

CHIROPRACTIC AND PHYSICAL THERAPY
CENTERS OF OHIO, HILLIARD CLINIC

PATIENT APPLICATION FORM /MVA

WELCOME TO OUR CLINIC. We specialize in assisting our patients to achieve their highest level of health through our *spinal and postural corrective programs*. Our approach is very unique and advanced from other rehabilitative programs. This allows our patients to achieve far superior results compared to most other systems.

Please fill out the following information thoroughly so the doctor or physical therapist can let you know if you are a case we can accept. Please feel free to ask any questions if you need assistance. We look forward to serving you.

Patient Signature:

Today's Date:

PATIENT APPLICATION SURVEY / MVA

Name: _____ (Age) _____ Gender: M F
Home Address: _____ Home Phone: _____
City, State, Zip: _____ Work Phone: _____
Email Address: _____ Cell Phone: _____
Birth Date: ____ / ____ / ____ Social Security #: ____ - ____ - ____ Marital Status: S M D W
Names of Children: _____ Ages: _____
Occupation: _____ Employer Name: _____
Spouse's Name: _____ Work Phone: () _____ Cell Phone: () _____
Spouse's Employer: _____ Occupation: _____
How were you referred to this office? _____

RESPONSIBLE PARTY INFORMATION

Your Auto Insurance Company Name _____ Phone # _____ ext _____
Claim number _____ Adjusters Name _____
Name of Insured person _____ Phone # _____ Relationship _____
Attorney Name (If applicable) _____ Phone # _____ ext _____

Other party involved Auto Insurance Company Name _____ Phone # _____
Claim number _____ Adjusters Name _____
Name of Insured person _____ Phone # _____ Relationship _____

Your Health Insurance Company _____ Phone # _____ ext _____
Group Number _____ Policy Number _____

ACCIDENT INFORMATION

Have you ever been under chiropractic or physical therapy care before if this accident yes no, If yes by whom _____

Is this visit related to the **auto accident** Yes No If so, when was the date of the accident _____

Please describe in detail the accident: _____

PLEASE ANSWER THE FOLLING QUESTIONS

1. Were you the driver the passenger a pedestrian on a bicycle on a motorcycle.
2. Were you hit (by another vehicle) or at fault (you caused the accident)?
3. From which side were you struck behind the front the right side the left side the right front the left front the right back the left back.
4. At the time of impacted were you stopped moving walking standing still running bicycling riding a motorcycle crossing the street.
5. Were you moving at the time of the accident yes or no? **If yes**, what was your speed _____?
6. Was the involved party moving when the accident occurred yes or no, **If yes** what was there speed _____?
7. Did you have your seatbelt on at the time of the accident yes no?
8. Was your head turned at the time of the accident yes or no, **If yes** were you looking foreword looking to the right looking to left looking behind you looking up looking down.
9. Were you alone at the time of the accident yes or no?
10. What parts of your body hit other structures at the time of impact head face forehead back of head right TMJ left TMJ
 right shoulder left shoulder right arm left arm right elbow
 left elbow right wrist left wrist right hand left hand
 Right leg left leg right knee left knee right ankle left ankle
 right foot left foot
11. What structures did you hit? steering wheel windshield side window door roof dashboard
 headrest seat floor Side of car hood of car bumper trunk
 the pavement tree another car another person another object
 a wall
12. How did you feel after the collision? stunned disoriented lost consciousness tightness felt mild discomfort felt moderate discomfort felt severe discomfort felt intense pain frightened felt a popping and ripping sensation when to hospital
13. Who was cited for the accident me other driver

AUTHORIZATION OF CARE

I authorize and agree to allow the Doctor and/or physical therapist to work with my spine through the use spinal adjustments and rehabilitative exercises for the sole purpose of postural and structural restoration of normal biomechanical and neurological function.

I understand that I am responsible for all fees incurred for the services provided, and agree to ensure full payment of all charges.

The Doctor and/or physical therapist will not be held responsible for any health conditions or diagnoses which are pre-existing, given by another health care practitioner, or are not related to the spinal structural conditions diagnosed at this clinic.

I also clearly understand that if I do not follow the Doctors and/or physical therapist specific recommendations at this clinic that I will not receive the full benefit from these programs, and that if I terminate my care prematurely that all fees incurred will be due and payable at that time. I authorize the assignment of all insurance benefits be directed to the Doctor and/or physical therapist for all services rendered.

Patient's Name Printed

Date

Patient's signature

Date

Minors Name

Guardian/Spouse's Signature of Authorizing care for minor

Date

RADIOGRAPH CONSENT FORM

I _____ do hereby give my consent to allow Chiropractic and Physical therapy Centers of Ohio and it's representatives, as deemed by the examining physician to take radiographs of my spine and/or extremities.

I also hereby declare that to my knowledge that I am not pregnant _____ (Initial)

Signature of Patient/or Guardian of said Minor _____ Date _____

IN CASE OF EMERGENCY CALL:

Name _____

Relationship _____

Work Phone _____

Home Phone _____

Cell Phone _____

HIPPA / HEALTH CARE AUTHORIZATION FORM

THE FOLLOWING AUTHORIZES **CHIROPRACTIC & PHYSICAL THERAPY CENTERS of OHIO** TO USE AND/OR DISCLOSE PROTECTED HEALTH CARE INFORMATION IN ACCORDANCE WITH THE FOLLOWING SPECIFIC AUTHORIZATIONS:

I give permission to Chiropractic & Physical Therapy Centers of Ohio to use my name, address, phone numbers and clinical records to contact me with birthday cards, holiday related cards, health related e-mails messages and information about treatment alternatives or other health related information as well as any advertisements, newsletters or patient of the week/month postings.

I give permission to Chiropractic & Physical Therapy Centers of Ohio to treat me in an open room where other patients are also being treated. I am aware that other persons in the office may overhear some of my protective health care information during the course of my treatment. Should I need to speak with a Doctor or Physical Therapist in private, the Doctor or Therapist will provide a private room for these conversations. By signing the following you are giving Chiropractic & Physical Therapy Centers of Ohio permission to use and disclose your protected health information in accordance with the directives listed above

ACKNOWLEDGEMENT OF RECIEPT & NOTICE OF PRIVACY PRACTICES

I _____ on this date _____ understand and have been provided with a notice of information practices that provides me a more complete description of information uses and disclosures, I understand that I have the following rights and privileges:

- * The right to review the notice prior to signing this consent
- * The right to object to the use of my health care information for directory purpose
- * The right to request restrictions as to how my health care information may be used or disclosed in this office to carry out treatment, payment, or health care operations

PLEASE READ THE FOLLOWING

At this time, we ask that you hand your application into the front desk. They will now assistance you on how you will describe your **complaints and/or symptoms** on the Kiosks in the lobby. Please be sure to mark all areas of discomfort, one area at a time. Thank you.

