

## PERSONAL INJURY VERIFICATION

Name \_\_\_\_\_ Email \_\_\_\_\_  
Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ Zip Code \_\_\_\_\_  
Birth Date \_\_\_\_\_ Age \_\_\_\_\_ Marital Status \_\_\_\_\_  
Employer \_\_\_\_\_ Occupation \_\_\_\_\_  
Name of Spouse \_\_\_\_\_  
In case of emergency, please notify \_\_\_\_\_ Phone \_\_\_\_\_

### MED-PAY

Policy Holder \_\_\_\_\_  
Insurance \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Policy Number \_\_\_\_\_ Claim Number \_\_\_\_\_  
\$ Amount of coverage available \_\_\_\_\_ Adjuster \_\_\_\_\_  
Phone Number \_\_\_\_\_ Fax Number \_\_\_\_\_

### LIABILITY (3RD PARTY)

Policy Holder \_\_\_\_\_  
Insurance \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Policy Number \_\_\_\_\_ Claim Number \_\_\_\_\_  
\$ Amount of coverage available \_\_\_\_\_ Adjuster \_\_\_\_\_  
Phone Number \_\_\_\_\_ Fax Number \_\_\_\_\_

### ATTORNEY

Name \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_  
Zip \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_  
Paralegal/Contact \_\_\_\_\_

# AUTO ACCIDENT PATIENT HISTORY

Name \_\_\_\_\_ Date \_\_\_\_\_

## History of the Occurrence

Date of Accident \_\_\_\_\_ Were you the DRIVER or PASSENGER

What type of vehicle were you in? CAR TRUCK VAN OTHER \_\_\_\_\_

Was it YOUR or SOMEONE ELSE's vehicle Were you wearing a seatbelt? YES or NO

Your vehicle: HIT ANOTHER VEHICLE or WAS HIT

In the: RIGHT LEFT REAR FRONT SIDE

Type of Accident: HEAD-ON COLLISION REAR-END COLLISION  
BROADSIDE COLLISION FRONT IMPACT (rear-end car in front)  
NON-COLLISION \_\_\_\_\_

## Symptoms From The Accident

Did you get bleeding cuts or bruises? YES or NO

If Yes, what bleeding cuts did you get from this accident? \_\_\_\_\_

If Yes, what bruises did you get from this accident? \_\_\_\_\_

Please describe how you felt. Please be specific.

Immediately after the accident \_\_\_\_\_

Later that day/night \_\_\_\_\_

The next day \_\_\_\_\_

## List of Medications

Medication	Purpose of Taking Medication	Any Side Effects

## Work Status History

Occupation or Job Title \_\_\_\_\_

Have you missed time from work? YES or NO

If Yes, full time off work \_\_\_\_\_ to \_\_\_\_\_

Returned to Modified work \_\_\_\_\_ to \_\_\_\_\_

( ) Been unable to work since the accident

**Arizona Chiropractic Neurology Center**

**Informed Consent Document**

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

**The nature of the chiropractic adjustment**

The primary treatment we use as a Doctor of Chiropractic is spinal manipulative therapy (SMT, CMT). We will use this procedure to treat you. We may use our hands or a mechanical instrument upon your body in such a way as you move your joints. That may cause an audible “pop” or “click”, much as you have experienced when you “crack” your knuckles. You may feel a sense of movement.

**Analysis/Examination/Treatment**

As part of the analysis, examination, and treatment, you are consenting to the following procedures:

- Spinal manipulative therapy    --Palpation    --Vital Signs
- Range of motion testing    --Orthopedic testing    --Neurological testing
- Postural analysis    --EMS/TENS/Galvanic    --Imaging and Lab studies as indicated
- hot/cold therapy    --Stretching    --massage therapy    --exercise rehabilitation
- Microcurrent    --low level laser therapy    --SSEP    --Functional medicine/supplements    --Other\_\_\_\_\_

**The material risks inherent in chiropractic care**

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and physiotherapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strains, ligament sprains, cervical myelopathy, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to complications including stroke (CVA). Some patients will feel some stiffness and soreness following the first few days of treatment. I 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 my attention, it is your responsibility to inform me. Cauda Equina Syndrome has been reported in rare cases which requires immediate medical care.

**The probability of those risks occurring**

Statistically, Chiropractic Care has been demonstrated to be one of the safest of all healthcare practices. Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the raking of your history and examination. CVA has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur one in five million cervical adjustments. Two major studies (2008, 2015) showed there was not causation between CMT and CVA but rather the patient was already presenting with arterial dissection. The other complications are also generally described as rare.

**The availability and nature of other treatment options**

Other treatment options for your condition may include:

- Self-administered, over-the-counter (OTC) analgesics, ice, head or rest.
- Medical care and prescription drugs such as anti-inflammatories, muscle relaxants and pain killers.
- Hospitalization/Surgery

If you choose to use on of the above noted “other treatment” options, you should be aware that there are severe risks associated with these treatments. Many patients taking OTC NSAID’s such as Ibuprofen and Acetaminophen are not aware that every year there are thousands of deaths associated with their use. No medicine should ever be taken without discussing their side effects and inherent statistical danger with their primary care physician or pharmacist. The PDR is also a good reference regarding pharmaceutical use.

**The risks and dangers attendant to remaining untreated**

Remaining untreated may create adhesions or scar tissue that can weaken the area and reduce mobility. Further joint degeneration may occur as well as the development of chronic pain syndromes. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

**DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.**

*I have read or have had read to me the above explanation of the chiropractic adjustment and related treatment. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.*

**DATED:\_\_\_\_\_ PATIENTS NAME:\_\_\_\_\_ SIGNATURE\_\_\_\_\_**

**SIGNATURE OF PARENT OR GUARDIAN (if minor)\_\_\_\_\_**

**DATED:\_\_\_\_\_ DOCTOR’S NAME:\_\_\_\_\_ SIGNATURE\_\_\_\_\_**

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

Patient: \_\_\_\_\_

Employer: \_\_\_\_\_

Claim #: \_\_\_\_\_

I hereby instruct and direct that \_\_\_\_\_ Insurance Company to pay  
by check made out and mailed to:

Dr. Trevor Berry AND Dr. Russell Teames  
3800 W. Ray Road Suite 12  
Chandler, AZ 85226

The professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the 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 any balance of said professional service charges over and above this insurance payment.

A photocopy of this Assignment shall be considered as effective and valid as the original.

I authorize the release of any information pertinent to my case to any Insurance Company, Adjuster, or Attorney, or for the purpose of filing a Health Care Lien.

For all Personal Injury cases, a medical lien/release of lien will be filed and copies will be sent to you.

I also authorize Doctor to complain to Insurance Commissioner on my behalf for any reason.

POLICY: Dr. Trevor Berry and Dr. Russell Teames will only file to Major Medical Carriers during Personal Injury Care if

- a) He is not credentialed with that company and/or
- b) If there are no other means for Settlement Re-Imbursement, ie: 3<sup>rd</sup> Party Liability, Med Pay, etc.

Dated at \_\_\_\_\_ this \_\_\_\_ day of \_\_\_\_\_ 20\_\_\_\_

\_\_\_\_\_  
Signature of Policy Holder/Claimant

\_\_\_\_\_  
Witness

# COMPLAINTS

Print Name \_\_\_\_\_

Date \_\_\_\_\_

Please answer all of the below by putting a checkmark in the appropriate box.

NECK OR CERVICAL SPINE	NONE	MILD	MODERATE	SEVERE
Neck Pain and Soreness				
Loss of Pain with Movement				
Shoulder Pain				
Pain/Numbness/Tingling in Arm or Hand				
Weakness in Arm or Hand				

MID-BACK OR THORACIC SPINE	NONE	MILD	MODERATE	SEVERE
Mid-back Pain				
Rib or Chest Pain				

LOWER BACK OR LUMBAR SPINE	NONE	MILD	MODERATE	SEVERE
Lower Back Pain and Soreness				
Loss or Pain with Movement				
Pain into Hips or Buttocks				
Pain into Legs, Knees, or Feet				
Numbness/Burning in Legs or Feet				

OTHER COMPLAINTS	NONE	MILD	MODERATE	SEVERE
Headaches				
Visual Disturbances/Blurry Vision				
Ringling or Buzzing in Ears				
Nausea or Vomiting				
Difficulty Breathing				
Dizziness				
Recent Weight Loss				
Bowel or Bladder Dysfunction				

OTHER INJURY AREAS	NONE	MILD	MODERATE	SEVERE

AGGRAVATED BY	NONE	MILD	MODERATE	SEVERE
Coughing				
Sneezing				
Prolonged Sitting				
Prolonged Standing				
Prolonged Riding in a Car				
Lying on Stomach				

Patient Signature \_\_\_\_\_

Doctor Signature \_\_\_\_\_