East Desert Inn Wellness Center

Patient Information

Last Name _____ First Name _____ Middle Initial _____

Address _____ City _____ State _____ Zip _____

Date of Birth _____/_____/_____ SS# _____-_____-_____
Email: _____
Cell Phone _____ Home Phone _____

Emergency contact? _____ Relationship: _____
Phone _____

Accident Information

Date of Accident: _____/_____/_____ Time of Accident ____ am / pm
Accident Location (streets/intersection): _____
Direction of your vehicle (ex: north, east south, west): _____
Direction of the other vehicle (ex: north, east south, west): _____

Your Vehicle: □ Car □ Van □ SUV □ Pickup Truck □ Other _____
Other Vehicle: □ Car □ Van □ SUV □ Pickup Truck □ Other _____

Where were your seated in the vehicle? □ Driver □ Front Passenger □ Rear Seat (**Left**/ **Right**/ **Middle**)

What was your vehicle doing at the time of the accident? □ Stopped at intersection □ Stopped at light □ Stopped in traffic □ Slowing Down □ Making a right turn □ Making a left turn □ Parking □ Proceeding along

Did other vehicle hit you? □ Yes □ No
If no, please explain: _____

Point of impact: □ Head-On □ Left Front □ Right Front □ Rear-End □ Left Rear □ Right Rear □ Side swiped Left side □ Side swiped Right side □ T-boned (Left / Right)

Where you wearing a seatbelt? □ Yes □ No
If Yes, did you receive any bruising from the seatbelt? □ Yes □ No

Time of day: □ Dawn □ Daylight □ Evening □ Dark

Road conditions at the time of the accident: □ Icy □ Wet □ Snow □ Clean and dry □ Other

Weather conditions were: □ Sunny □ Raining □ Snowing □ Foggy □ Windy □ Clean

Impending Collision, were you: □ Unaware □ Aware □ Surprise □ Not braced

Did your head: □ Strike Object □ Not strike Object □ Break Glass □ Other

Did you lose consciousness upon impact? □ Yes □ No
Did your experience a flash of light or explosion in your head? □ Yes □ No

Did any part of your body strike the inside of the vehicle? □ Yes □ No

Was the seat broken by the accident? □ Yes □ No

Did the airbags deploy? □ Yes □ No
If yes, did it strike you? □ Yes □ No If yes, where? _____

Which way was your head pointing at the point of impact? □ Straight □ Left □ Right

Body position? □ Straight □ Left □ Right

Where were your Hands? □ Both on the wheel □ One on the wheel □ N/A

Did the police come to the accident scene? □ Yes □ No

Is there a police report? □ Yes □ No

Did you go to the hospital? □ Yes □ No
When? □ Immediately □ ___hour/s later □___ day/s later

How did you get there? □ Drove self □ Ambulance □ Police □ Somebody else

Which Hospital? _____

What did they do for your injuries? (collar, splints, x-rays, medication etc.)
_____

What areas were x-rayed?
_____

Was any other doctor consulted after the accident? □ Yes □ No If yes, please complete information below.

Dr. _____ Specialty? _____ Date seen _____

Dr. _____ Specialty? _____ Date seen _____

Illicit/recreational drug use? □ Yes □ No

Do you smoke? □ Yes □ No If yes, how many packs per week? _____

Do you consume Alcohol? □ Yes □ No If yes, how many drinks per week? _____

Check off your symptoms after the accident:

☐ Pain in the Arm / Shoulder	☐ Pain in the Abdomen	☐ Pain in the leg
☐ Anxiety / Depression	☐ Memory loss	☐ Dizziness
☐ Back pain / stiffness	☐ Ringing in the ears	☐ Cold hands / feet
☐ Jaw problems	☐ Loss of smell	☐ Neck pain
☐ Shortness of breath	☐ Painful muscles	☐ Nausea
☐ Difficulty sleeping	☐ Loss of balance	☐ Tension
☐ Jaw problems	☐ Chest pain	☐ Irritability
☐ Upset stomach	☐ Blurred vision	☐ Headaches
☐ Numbness of the fingers	☐ Numbness in the feet	☐ Fatigue
☐ Numbness of hands		

What kind of pain are you experiencing today ?

☐ Dull Pain ☐ Burning ☐ Sharp Pain ☐ Stabbing Pain ☐ Tingling

Pain frequency:

☐ Occasional ☐ Frequent ☐ Constant ☐ Rarely ☐ Intermittent ☐ None

Rate your pain:

☐ (1) Very Mild ☐ (2) ☐ (3) ☐ (4) ☐ (5) ☐ (6) ☐ (7) ☐ (8) ☐ (9) ☐ (10) Nobly Severe

List any **important** Surgeries you have had:

1. _____ How long ago? _____
2. _____ How long ago? _____
3. _____ How long ago? _____
4. _____ How long ago? _____
5. _____ How long ago? _____

Please list any medications you are currently taking:

_____ Frequency _____ What is this for? _____
_____ Frequency _____ What is this for? _____
_____ Frequency _____ What is this for? _____
_____ Frequency _____ What is this for? _____
_____ Frequency _____ What is this for? _____

Any allergies to medications? □ Yes □ No If so, please list: _____

Any previous trauma ? (for example; previous car accidents, work accidents, slips or falls, fractures)

1. _____ Accident Date: _____
2. _____ Accident Date: _____

3. _____ Accident Date: _____
4. _____ Accident Date: _____

AUTHORIZATION TO RELEASE/RECEIVE HEALTHCARE INFORMATION

I, _____, request and authorize East Desert Inn Wellness Center to release/receive healthcare information on my behalf or on behalf of my word.

This request and authorization applies to:

_____ All healthcare information
_____ Healthcare information relating to the following treatment or condition:

☐ Motor Vehicle Accident
☐ Work Related Injury
☐ _____

Patient Signature: _____ Date: _____

Signature of Parent or Legal Guardian: _____

Relationship: _____

Please fax all records including all radiology reports to # 702-333-0602 "Attention Medical Records"

East Desert Inn Wellness Center

Confidential Patient Health Information

Patient Health Information Consent form

We want you to know how your Patient Health Information (**PHI**) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPPA NOTICE that is available to you at the front desk before signing this consent.

1. The Patient understands and agrees to allow this chiropractic office to use their Patient Health Information (**PHI**) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The Patient has the right to examine and obtain a copy of his or her own health records, at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a compliance officer has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our compliance officer about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

Patient Signature: _____Date:_____

Printed Name: _____

Consent to Treatment of a minor Child:

I hereby authorize the doctors of the East Desert Inn Wellness Center, and/or whomever they may designate as assistants, to administer treatment as deemed necessary to _____

Signature of Parent Legal Guardian: _____ Relationship: _____

Date: ____/____/____ Witness signature: _____

Informed Consent for Chiropractic Spinal Manipulation, Diagnostic X- Rays and Treatment

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of therapy modalities and diagnostic x-rays, on myself (or on the patient named below for whom I am legally responsible) by the licensed doctors of chiropractic of the East Desert Inn Wellness Center or any doctor, who now or in the future, works as a relief doctor.

I have had the opportunity to discuss with my doctor the nature and purpose of chiropractic adjustments and other procedures and understand that spinal manipulation involves the doctor placing his or her hands on my spine and delivering a quick thrust or impulse to the involved area(s). I also understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment including, but not limited to: fractures, disc injuries, strokes, dislocations, sprains, soreness, and physical therapy burns. I understand and comprehend all such risks and complications. I, by my signature below, confirm and accept care and therefore consent to and agree to those treatments deemed necessary by my doctor to be in my best interest.

I authorize payment of insurance benefits directly to the East Desert Inn Wellness Center. I understand and agree to allow this office to use my Confidential Patient Health Information forms for the purpose of treatment, payment, healthcare operations and coordination of care and authorize the East Desert Inn Wellness Center to communicate with my medical physician(s) about my condition and treatment. I understand and agree that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand and agree that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

I understand the Federal Government has deemed it mandatory to notify my doctor of any other party or insurance company who may be responsible for reimbursement for my treatment.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

I have also read, or have had read to me the above informed consent, authorization and release. I have had an opportunity to ask any and all questions about its content, and by signing below, I agree to the above-named procedures. I intend his consent from to cover the entire course of treatment for my present condition and for future condition(s) for which I seek treatment in this office.

Patient Signature: _____ Date: _____

Printed Name: _____

X-Ray Confirmation – FEMALES

Are you pregnant or any chance you may be: _____ YES _____ NO

_____At this time, to the best of my knowledge, I am not pregnant, and I consent to radiographic pictures if necessary.

_____ _____

Patient Signature Date

East Desert Inn Wellness Center

Attorney Lien

Patient Name: _____

Doctor's lien

I hereby authorize Glen S. Cochrane, D.C. to furnish you, my attorney, with the necessary reports regarding my diagnosis, treatment, prognosis and the like in regard to the accidental injuries I have suffered.

I hereby give a lien on my case to Glen S. Cochrane, D.C., against any and all proceeds of any settlement, judgment, or verdict, which may be paid to you, my attorney, or to myself as a result of the injuries for which I have been treated.

This lien shall be irrevocable until such time that any and all of my outstanding balances have been satisfied.

I hereby authorize and direct you, my attorney, to pay directly to Glen S. Cochrane D.C. such sums as may be due and owing him for professional services rendered me, both by reason off this accident and by reason of any other bills that are due his office in my behalf, and to withhold such sums from any settlement, judgment, or verdict as may be necessary to satisfy and all of my outstanding balances.

I agree that I will not rescind this document and that you, my attorney, shall not honor a rescission. I hereby instruct that in the event another attorney is substituted in this matter, the new attorney must honor this lien as inherent to the settlement and enforceable on the case as if it were executed by him. My agreement not to rescind this document is in consideration for Glen S. Cochrane D.C. rendering treatments to me while my case is being actively pursued through the process of negotiation, settlement and/or litigation.

I fully understand that I am directly and fully responsible to Glen S. Cochrane D.C. for all bills submitted by him for services rendered to me. I further understand that payment of my bills is not contingent upon settlement, judgment, verdict by which I may eventually recover said fees. I further understand and grant Glen S. Cochrane D.C. shall be entitled to all reasonable cost of collections, including, but not limited to, his attorney's fees and costs, if he should need to enforce collections of my including, but not limited to, his attorney's fee and costs, if he should need to enforce collections of my outstanding balance(s).

I expressly waive any statute of limitations regarding my doctor's right to recover.

I agree that a photocopy of this document shall be as valid as the original.

_____ _____

Patient's Signature **Date**

The undersigned, being attorney of record for the above patient, does hereby agree to observe and honor all the terms of this document and aggress to withhold such sums from any settlement, judgment, or verdict and forward payment directly to and to the order of Glen S. Cochrane D.C

_____ _____

Attorney's Signature **Date**

DOI: _____ **DOB:** _____

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