fully understand and agree to the above statements.

Please review my application and accept me as a new patient in this clinic.

Name: _____ Signature: _____ Date: _____

**Female patients**: I, _____ do hereby state that to the best of my knowledge:

- ☐ I am pregnant
- ☐ I am not pregnant, nor is pregnancy suspected or confirmed at this time.
- ☐ I agree to notify this office as soon as I know that my pregnancy status has changed.

## Assignment of Benefits to YOUR Accident Center

The undersigned patient/client and/or additional responsible party ("patient"), in consideration of treatment rendered by YOUR Accident Center hereby irrevocably assigns to YOUR Accident Center all rights of the patient to any insurance, health care plan or other medical expense reimbursement benefits and payments ("Claims") to the extent of the patients bill for services rendered and costs incurred by YOUR Accident Center, including without limitation, the right to apply for or prosecute Claims and the right to make demand and sue in the patient's name for any benefits and payments arising out of the Claims, including penalties, interest, court costs, collection fees or other legally compensable amounts owed by the insurance or other payor. The patient further agrees to cooperate, provide information as needed, and appear as needed, wherever and whenever to assist in the prosecution of Claims upon the offices request. The assignment to YOUR Accident Center of the patient's right to prosecute Claims does not obligate YOUR Accident Center to pursue payment only from, or otherwise prosecute in any manner or to any extent, the patient's Claims. YOUR Accident Center shall have no liability for any acts or omission on its part in dealing with Claims. YOUR Accident Center may in its sole discretion proceed to obtain payment for services rendered and costs incurred directly from the patient without prosecuting any Claims.

The patient further empowers YOUR Accident Center and its representatives to request and receive from any insurance or other health care plan, any and all information and documents pertaining to policies or plans including a copy of such a policy or plan document, and any information of supporting documentation concerning the handling, calculation, processing, or payment of any claim, without further consent from the patient. YOUR Accident Center may perform a credit check of my credit history.

A copy of this agreement shall evidence the patient's consent and direction to any insurance or health plan providing benefits of any kind to or on the patient's behalf for treatment rendered by YOUR Accident Center for the payment in full of the office's bill for treatment rendered upon receipt of such a bill, to the extent payable under the terms of the applicable insurance policy or plan. Furthermore, the patient grants YOUR Accident Center the power to endorse the patient's name upon any checks, drafts, or other negotiable instrument representing payment upon Claims. Any payment received by YOUR Accident Center in an amount exceeding the outstanding balance on the patient's account with YOUR Accident Center shall be credited to the patients account or forwarded to the patient upon request in writing to this office.

YOUR Accident Center is hereby authorized to release and permit the examination or copying by such person(s) as YOUR Accident Center or its authorized representatives deem appropriate, of any of the patient's medical records, x-ray, laboratory reports, and the results of all tests of any type or character. Such authorization shall include any insurance Name or health care plan providing benefits of any kind on the patient's behalf for treatment rendered by YOUR Accident Center.

This authorization does not authorize my insurance or health care plan to release any medical records to any third party, including fee review consultants or other reviewing agencies without my express written consent. Any release of such privileged information without my express written consent shall be deemed a violation of my rights of privacy under all applicable state and federal law and may result in legal action.

The patient further grants and assigns to YOUR Accident Center all rights, claims against and recoveries or payments from any third party for injuries, which are treated by YOUR Accident Center to the extent of the office's bills for services for the patient.

So long as YOUR Accident Center shall diligently prosecute collection of any payments due from insurance companies, health companies, health care plans or third parties, the patient waives any defense based on an applicable statute of limitations, estoppel or otherwise, with respect to any action by YOUR Accident Center to recover from the patient for services rendered by YOUR Accident Center to or for the patient. The patient agrees that regardless of the Assignment, he or she has continuing legal responsibility for the payment of the full amount due YOUR Accident Center and shall pay the full amount due on demand. Any amounts due and not paid shall bear interest at 18% per annum from the due date. The undersigned further agrees to pay YOUR Accident Center all reasonable costs of collection, including attorney's fees, court costs, collection fees, interest and including any other costs incurred by YOUR Accident Center whether before or after litigation. The terms and conditions of any applicable insurance Name, health care plan or their reimbursement program shall limit the assignment of rights evidenced by this agreement. In the event that any provision of this agreement is determined to be invalid or unenforceable, all other provisions of this agreement shall remain valid and enforceable. This agreement shall be construed in accordance with Utah Law.

Patient: _____

Employer: _____
if treated for job related injury

Date: _____

Witness: _____

YOUR Accident Center
141 E 5600 S #204
Murray UT 84107
(801)905-1466

YOUR ACCIDENT CENTER™

**LIEN AGREEMENT**

Patient: Doctor:

I do hereby authorize the above doctor to furnish you, my representative, with a full report of his examination, diagnosis, treatment, prognosis, etc., of myself with regard to the accident in which I was involved.

I hereby authorize and direct you, my representative, to pay directly to Dr. Omar Arrieta and/or YOUR Accident Center such sums as may be due and owing for medical service rendered me both by reason of this accident and by reason of any other bills that are due, and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect Dr. Omar Arrieta and/or YOUR Accident Center. I do hereby grant power of attorney to Dr. Omar Arrieta for the discrete sole purpose of (a) signing two-party checks received at YOUR Accident Center or when dual signatures are required for payment on a check from and insurance company, (b) the signing privilege related to PIP benefit applications in lieu of habeas corpus and forms related to the stated injury for which services have been rendered to facilitate the completion of insurance for procession of the claim. This assures the presenting patient that only the amount outstanding on his\her bill will be paid to YOUR Accident Center. And I hereby further give a lien on my case to Dr. Omar Arrieta and/or YOUR Accident Center against any and all proceeds of any settlement, judgment or verdict which may be paid to you, my legal representative, myself or Dr. Omar Arrieta 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 Dr. Omar Arrieta and/or YOUR Accident Center for all medical bills submitted for service rendered to me and that this agreement is made solely for said Dr. Omar Arrieta's protection and in consideration of Dr. Omar Arrieta and patient's waiting period for payment. I further understand that such payment is not contingent on any settlement, judgment, or verdict by which I may eventually recover said fee.

I hereby state and agree that a photocopy of this document will be as valid and binding on all parties involved as the original document.

_____

Date: Patient Signature

The undersigned being Representative 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 Dr. Omar Arrieta and/or YOUR Accident Center.

_____

Date: Representative of Record Signature

Please date, sign and return one copy to the address below:

YOUR Accident Center
141 E 5600 S #204
Murray, UT 84107
(801)905-1466

YOUR Accident Center 141 E 5600 S #204 Murray, Utah 84107 (801) 905-1466

## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received, reviewed, understand and agree to the Notice of Privacy Practices of YOUR Accident Center , which describe the Practice's policies and procedures regarding use and disclosure of any of my Protected Health Information created, received or maintained by this clinic.

_____
Print Name

_____ Date: _____
Signature

## FOR OFFICE USE ONLY IF NOTICE NOT PROVIDED TO PATIENT

The Practice has made a good-faith effort to obtain an acknowledgement of receipt of our Notice of Privacy Practices. In spite of these efforts, the Practice has been unable to obtain a acknowledgement of receipt for the following reasons (check all that apply):

- o Patient Unavailable due to: _____
- o Patient Physically Unable
- o Patient Unwilling

In an effort to obtain the patients acknowledgement, the Practice has attempted to provide patient with a Notice of Privacy Practices in the following manner (check all that apply):

☐ Personally ☐ Mail ☐ Phone Follow up ☐ Email ☐ Fax

☐ Other _____

_____
Clinic Representative

_____ Date: _____
Signature