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 ____
____

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

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				
Ringing 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 ______________________________

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___________________________

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND PATIENT FINANCIAL RESPONSIBILITY

Thank you for choose Arizona Chiropractic Neurology Center. We are committed to providing you with the highest quality healthcare. We ask that you read and sign this form to acknowledge your understanding of our Privacy Practices and Patient Financial Responsibility Policies.

The patient (or patients guardian, if a minor) is ultimately responsible for the payment for treatment and care. We will bill your insurance for you, however, it is the patients responsibility to know the details of their insurance in addition to any lapses in insurance coverage. If you do not inform us of special requirements required by your plan, and we provide medically necessary services that are not covered by your plan, we may bill you directly for those charges. (DEDUCTIBLES, CO-INSURANCE, AND ALL OTHER PROCEDURES OR TREATMENTS NOT COVERED BY INSURANCE ARE ALSO THE PATIENTS RESPONSIBILITY). All Co-Pays are due at time of service.

(PLEASE NOTE THAT ANY BENEFIT INFORMATION FURNISHED IS NOT A GUARANTEE OF PAYMENT NOR A DETERMINATION OF MEDICAL NECESSITY AND FINAL CLAIM DETERMINATION WILL BE MADE UPON RECEIPT AND REVIEW OF THE CLAIM. THE PATIENT IS RESPONSIBLE FOR ALL BALANCES OUTSTANDING). Patients may incur and are responsible for payment of additional charges, which may include charge for returned checks, and charge for missed appointments without 24 hour notice.

I, ______________________________ acknowledge that I have received, reviewed, understand and agree to the Notice of Privacy Practices and Patient Financial Responsibility of the Arizona Chiropractic Neurology Center, which describes the practice's policies and procedures regarding the use and disclosure of my Protected Health Information created, received or maintained by the practice.

YOUR SIGNATURE BELOW FORMS A BINDING AGREEMENT BETWEEN ARIZONA CHIROPRACTIC NEUROLOGY CENTER AND THE PATIENT (OR RESPONSIBLE PARTY FOR A MINOR PATIENT).

Date:____________ **SIGNATURE OF PATIENT:________________________________**

PATIENT RECORD OF DISCLOSURES

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 signed acknowledgement of receipt for the following reasons. __Patient Unavailable___Mail___Phone Follow-Up___Fascimile___Other.

Date:__________ **SIGNATURE OF STAFF MEMBER________________________________**

PATIENT LECTURE OF DISCLOSURES

The privacy rule generally requires healthcare providers to take reasonable steps to limit the use of disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual. Healthcare entities must keep records of PHI disclosures for Non-TPO purposes. Information below will constitute an adequate record.

Date	Disclosed to whom	Description of Disclosure	Disclosed by

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.

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: 3rd Party Liability, Med Pay, etc.

Dated at __________________________ this ____ day of ________________ 20_____

___________________________________ ______________________________

Signature of Policy Holder/Claimant Witness