CAD Injury History Form

CHAMPION HEALTH

GENERAL INFORMATION

Name: _____ Appointment Date: _____

Address: _____
Street City State Zip Code

Check appropriate boxes: ☐ Female ☐ Male ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Date of Birth: _____ Height: _____ Weight: _____ ☐ Left-Handed ☐ Right-Handed

Home / Cell Phone: _____ Work Phone: _____

☐ Okay to leave message with detailed information
☐ Leave message with call-back number only

☐ Okay to leave message with detailed information
☐ Leave message with call-back number only

Employer: _____ Occupation: _____

Employer Address: _____
Street City State Zip Code

Email Address: _____ Who may we thank for referring you? _____

Number of Children: ___ Emergency Contact Name: _____ Phone: _____

INSURANCE INFORMATION

Auto Insurance Company: _____ Phone: _____

Address: _____
Street or PO Box City State Zip Code

Claim Number: _____ Group/Policy Number: _____

Name of Insured: _____ Name of Adjuster: _____

Relationship to Patient: _____ Phone Number of Adjuster: _____

Address of Insured: _____ Phone: _____
City State Zip Code

Name of Attorney: _____ Phone: _____

Habits

Smoke: ☐ None ☐ Packs/Day ☐ Years

Alcohol: ☐ Never ☐ Social ☐ Light ☐ Moderate ☐ Heavy

Employment

At time of crash: _____
☐ Unemployed

Currently: _____
☐ Unemployed

If unemployed, due to crash? ☐ Yes ☐ No

Type of work: ☐ Office/Clerical ☐ Light Labor ☐ Moderate Labor ☐ Heavy Labor

Medical History

Surgeries *(dates and residuals):* _____

Fractures *(dates and residuals):* _____

Serious Illness *(dates and residuals):* _____

W/C Injuries *(dates, treatment, awards, residuals):* _____

Personal Injuries *(dates, treatment, awards, residuals):* _____

CHAMPION HEALTH

Medical History *(continued)*

1) **Date of injury:** _____
2) **State where accident occurred:** _____
3) **Automobile accident?** *(please circle)* Yes No

Sports or other injuries *(head, neck, or back):* _____

Any prior history of current complaints?

1) _____
2) _____
3) _____

Any prior treatment by chiropractic for these?

1) _____
2) _____
3) _____

Current Medical History

Current health problems: ☐ None

Current medications taken: ☐ None

Injury History General

Was the crash on the job? *(please circle)* Yes No

You were: ☐ Driver ☐ Front seat passenger ☐ Passenger ☐ Rear seat passenger Motorcycle ☐ Motorcycle rider/passenger Other: _____

Vehicle driven by: _____

Your vehicle *(year, make, model):* _____

Your estimated speed at moment of crash:

☐ Stopped ☐ Slowing ☐ Accelerating

Other vehicle *(year, make, model):* _____

Time of day: ☐ Dawn ☐ Daylight ☐ Dusk ☐ Dark

Road conditions: ☐ Dry ☐ Damp ☐ Wet ☐ Snow ☐ Ice ☐ Other _____

Head restraint: ☐ None ☐ Integral type
Adjustable type: ☐ Up ☐ Down ☐ Don't know

If adjustable, was the position altered by the crash? ☐ Yes ☐ No

Was the seat broken? ☐ Yes ☐ No

Wearing lap belt? ☐ Yes ☐ No

Wearing shoulder belt? ☐ Yes ☐ No

Did the airbag deploy? ☐ Yes ☐ No

If yes, were you struck? ☐ Yes ☐ No

Body position: ☐ Good ☐ Forward lean ☐ Other _____

Head position: _____

Hands position: ☐ One on wheel ☐ Two on wheel ☐ N/A

Were brakes applied? ☐ Yes ☐ No

Injury History General *(continued)*

Crash description: _____

Crash Diagram

Aware of impending crash? ☐ Yes ☐ No

During the Crash

Did you strike any parts of the vehicle? ☐ Yes ☐ No

If yes, describe: _____

Did the vehicle strike any other objects after the crash? ☐ Yes ☐ No

If yes, describe: _____

Wearing hat or glasses? ☐ Yes ☐ No

If yes, still on after crash? ☐ Yes ☐ No

Did you lose consciousness? ☐ Yes ☐ No

If yes, for how long? ☐ Yes ☐ No

Estimated property damage to your vehicle:

$ _____

Estimated damage to your vehicle:

$ _____

Estimated damage to other vehicle(s):

☐ None ☐ Minimal ☐ Moderate ☐ Major

Were police on-scene? ☐ Yes ☐ No

If yes, was a report made? ☐ Yes ☐ No

Name: _____

Date of Birth: _____

Today's Date: _____

CHAMPION HEALTH

After the Crash

Symptoms: ☐ Headache ☐ Dizziness
☐ Nausea ☐ Confusion/Disorientation
☐ Neck Pain ☐ Paresthesia(s)

If yes, where? _____

☐ Extremity pain

If yes, where? _____

☐ Back pain

When did symptons first appear? ☐ Immediately
(describe which symptoms) _____Hour(s) afterward

Where did you go after the crash?

☐ Home ☐ Work ☐ Hospital

Mode of transportation: _____

Private doctor:_____

Emergency Department

Radiographs? ☐ Yes ☐ No

Body part imaged: _____

Results: _____

Lab work? ☐ Yes ☐ No
☐ Ice ☐ Cervical collar

Medications: _____

Other: _____

Follow-up instructions: ☐ None

Treatment History

1) Doctor: _____
Speciality:_____ Date first seen:_____
Referred by:_____ Treatment type:_____
Treatment frequency: _____ Treatment duration: _____
Currently treating? ☐ Yes ☐ No
Any disability? ☐ Yes ☐ No
If yes, describe: _____
Special tests: _____
Referred to: _____
Did treatment help? ☐ Yes ☐ No
Notes: _____

2) Doctor: _____
Speciality:_____ Date first seen:_____
Referred by:_____ Treatment type:_____
Treatment frequency: _____ Treatment duration: _____
Currently treating? ☐ Yes ☐ No
Any disability? ☐ Yes ☐ No
If yes, describe: _____
Special tests: _____
Referred to: _____
Did treatment help? ☐ Yes ☐ No
Notes: _____

3) Doctor: _____
Speciality:_____ Date first seen:_____
Referred by:_____ Treatment type:_____
Treatment frequency: _____ Treatment duration: _____
Currently treating? ☐ Yes ☐ No
Any disability? ☐ Yes ☐ No
If yes, describe: _____
Special tests: _____
Referred to: _____
Did treatment help? ☐ Yes ☐ No
Notes: _____

4) Doctor: _____
Speciality:_____ Date first seen:_____
Referred by:_____ Treatment type:_____
Treatment frequency: _____ Treatment duration: _____
Currently treating? ☐ Yes ☐ No
Any disability? ☐ Yes ☐ No
If yes, describe: _____
Special tests: _____
Referred to: _____
Did treatment help? ☐ Yes ☐ No
Notes: _____

5) Doctor: _____
Speciality:_____ Date first seen:_____
Referred by:_____ Treatment type:_____
Treatment frequency: _____ Treatment duration: _____
Currently treating? ☐ Yes ☐ No
Any disability? ☐ Yes ☐ No
If yes, describe: _____
Special tests: _____
Referred to: _____
Did treatment help? ☐ Yes ☐ No
Notes: _____

6) Doctor: _____
Speciality:_____ Date first seen:_____
Referred by:_____ Treatment type:_____
Treatment frequency: _____ Treatment duration: _____
Currently treating? ☐ Yes ☐ No
Any disability? ☐ Yes ☐ No
If yes, describe: _____
Special tests: _____
Referred to: _____
Did treatment help? ☐ Yes ☐ No
Notes: _____

Name: _____

Date of Birth:_____

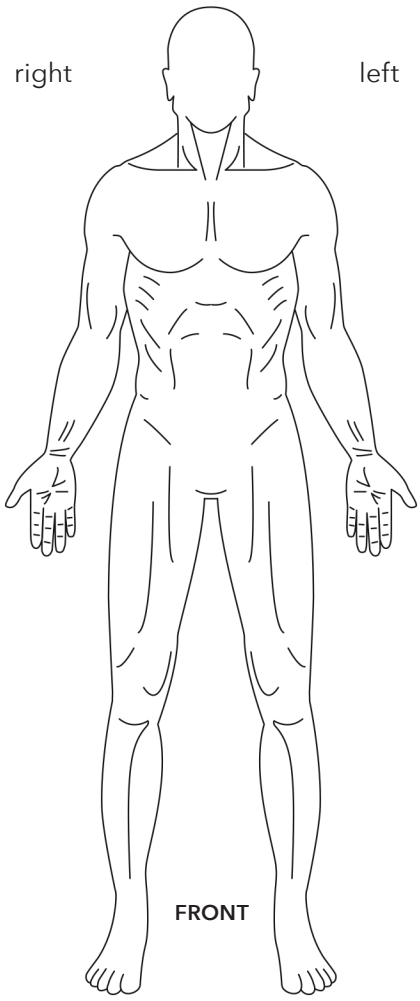
Today's Date:_____

Pain Diagram

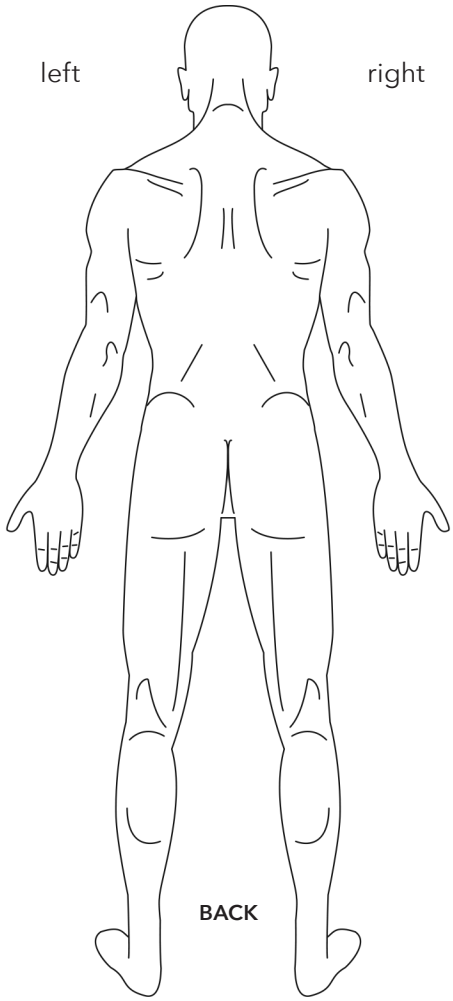
CHAMPION HEALTH

Patient Name:_____ Date of Birth:_____ Today's Date: _____

Please be sure to fill out the diagram below extremely accurately. Mark the area on your body where you feel the described sensation(s). Use the appropriate symbol(s), mark areas of radiating pain, and include all affected areas. You may draw in the face as well.



KEY	
Numbness	-----
Pins and Needles	OOOOO
Burning Pain	XXXXXX
Stabbing Pain	/////
Aching Pain	(((((



Visual Analogue Scale

Please mark on the lines below the level that most accurately represents your pain:

Right Now:	0 1 2 3 4 5 6 7 8 9 10 *No pain* *Unbearable pain*	At Best:	0 1 2 3 4 5 6 7 8 9 10 *No pain* *Unbearable pain*
Average Pain:	0 1 2 3 4 5 6 7 8 9 10 *No pain* *Unbearable pain*	At Worst:	0 1 2 3 4 5 6 7 8 9 10 *No pain* *Unbearable pain*

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Whiplash Disability Questionnaire

Patient Name:_____ Date of Birth:_____ Today's Date: _____

Please read instructions: This questionnaire provides information on the impact that your whiplash injury and symptoms have upon your lifestyle. Please circle **one** number in each section to indicate how you have been affected by the whiplash injury and symptoms. If one or more questions are not relevant to you, please leave that section blank.

1) How much pain do you have today?	0 1 2 3 4 5 6 7 8 9 10 *No pain* — *Worst pain imaginable*
2) How much do your whiplash symptoms interfere with your personal care *(washing, dressing, etc)?*	0 1 2 3 4 5 6 7 8 9 10 *Not at all* — *Unable to perform*
3) How much do your whiplash symptoms interfere with your work/home/study duties?	0 1 2 3 4 5 6 7 8 9 10 *Not at all* — *Unable to perform*
4) How much do your whiplash symptoms interfere with driving or using public transport?	0 1 2 3 4 5 6 7 8 9 10 *Not at all* — *Unable to travel in car/use public transport*
5) How much do your whiplash symptoms interfere with sleep?	0 1 2 3 4 5 6 7 8 9 10 *Not at all* — *Cannot sleep*
6) How tired/fatigued do you feel as a result of your whiplash injury/symptoms?	0 1 2 3 4 5 6 7 8 9 10 *Not at all* — *Extreme tiredness/fatigue all the time*
7) How much do your whiplash symptoms interfere with social activity?	0 1 2 3 4 5 6 7 8 9 10 *Not at all* — *Unable to socialize*
8) How much do your whiplash symptoms interfere with sporting activity?	0 1 2 3 4 5 6 7 8 9 10 *Not at all* — *Unable to participate*
9) How much do your whiplash symptoms interfere with non-sporting leisure activities?	0 1 2 3 4 5 6 7 8 9 10 *Not at all* — *Unable to participate*
10) How much sadness/depression do you experience as a result of your whiplash injury/symptoms?	0 1 2 3 4 5 6 7 8 9 10 *Not at all* — *Extreme sadness/depression*
11) How much anger do you experience as a result of your whiplash injury/symptoms?	0 1 2 3 4 5 6 7 8 9 10 *Not at all* — *Extreme anger*
12) How much anxiety do you experience as a result of your whiplash injury/symptoms?	0 1 2 3 4 5 6 7 8 9 10 *Not at all* — *Extreme anxiety*
13) How much difficulty do you have concentrating as a result of your whiplash injury/symptoms?	0 1 2 3 4 5 6 7 8 9 10 *Not at all* — *Unable to concentrate*

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Neck Disability Index

CHAMPION HEALTH

Patient Name:_____ Date of Birth:_____ Today's Date: _____

Please read instructions: This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage everyday life. Please answer every section and mark in each section only the **one** box that applies to you. We realize that you may consider that two of the statements in any one section relate to you, but please just mark the box that most closely describes your problems.

SECTION 1: Pain Intensity

- ☐ I have no pain at the moment.
- ☐ The pain is very mild at the moment.
- ☐ The pain is moderate at the moment.
- ☐ The pain is fairly severe at the moment.
- ☐ The pain is very severe at the moment.
- ☐ The pain is the worst imaginable at the moment.

SECTION 2: Personal Care

- ☐ I can look after myself normally, without causing extra pain.
- ☐ I can look after myself normally, but it causes extra pain.
- ☐ It is painful to look after myself and I am slow and careful.
- ☐ I need some help but manage most of my personal care.
- ☐ I need help every day in most aspects of self care.
- ☐ I do not get dressed; I wash with difficulty and stay in bed.

SECTION 3: Lifting

- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights, but it causes extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can lift very light weights.
- ☐ I cannot lift or carry anything at all.

SECTION 4: Reading

- ☐ I can read as much as I want to with no pain in my neck.
- ☐ I can read as much as I want to with slight pain in my neck.
- ☐ I can read as much as I want to with moderate pain in my neck.
- ☐ I can't read as much as I want because of moderate pain in my neck.
- ☐ I can hardly read at all because of severe pain in my neck.
- ☐ I cannot read at all because of severe pain in my neck.

SECTION 5: Headaches

- ☐ I have no headaches at all.
- ☐ I have slight headaches that come infrequently.
- ☐ I have moderate headaches that come infrequently.
- ☐ I have moderate headaches that come frequently.
- ☐ I have severe headaches that come frequently.
- ☐ I have headaches almost all the time.

SECTION 6: Concentration

- ☐ I can concentrate fully when I want to, with no difficulty.
- ☐ I can concentrate fully when I want to, with slight difficulty.
- ☐ I have a fair degree of difficulty in concentrating when I want to.
- ☐ I have a lot of difficulty in concentrating when I want to.
- ☐ I have a great deal of difficulty in concentrating when I want to.
- ☐ I cannot concentrate at all.

SECTION 7: Work

- ☐ I can do as much work as I want to.
- ☐ I can do my usual work, but no more.
- ☐ I can do most of my usual work, but no more.
- ☐ I cannot do my usual work.
- ☐ I can hardly do any work at all.
- ☐ I can't do any work at all.

SECTION 8: Driving

- ☐ I can drive my car without any neck pain.
- ☐ I can drive my car as long as I want with slight pain in my neck.
- ☐ I can drive my car as long as I want with moderate pain in my neck.
- ☐ I can't drive my car as long as I want because of moderate pain in my neck.
- ☐ I can hardly drive at all because of severe pain in my neck.
- ☐ I can't drive my car at all because of severe pain in my neck.

SECTION 9: Sleeping

- ☐ I have no trouble sleeping.
- ☐ My sleep is slightly disturbed *(less than 1 hour sleepless).*
- ☐ My sleep is mildly disturbed *(1-2 hours sleepless).*
- ☐ My sleep is moderately disturbed *(2-3 hours sleepless).*
- ☐ My sleep is greatly disturbed *(3-5 hours sleepless).*
- ☐ My sleep is completely disturbed *(5-7 hours sleepless).*

SECTION 10: Recreation

- ☐ I am able to engage in all my recreation activities with no neck pain at all.
- ☐ I am able to engage in all my recreation activities with some neck pain.
- ☐ I am able to engage in most, but not all, of my recreation activities because of my neck pain.
- ☐ I am able to engage in a few of my recreation activities because of my neck pain.
- ☐ I can hardly do any recreation activities because of my neck pain.
- ☐ I can't do any recreation activities at all because of my neck pain.

Headache Disability Index

Patient Name:_____ Date of Birth:_____ Today's Date: _____

Instructions: Please **circle** the correct response.

I have headaches:
- [1] **1** per month
- [2] more than **1** per month but less than **4** per month
- [3] more than **1** per week

My headache is:
- [1] mild
- [2] moderate
- [3] severe

The purpose of the scale is to identify difficulties that you may be experiencing because of your headache. Please check the box for **YES**, **SOMETIMES**, or **NO** pertaining to each item.

	YES	SOMETIMES	NO
Because of my headaches I feel handicapped.	☐	☐	☐
Because of my headaches I feel restricted in performing my routine daily activities.	☐	☐	☐
No one understands the effect my headaches have on my life.	☐	☐	☐
I restrict my recreational activities (e.g. sports, hobbies) because of my headaches.	☐	☐	☐
My headaches make me angry.	☐	☐	☐
Sometimes I feel that I am going to lose control because of my headaches.	☐	☐	☐
Because of my headaches I am less likely to socialize.	☐	☐	☐
My spouse/significant other or family and friends have no idea what I am going through because of my headaches.	☐	☐	☐
My headaches are so bad that I feel I am going to go insane.	☐	☐	☐
My outlook on the world is affected by my headaches.	☐	☐	☐
I am afraid to go outside when I feel a headache is starting.	☐	☐	☐
I feel desperate because of my headaches.	☐	☐	☐
I am concerned that I am paying penalties at work or at home because of my headaches.	☐	☐	☐
My headaches place stress on my relationships with family or friends.	☐	☐	☐
I avoid being around people when I have a headache.	☐	☐	☐
I believe my headaches are making it difficult for me to achieve my goals in life.	☐	☐	☐
I am unable to think clearly because of my headaches.	☐	☐	☐
I get tense (e.g. muscle tension) because of my headaches.	☐	☐	☐
I do not enjoy social gatherings because of my headaches.	☐	☐	☐
I feel irritable because of my headaches.	☐	☐	☐
I avoid traveling because of my headaches.	☐	☐	☐
My headaches make me feel confused.	☐	☐	☐
My headaches make me feel frustrated.	☐	☐	☐
I find it difficult to read because of my headaches.	☐	☐	☐
I find it difficult to focus my attention away from my headaches and on other things.	☐	☐	☐

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Revised Oswestry Disability Index for Low Back Pain/Dysfunction

CHAMPION HEALTH

Patient Name:_____ Date of Birth:_____ Today's Date: _____

Please read instructions: This questionnaire has been designed to give the doctor information as to how your low back pain has affected your ability to manage everyday life. Please answer every section and mark in each section only the **one** box that applies to you. We realize that you may consider that two of the statements in any one section relate to you, but please just mark the box that most closely describes your problems.

SECTION 1: Pain Intensity

- ☐ The pain comes and goes and is very mild.
- ☐ The pain is mild and does not vary much.
- ☐ The pain comes and goes and is moderate.
- ☐ The pain is moderate and does not vary much.
- ☐ The pain comes and goes and is very severe.
- ☐ The pain is severe and does not vary much.

SECTION 2: Personal Care

- ☐ I do not have to change my way of washing or dressing in order to avoid pain.
- ☐ I do not normally change my way of washing or dressing even though it causes some pain.
- ☐ Washing and dressing increases the pain, but I manage not to change my way of doing it.
- ☐ Washing and dressing increases the pain, and I find it necessary to change my way of doing it.
- ☐ Because of the pain, I am unable to do some washing and dressing without help.
- ☐ Because of the pain, I am unable to do any washing and dressing without help.

SECTION 3: Lifting

- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights, but it causes extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I manage if they are conveniently positioned.
- ☐ Pain prevents me from lifting heavy weights off the floor.
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can only lift very light weights at the most.

SECTION: 4 Walking

- ☐ I have no pain while walking.
- ☐ I have some pain while walking but it does not increase with distance.
- ☐ I cannot walk more than one mile without increasing pain.
- ☐ I cannot walk more than ½ mile without increasing pain.
- ☐ I cannot walk more than ¼ mile without increasing pain.
- ☐ I cannot walk at all without increasing pain.

SECTION 5: Sitting

- ☐ I can sit in any chair as long as I like.
- ☐ I can only sit in my favorite chair as long as I like.
- ☐ Pain prevents me from sitting more than one hour.
- ☐ Pain prevents me from sitting more than ½ hour.
- ☐ Pain prevents me from sitting more than 10 minutes.
- ☐ I avoid sitting because it increases pain right away.

SECTION 6: Standing

- ☐ I can stand as long as I want without pain.
- ☐ I have some pain while standing, but it does not increase with time.
- ☐ I cannot stand for longer than one hour without increasing pain.
- ☐ I cannot stand for longer than ½ hour without increasing pain.
- ☐ I cannot stand for longer than 10 minutes without increasing pain.
- ☐ I avoid standing because it increases the pain right away.

SECTION 7: Sleeping

- ☐ I get no pain in bed.
- ☐ I get pain in bed, but it does not prevent me from sleeping well.
- ☐ Because of pain, my normal night's sleep is reduced by less than 1/4.
- ☐ Because of pain, my normal night's sleep is reduced by less than ½.
- ☐ Because of pain, my normal night's sleep is reduced by less than ¾.
- ☐ Pain prevents me from sleeping at all.

SECTION 8: Social Life

- ☐ My social life is normal and gives me no pain.
- ☐ My social life is normal but increases the degree of pain.
- ☐ Pain has no significant effect on my social life and I do not go out very often.
- ☐ Pain has restricted my social life to my home.
- ☐ I have hardly any social life because of pain.

SECTION 9: Traveling

- ☐ I get no pain while traveling.
- ☐ I get some pain while traveling, but none of my usual forms of travel makes it any worse.
- ☐ I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
- ☐ I get extra pain while traveling, which compels me to seek alternative forms of travel.
- ☐ Pain restricts all forms of travel.
- ☐ Pains prevents all forms of travel except that done lying down.

SECTION 10: Changing Degree of Pain

- ☐ My pain is rapidly getting better.
- ☐ My pain fluctuates but is definitely getting better.
- ☐ My pain seems to be getting better, but improvements slow at present.
- ☐ My pain is neither getting better nor worse.
- ☐ My pain is gradually worsening.
- ☐ My pain is rapidly worsening.

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Roland-Morris Low Back Pain and Disability Questionnaire

CHAMPION HEALTH

Patient Name:_____ Date of Birth:_____ Today's Date: _____

Please read instructions: When your back hurts, you may find it difficult to do some things you normally do. Mark only the sentences that describe you **today.**

- ☐ I stay at home most of the time because of my back.
- ☐ I change position frequently to try to get my back comfortable.
- ☐ I walk more slowly than usual because of my back.
- ☐ Because of my back, I am not doing any jobs that I usually do around the house.
- ☐ Because of my back, I use a handrail to get upstairs.
- ☐ Because of my back, I lie down to rest more often.
- ☐ Because of my back, I try to get other people to do things for me.
- ☐ I get dressed more slowly than usual because of my back.
- ☐ I only stand up for short periods of time because of my back.
- ☐ Because of my back, I try not to bend or kneel down.
- ☐ I find it difficult to get out of a chair because of my back.
- ☐ My back is in pain almost all the time.
- ☐ I find it difficult to turn over in bed because of my back.
- ☐ My appetite is not very good because of my back.
- ☐ I have trouble putting on my socks (stockings) because of the pain in my back.
- ☐ I can only walk short distances because of my back.
- ☐ I sleep less well because of my back.
- ☐ Because of my back pain, I get dressed with the help of someone else.
- ☐ I sit down for most of the day because of my back.
- ☐ Because of my back pain, I am more irritable and bad tempered with people.
- ☐ Because of my back, I go upstairs more slowly than usual.
- ☐ I stay in my bed most of the time because of my back.

Financial Policy

We are doing everything possible to hold down the cost of chiropractic care. You can help a great deal by eliminating the need for us to bill you. The following is a summary of our financial policy.

All payment is expected at time of service.

Payment is required at the time services are rendered, unless other arrangements have been made in advance. This includes co-payments and deductibles. We gladly accept cash, checks, or credit cards.

We bill participating insurance companies as a courtesy to you. You are expected to pay your deductible and co-payments at the time of service. If we have not received payment from your insurance company within 45 days of the date of service, you will be expected to pay the balance in full. You are responsible for all charges.

Those insured under Personal Injury Protection *(i.e. auto accidents)* or Workers' Compensation, are required to complete specific forms pertaining to their situation.

For those patients who have insurance coverage, we will be happy to fill out and submit claims at no additional charge. If our office is filing your insurance claims, payment in full is not required on the date of service. If, however, you choose to submit your own claims, payment in full is required at the time of service.

We will verify your chiropractic insurance benefits as a courtesy, however it is not a guarantee of benefits. Those covered by general insurance are responsible for the patient portion *(i.e. deductibles, co-pays, etc.)* when services are rendered.

Insurance patients who neglect to supply our office with necessary information/forms within a reasonable amount of time will be responsible for payment in full.

I have read and understand the above stated financial policy. I agree to assign insurance benefits to the office whenever necessary. I also agree that if it become necessary to forward my account to a collection agency, in addition to the amount owed, I will be responsible for the fee charged by the collection agency for costs of collection.

Signature: _____ Date of Birth: _____ Today's Date: _____

Acknowledgement for Consent to Use and Disclosure of Protected Health Information

CHAMPION HEALTH

Use and Disclosure of Your Protected Health Information

Your Protected Health Information will be used by Champion Health Associates, LLC or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. You may review the Notice prior to signing this consent. You may request a copy of the Notice at the Front Desk.

Requesting a Restriction on the Use or Disclosure of Your Information

- *You may request a restriction on the use or disclosure of your Protected Health Information.*
- *This office may or may not agree to restrict the use or disclosure of your Protected Health Information.*
- *If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.*

Revocation of Consent

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

By my signature below I give my permission to use and disclose my health information.

Patient or Legally Authorized Individual Signature	*Date*
Print Patient's Full Name	*Time*
Witness Signature	*Date*

Notice to Auto Insurance Company of Assignment

CHAMPION HEALTH

To: **Auto Insurance**

Date: _____

_____

Patient Name: _____

_____

Date of Birth: _____

_____

Policy Number: _____

Pay: **Champion Health Associates, LLC**

Phone: _____

You are instructed to pay directly to the doctor, at the doctors office, for all professional services rendered to me. This instruction to you is an assignment of my rights under medical coverage to the extent of this bill. Any sum of money paid under this assignment shall be credited to my account, and I shall be personally liable for any unpaid balance to the doctor. Also, I am personally liable for any unpaid accounts for hospital, diagnostic, and consultant services.

In the event you should make payment directly to me, I agree that I will be personally liable for all insurance payments that were paid directly to me.

I hereby authorize the doctor listed above to furnish you the information evidence in the doctor's possession regarding my history and physical condition.

Signed: _____

Address: _____

_____

_____

Witness: _____

ASSIGNMENT, LIEN, RELEASE, AND POWER OF ATTORNEY

THIS AGREEMENT is entered into _____ (date), by and between _____ called "PATIENT" and CHAMPION HEALTH ASSOCIATES, LLC called "CHAMPION".

WHEREAS Patient desires to receive chiropractic services from CHAMPION, and desires to assign certain rights and benefits to CHAMPION as consideration to CHAMPION who is awaiting payment of such benefits.

Accordingly, it is hereby agreed:

A. Patient authorizes CHAMPION to furnish a full report and records regarding case history, examination, diagnosis, treatment and prognosis, x-rays, laboratory reports, and the results of all tests of any type or character of Patients' such persons as CHAMPION deems appropriate.

B. Patient assigns to CHAMPION any and all benefits payable by Patients' insurance or health care plan(s) as a result of charges incurred by Patient for services rendered by CHAMPION. Patient also assigns to CHAMPION any and all contractual rights Patient has against any insurance company, health company benefit plan, or any other party possibly liable to Patient for payment of healthcare costs incurred by Patient as a result of services rendered by CHAMPION.

C. Patient understands that Patient is directly and fully responsible to CHAMPION for all bills submitted for services rendered, and that this agreement is made solely for additional protection and consideration for awaiting payment. Patient further understands that such payment is not contingent on any settlement, claim, judgment, or verdict which patient may eventually recover. In the event of non-payment by any insurance company, health care benefit plan, or any other party possibly liable to patient for payment of health care costs incurred by patient as a result of services rendered by CHAMPION, Patient agrees to be responsible for any such outstanding balance, including interest at a rate of 9% per annum, reasonable attorney's fees incurred by CHAMPION in collection of any outstanding balance, and costs.

D. Patient fully understands that the lien and assignment given to CHAMPION herein is irrevocable.

E. By executing this agreement, Patient hereby instructs and directs any attorney representing Patient to honor the above lien and assignments and make payment under the lien and assignment directly to CHAMPION. Patient directs that attorney be bound by this lien and treat it, irrevocably, as an assignment due to CHAMPION. CHAMPION is relying upon this lien, and is providing care and treatment for which this lien, assignment, and directive provides security for payment. Moreover, Patient agrees that CHAMPION is to be viewed as a third party beneficiary of this direction to Patients' attorney, and it is Patients' intent to impose upon Patients' attorney an obligation to comply with the terms of this directive.

F. Patient hereby directs all insurers and other persons possibly responsible for Patients' healthcare costs to make all payments for healthcare services rendered by CHAMPION directly to CHAMPION.

G. Patient agrees that in the event Patient receives any check, draft, or other payment subject to this agreement, Patient agrees to act as fiduciary agent for CHAMPION and will immediately deliver said check, draft or payment to CHAMPION to be applied to Patients' debt for services rendered.

H. Patient hereby appoints CHAMPION as Patient's true and lawful attorney, irrevocable and with full power of substitution, for Patient and in Patients' name to ask, demand, sue for, collect, endorse, sign, and receive proceeds from insurance, other health benefits, and third party claims relating to services rendered to Patient by CHAMPION. CHAMPION is not obligated or compelled to exercise such powers but may do so in CHAMPION's sole discretion. Patient agrees to fully cooperate with CHAMPION in collecting said amounts.

I. CHAMPION agrees to submit a copy of this agreement with the initial claim form(s) which CHAMPION submits to third party payor(s) as notice to the third party payor(s) of assignment and other agreements contained herein. At the time each claim is submitted, a copy of the claim will be stored for safekeeping in Patients' file and may be picked up by Patient upon reasonable request and during normal business hours, or, upon written request by patient, be mailed to address designated in writing by patient.

J. Patient hereby authorizes CHAMPION to receive a complete copy of Patients' insurance policy, including any endorsements, conditions, limitations, or exclusions.

K. A copy of this Agreement shall be as binding as the document bearing the original signatures.

L. Should any clause or part of this Agreement be deemed legally invalid or unenforceable, the rest of the Agreement shall survive and remain enforceable.

Patient's Signature *Date*

Attorney's Signature *Date*

Champion Health Associates, LLC, Representative's Signature *Date*