



**IV. EMERGENCY NOTIFICATION**

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

Your closest friend or relative to contact in case of an emergency

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
(first) (middle) (last)

HOME ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_

STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_ Hm. Ph. (\_\_\_\_)\_\_\_\_-\_\_\_\_ Cell Ph. # (\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_

Place of Employment: \_\_\_\_\_ Bus. Ph.: (\_\_\_\_)\_\_\_\_-\_\_\_\_\_

**V. FINANCE**

Fees Are Payable At Time Of Consultation, Examination, Laboratory, Diagnostic Imaging (X-RAY), Treatment Or When Other Services Are Performed. Exceptions Must Be Made In Advance. X-RAY Films Remain The Property Of Your Medical File And Need To Remain At This Clinic. Films Will Be Made Available For Loan To Other Healthcare Facilities Or Copies Will Be Made Available Upon Request And Advance Payment Of The Copy Fee.

Who Will Assist You In Paying For Your Care?

Self \_\_\_ Spouse \_\_\_ Employer \_\_\_ Insurance \_\_\_ Other \_\_\_\_\_

How Will Payment Be Made? Cash \_\_\_ Check \_\_\_ Health Ins. \_\_\_ Auto Ins. \_\_\_  
Other: \_\_\_\_\_

PATIENT'S SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_  
(Self/Legal Guardian)

**VI. AUTHORIZATIONS**

I Authorize Communications Between \_\_\_\_\_ Insurance Company And/Or Attorney's Office And Atkinson Family Chiropractic, PC. I Also Authorize Said Insurance Company and/or Attorney's Office To Make Benefit Payments Directly To Atkinson Family Chiropractic, PC For Services Relating To My Medical Claim/File.

I Understand, As With Any Medical Examination Or Procedure, There Are Inherent Risks To Examination And Care With Chiropractic Medicine. The Doctor Has Explained These Risks To My Satisfaction. With This Understanding, I Accept These Risks. Initials: \_\_\_\_\_

Claims Past 90 Days Due Will Be Charged 1.5% Or \$5 Per Month Late Fee, Which Ever Is Greater. Claims Past 120 Days Due Can Be Sent To Collections. The Patient/Responsible Party Will Incur All Fees And Expenses Associated With This Process.

PATIENT'S SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_  
(Self/Legal Guardian)

Information Taken By: \_\_\_\_\_  
(Office Staff)



# ATKINSON FAMILY CHIROPRACTIC, P.C.

BRYAN C. ATKINSON, D.C.

2830 E. Brown Rd. Ste A-2 Mesa, AZ 85213 (480) 324-1000

Providing Quality Care For Over 15 Years!

## Patient Financial Agreement

(Equitable Lien/Benefit Assignment Contract and Indemnification Agreement)

*Please read the following very carefully as it concerns your financial responsibility to the Health Care or Service Provider from whom you are about to receive services.*

I the undersigned Patient hereby agree to establish a lien/assignment of benefits or claim in favor of Atkinson Family Chiropractic, PC by this contract and pursuant to any state statutes that apply in the state of Arizona. I give my permission for Atkinson Family Chiropractic, PC and/or their agent, to file, record and serve notice of this agreement (lien/assignment) upon myself and all other parties who may be liable to me for damages arising from the accident which occurred on (mm/dd/yy) \_\_\_\_\_ and any subsequent claims arising from this accident for which I am about to receive health care. I understand that by doing so, I have entered into a contract with the above named health care or service provider. **This agreement authorizes direct payment to said provider from any and all proceeds from any insurance policy,** settlement, compromise, judgment verdict or damages to which I may be entitled and paid in connection with the settlement of claims or litigation arising from this accident, in sums necessary to fully compensate the health care or service provider from whom I have received care. The lien/assignment created by this Equitable Lien Contract and Indemnification Agreement shall have priority from the time and date on which said documents are actually filed, or recorded or served on the liable parties, over any subsequent liens or assignments of my interests in claims arising from this accident.

In exchange for providing necessary medical care without requiring payment in full at the time service is received, I agree to be responsible for all charges associated with my care, regardless of the insurance companies' reimbursement, settlement or compromise. Charges for which I agree to be responsible include any administrative expenses associated with processing my claim such as charges incurred by the provider for recording and or serving notice of this lien/assignment upon any liable parties and their insurance companies. Also included are any collection charges or legal cost and fees incurred by the provider while attempting to collect the medical bills related to this claim should such activity become necessary.

Should my health insurance not allow balance billing, I agree to forego submission to my health insurance, and allow my attorney to pay Atkinson Family Chiropractic, PC all medical expenses out of my settlement proceeds. If Atkinson Family Chiropractic, PC elects to bill an indemnification health insurance plan, I will not, nor will my attorney assert a claim for a pro rata of attorney fees for collection of settlement funds. I nor will my attorney make a claim for a reduction of my medical expenses to Atkinson Family Chiropractic, PC under Samaritan v LaBombard or the Common Fund doctrine.

\_\_\_\_\_  
Initial

I further understand that as a part of the process of recording a lien/assignment, I will receive certified mail with a copy of the lien/assignment enclosed and that this copy is for my own records and does not require any response on my part.

\_\_\_\_\_  
Patient's Signature. If legal guardian, please indicate.

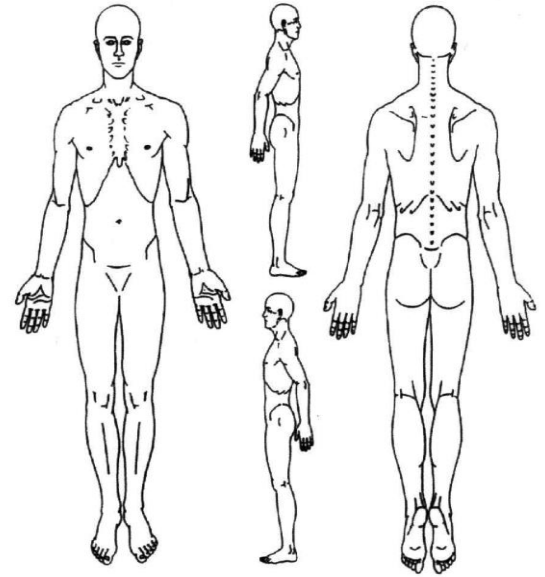
\_\_\_\_\_  
Date

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

**Please list your symptoms below and the relative pain intensity (0 – 10) for each symptom. (Example: Low back pain – 4)**

	No Pain	Mild	Moderate	Severe	Unbearable
1) _____	0	1 2	3 4 5	6 7	8 9 10
2) _____	0	1 2	3 4 5	6 7	8 9 10
3) _____	0	1 2	3 4 5	6 7	8 9 10
4) _____	0	1 2	3 4 5	6 7	8 9 10
5) _____	0	1 2	3 4 5	6 7	8 9 10
6) _____	0	1 2	3 4 5	6 7	8 9 10
7) _____	0	1 2	3 4 5	6 7	8 9 10
8) _____	0	1 2	3 4 5	6 7	8 9 10

**Please mark on the diagram to the right with the following symbols as they relate to your symptoms location and description:**  
 SS = spasms      ST = stiffness      DP = dull pain      SP = sharp pain  
 SH = shooting pain      TI = tingling      NU = numbness      O = Other



Over all, has this been getting \_\_\_worse? \_\_\_better? \_\_\_staying the same?

How has this affected your life?

Home: \_\_\_\_\_

Occupation: \_\_\_\_\_

Recreation: \_\_\_\_\_

Rest and Sleep: \_\_\_\_\_

Duties Under Duress: What activities are you required to perform that cause pain or discomfort that under normal circumstances would not be a problem? \_\_\_\_\_

Loss Of Enjoyment: What activities have you missed or postponed due to pain or discomfort that under normal circumstances would not be a problem? \_\_\_\_\_

Have you ever received treatment for this condition before? \_\_\_Yes \_\_\_No  
 If yes, When, Where, and What were your results? \_\_\_\_\_

Doctors you have consulted with in the past for this problem:

Name: \_\_\_\_\_ Ph. (\_\_\_\_) \_\_\_\_\_

Name: \_\_\_\_\_ Ph. (\_\_\_\_) \_\_\_\_\_

Do you have a family Dr.? Name: \_\_\_\_\_ Ph. (\_\_\_\_) \_\_\_\_\_

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

Have you had any surgeries? \_\_\_\_\_

Are you currently taking medication? Heart, Birth Control, Diabetes, Pain, Anti-Inflammatory....?

Name of Rx: \_\_\_\_\_ For condition: \_\_\_\_\_

Name of Rx: \_\_\_\_\_ For condition: \_\_\_\_\_

Name of Rx: \_\_\_\_\_ For condition: \_\_\_\_\_

Name of Rx: \_\_\_\_\_ For condition: \_\_\_\_\_

Have you ever been involved in any other motor vehicle or personal injury accidents? **Y N**

When? 1) \_\_\_\_\_ Hit from: Front/Back, Right side/Left side? Any injuries? \_\_\_\_\_

2) \_\_\_\_\_ Hit from: Front/Back Right side/Left side? Any injuries? \_\_\_\_\_

3) \_\_\_\_\_ Hit from: Front/Back Right side/Left side? Any injuries? \_\_\_\_\_

Check any of the following symptoms you have experienced as a result of or since your injury:

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Pregnancy (Pre or Post Injury) | <input type="checkbox"/> Low Back Pain              | <input type="checkbox"/> Tension                  |
| <input type="checkbox"/> Headache                       | <input type="checkbox"/> Head Seems Heavy           | <input type="checkbox"/> Fever                    |
| <input type="checkbox"/> Muscle Spasms                  | <input type="checkbox"/> Stiff Neck                 | <input type="checkbox"/> Sleep Disturbances       |
| <input type="checkbox"/> Decreased Range of Motion      | <input type="checkbox"/> Feet Hot/Cold              | <input type="checkbox"/> Bruising Anywhere        |
| <input type="checkbox"/> Dizziness                      | <input type="checkbox"/> Hands Hot/Cold             | <input type="checkbox"/> Cuts &/or Stitches       |
| <input type="checkbox"/> Visual Disturbances            | <input type="checkbox"/> Pins/Needles in Hands/Arms | <input type="checkbox"/> Arm Pain (upper/lower)   |
| <input type="checkbox"/> Radiating Pain                 | <input type="checkbox"/> Pins/Needles in Feet/Legs  | <input type="checkbox"/> Leg Pain (upper/lower)   |
| <input type="checkbox"/> Anxiety/Depression             | <input type="checkbox"/> Numbness in Hands          | <input type="checkbox"/> Loss of Smell            |
| <input type="checkbox"/> TMJ dysfunction (Jaw)          | <input type="checkbox"/> Numbness in Feet           | <input type="checkbox"/> Loss of Taste            |
| <input type="checkbox"/> Hearing Changes                | <input type="checkbox"/> Chest Pain or Bruising     | <input type="checkbox"/> Mid Back Stiffness       |
| <input type="checkbox"/> Loss of Balance                | <input type="checkbox"/> Upset Stomach              | <input type="checkbox"/> Lower Back Stiffness     |
| <input type="checkbox"/> Neck Pain                      | <input type="checkbox"/> Constipation/Diarrhea      | <input type="checkbox"/> Mental focusing problems |
| <input type="checkbox"/> Mid Back Pain                  | <input type="checkbox"/> Fatigue                    | <input type="checkbox"/> Any Burns                |

Symptoms other than listed above? \_\_\_\_\_

What is your most comfortable position (D=Day, N=Night)?  Sitting  Standing  
 On Back  On Stomach  On Right Side  On Left Side Other: \_\_\_\_\_

- |   |   |
|---|---|
| Difficult to move around in bed? <input type="checkbox"/> Yes/ <input type="checkbox"/> No  | Knee Problems? <input type="checkbox"/> Yes/ <input type="checkbox"/> No <input type="checkbox"/> Right <input type="checkbox"/> Left |
| Difficult to Stretch or Twist? <input type="checkbox"/> Yes/ <input type="checkbox"/> No    | Cramps? <input type="checkbox"/> Yes/ <input type="checkbox"/> N Where? _____   |
| Do you feel better moving around? <input type="checkbox"/> Yes/ <input type="checkbox"/> No | Any Recent Change In <input type="checkbox"/> Bowels? <input type="checkbox"/> Bladder?   |
| Do you feel better Resting? <input type="checkbox"/> Yes/ <input type="checkbox"/> No       | and/or <input type="checkbox"/> Reproductive System(s)? None  |
| Have you tried a brace? <input type="checkbox"/> Yes/ <input type="checkbox"/> No           | Are you able to take care of your own personal  |
| Heel height change your pain? <input type="checkbox"/> Yes/ <input type="checkbox"/> No     | needs? Eating, Bathing, Dressing: <input type="checkbox"/> Yes/ <input type="checkbox"/> No   |

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Phys: \_\_\_\_\_



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### **PATIENT'S AFFIRMATION OF RECEIPT OF PATIENT'S NOTICE OF PRIVACY RIGHTS**

**I hereby acknowledge receipt of this office's Patient's Notice of Privacy Rights, provided on my behalf and in accordance with law, and have read and understand my rights to privacy and security of Personal Health Information, as a patient of this practice. This document can be reviewed online at [www.afcmesa.com](http://www.afcmesa.com), under the "New Patient Center" tab, "Online Forms" page.**

**Affirmed,**

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**Patient Name (or legal guardian)**

---

**Date**

**Personal Injury Information Review**

Patient Name: \_\_\_\_\_ Date of Injury: \_\_\_\_/\_\_\_\_/\_\_\_\_ Time: \_\_\_\_\_ am/pm

Location/Address: \_\_\_\_\_

Describe in your own words how the injury occurred: \_\_\_\_\_

\_\_\_\_\_

If a motor vehicle accident, were you the \_\_\_ Driver? \_\_\_ Passenger? \_\_\_ Pedestrian? \_\_\_ Other? \_\_\_\_\_

If passenger, were you sitting \_\_\_ Front? \_\_\_ Middle Front? \_\_\_ Right Rear? \_\_\_ Left Rear? \_\_\_ Middle Rear?

Was your vehicle struck by another? \_\_\_ Yes/No Did your vehicle strike another? \_\_\_ Yes / No / Do not remember

Was a traffic citation issued to you or the driver of your vehicle? \_\_\_ Yes/No To the other vehicle driver? \_\_\_ Yes/No

At the time of impact, were you looking : \_\_\_ Straight ahead? \_\_\_ Right? \_\_\_ Left? \_\_\_ In the Rear View Mirror?

I was looking somewhere else: \_\_\_\_\_ Were you braced for the impact? \_\_\_ Yes/No

Were your hands on the steering wheel? \_\_\_ One, \_\_\_ Both \_\_\_ Neither Were you wearing a seatbelt? \_\_\_ Lap Belt?

\_\_\_ Shoulder Belt? Did you strike anything inside the vehicle at the time of impact? \_\_\_ Yes / No / Do not remember

If so, please state what body part struck what part of the vehicle: (Chest, Head, Chin, Shoulder, Knee, Hand...), (Head Restraint, Air Bag, Steering Wheel, Dashboard, Arm Rest, Side Window, Windshield, Side of Door...): \_\_\_\_\_

Did your body shift or move during impact, if so where? \_\_\_\_\_

If you had a hat or glasses on at the time of impact, did they stay on or did you find them else where after the accident?

Immediately after the accident, how did you feel? \_\_\_\_\_

Did you loose consciousness? \_\_\_ Yes / No / Do not remember Did Paramedics Provide Care? \_\_\_ Yes/No If so, what care did they provide? \_\_\_\_\_

Did you go to the hospital? \_\_\_ Yes/No By ambulance? \_\_\_ Yes/No Personal Vehicle? \_\_\_ Yes/No Did you drive yourself, or did someone drive you? \_\_\_\_\_

Did you go immediately after accident? \_\_\_ Yes/No Next Day? \_\_\_ Yes/No Later? \_\_\_ Yes/No, Date: \_\_\_\_\_

Which hospital did you go to? \_\_\_\_\_ What exams and or care was performed? (X-Rays, Blood Work, Medications, bracing) \_\_\_\_\_

What recommendations were given before leaving the hospital? \_\_\_\_\_

Date and time of release: \_\_\_\_\_ : \_\_\_\_\_ am/pm

(continued next page)

Patient Name: \_\_\_\_\_ Date of Injury: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Have you seen any other physician for this injury? \_\_\_ Yes/No If so whom? \_\_\_\_\_

What exams and or care was performed? \_\_\_\_\_

Did they give you any recommendations? \_\_\_ Yes/No If so, What were they? \_\_\_\_\_

Please list your injuries, related to this accident, as you understand them? \_\_\_\_\_

Have you lost time at work/school as a result of this injury? \_\_\_ Yes/No If so please give dates of time lost:

From: \_\_\_\_\_ to \_\_\_\_\_

Totally Disabled from: \_\_\_\_\_ to \_\_\_\_\_

Partially disabled from: \_\_\_\_\_ to \_\_\_\_\_

**Your Vehicle Information:**

Vehicle information: Make: \_\_\_\_\_ Model: \_\_\_\_\_ Year: \_\_\_\_\_

Please list your auto insurance company and name of agent: \_\_\_\_\_

Contact phone number: (\_\_\_\_) \_\_\_\_ - \_\_\_\_ Name of the insured listed for your vehicle: \_\_\_\_\_

Policy #: \_\_\_\_\_ Claim ID # for this injury: \_\_\_\_\_

Do you have Med Pay Coverage with this policy? \_\_\_ Yes/No Uninsured / Underinsured Coverage? \_\_\_ Yes/No

Do you have other insurance coverage that may help you cover your medical expenses? \_\_\_ Yes/No If so please provide the following: Insurance Company: \_\_\_\_\_ Provider Contact Phone #: (\_\_\_\_) \_\_\_\_ - \_\_\_\_

Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_ Primary Policy Holder: \_\_\_\_\_

**Other Vehicle Information:**

Vehicle information: Make: \_\_\_\_\_ Model: \_\_\_\_\_ Year: \_\_\_\_\_

Please list their auto insurance company and name of agent: \_\_\_\_\_

Contact phone number: (\_\_\_\_) \_\_\_\_ - \_\_\_\_ Ext: \_\_\_\_

Name of the insured listed for their vehicle: \_\_\_\_\_ Policy #: \_\_\_\_\_

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

Have you retain legal counsel for this injury? \_\_\_ Yes/No If so, please provide their name and contact information:

The above information is accurate and correct to the best of my knowledge. I authorize Atkinson Family Chiropractic, PC and its agent(s) to discuss information regarding this injury to the above named legal counsel or agents of my personal insurance company if no legal counsel has been retain.

\_\_\_\_\_  
(Patient Signature)

\_\_\_\_\_  
(Date)