HEALTH for LIFE
SPINE & DISC CENTER

Auto Accident New Patient Intake Form

Name _____ Age _____ Birthdate _____ Sex M or F
Home Address _____
City_____ State _____ Zip _____
Cell Phone _____ Email Address: _____
Who Referred You, Or How Did You Hear About Our Office? _____
Employer _____ Occupation_____ Length of Employ _____
Marital Status: S M W D Spouses Name _____

What is your highest level of education?	High School	Some College	2 Years College	4+ Years College
How often do you use caffeine?	Never	Occasionally	Often	
How much water do you drink daily?	More than 64oz	Less than 64oz		
How often do you consume alcohol?	Never	Occasionally	Often	
How often do you smoke?	More than 1 pack daily	Less than 1 pack daily	I don't smoke	
How often do you exercise?	Never	Occasionally	Often	
How much sleep do you get nightly?	8 hours or more	Less than 8 hours		
How often do you use recreational drugs?	Never	Occasionally	Often	

Please describe in **detail** the problem you're currently having, the very first time you recall having this problem and what it felt like?

_____

_____

Where is the pain located? Does it move around or stay in one location? _____

_____

Please **Circle** the pain as being… **Sharp** **Dull Ache** **Shooting** **Numb** **Stabbing** **Tingly** **Constant** **Comes and Goes**

How Serious Do You Think This Problem Is (circle one) … **MILD** **MODERATE** **SEVERE**
List any **Serious Medical Conditions** _____
List any **Broken Bones** _____
List any **Surgeries** _____
Pharmaceutical Drugs you are taking and for what condition: _____

_____

Previous **Accidents and Injuries**: _____

_____

List other **Treatments** you have tried: _____

Do you have any family members with significant medical conditions?

_____

What is your level of interest in **Non-Surgical Spinal Decompression** as a combined treatment option (if necessary)? Yes No Possibly

What is your level of interest in **RENU Aesthetic Treatment Plans** as a combined treatment option (if necessary)? Yes No Possibly

What do you think will happen to you if you cannot find a solution to your problem? _____

_____

Describe what will be different in your life if you can get better. _____

_____

What do you hope happens as a result of spending time with the doctor today?

_____

I (signature) _____certify that the information written above is both current and accurate to my personal knowledge and experience.

6033 Fashion Point, Suite 120
South Ogden, Utah 84403
Phone (801) 475-6800
Fax (801) 475-6802

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Name _____
Date of Accident _____ Location _____
Were you the driver or the passenger Driver Passenger
Were your wearing your seatbelt? Yes No
If you were the driver, were you at fault? Yes No
Was anyone else in the car with you? Yes No If Yes, please list names: _____
Describe the accident _____
_____
Did you strike anything at the time of impact? _____
Did you go to the hospital? _____ Discharge Date _____
What treatment was given at the hospital? Medication Scans Referred to doctor Other _____
Have you seen any other doctors because of this accident? _____

Have you lost any time from work due to injuries? _____ Please give dates if so _____

AUTO INSURANCE INFORMATION
Auto Insurance _____ Claim Number _____
Name of Adjuster _____ Phone _____

ATTORNEY INFORMATION
Law Firm _____ Phone _____

FINANCIAL AGREEMENT PERSONAL INJURY

PARTY RESPONSIBILITY
If you were involved in an auto accident in your own vehicle, we will bill the medical payments portion or Personal Injury Protection portion of your automobile insurance policy to cover the treatment charges incurred in our office.

MED PAY
If you were a passenger in another vehicle, the insurance company which ensures the automobile may be billed for your medical services incurred.

3RD PARTY
If another vehicle has caused the accident, we will first bill your automobile Med Pay or PIP policy for coverage PRIOR to submitting a claim to the insurance carrier of the party at fault. If we rely solely on a 3rd party settlement for payment, please understand that the insurance carrier will pay you directly upon settlement.

ATTORNEY LIENS
If you hire an attorney to represent you in a lawsuit, it is our policy to have your attorney sign a Doctor's Lien. This will guarantee direct payment to our office for any unpaid balance upon the upon the settlement of your lawsuit. We retain the right to first submit all charges to your private and/or auto insurance policy for payment. Further, this office does not discount or reduce the amount of your balance based upon the outcome of your settlement.

RESPONSIBILITY FOR PAYMENT
As a courtesy to you, we will gladly submit your charges to your insurance company and/or your attorney; however, all services rendered by this office are charged directly to you, and, ultimately, you are personally responsible for payment of these charges regardless of any insurance reimbursement or settlement your may or may not receive.

VOLUNTARY TERMINATION OF CARE
If you suspend or terminate your care at any time, your portion of all charges for professional services is immediately due and payable to this office.

We hope this answers any questions you might have concerning the financial policy of this office. Once again, we welcome you to our office, and will be glad to answer any further questions that you might have.

Signature _____ Date _____

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ASSIGNMENT OF BENEFITS
The undersigned patient and/or responsible party, in addition to continuing personal responsibility, and in consideration of treatment rendered or to be rendered assigns to the physician and/or facility names above the following rights, power, and authority.

RELEASED INFORMATION: You are authorized to release and permit the examination or copying of any of my medical records, x-rays, laboratory reports, and the results of all tests of any type or character as needed for treatment, payment, and health care operations.

DEMAND FOR PAYMENT: To any insurance company providing benefits of any kind to me/us for treatment rendered by the physician/facility named above, you are hereby tendered demand to pay in full the bill for services rendered by the physician/facility named above following your receipt of such bill for services to the extent such bills are payable under the terms or my/our policy for benefits, less any amounts which I/we owe personally which are not payable under the terms of your policy.

LIMITED POWER OF ATTORNEY: I hereby grant to the physician and/or facility named above the power to endorse my name upon any checks, drafts, or other negotiable instrument representing payment from any insurance company representing payment for treatment and health care rendered by physician and/or facility. I agree that any insurance payment representing an amount in excess of the charges for treatment rendered will be credited to my/our account or forwarded to my/our address upon request in writing to the physician/facility named above.

Signature _____ Date _____

FINANCIAL AGREEMENT AND CONSENT TO TREAT
1. Insurance is a method of reimbursement to the patient for fees paid to the doctor and is not considered a substitute for payment. We are willing to extend credit for a period of 45 days, allowing your insurance time to pay your claim. If your insurance has not paid within this amount of time, payment in full is expected from the patient or, in the case of a minor, the responsible party.
2. All co-pays, deductible, and co-insurance amounts are DUE AT THE TIME OF SERVICE.
3. It is the responsibility of the patient or, in the case of a minor, the responsible party, to obtain any and all referrals or authorizations required by your insurance.
4. Payment in full is expected at the time of service for all cash pay accounts. Treatment plan payments may be arranged with authorization from the doctor.
5. Services covered by a third party payer (Workers Compensation, Auto Insurance, etc.,) in legal action will be suspended from the patient's liability, with the exception of a lien patient payment made at the time of each service, as long as complete and correct information is given, including a signed lien.

I hereby consent to any medical treatment rendered to me or in the case of a minor, for whom I am legally responsible (hereafter known as "the minor"), the minor, and guarantee payment of charges incurred on my or the minor's behalf regardless of insurance coverage. I know that I am responsible for payment of this account.
I hereby assign and authorize payment of all medical (chiropractic and physical therapy) to which I or the minor are entitled for these services, including major medical benefits, Medicare, Worker's Compensation, Auto, Private Insurance and all other health plans to: Health for Life 6033 Fashion Point, Suite 120, South Ogden, Utah, 84403. A photocopy of this assignment is as valid as the original. I hereby authorize said assignee to release all information necessary to secure the payment of this account.

Signature _____ Date _____

ARBITRATION AGREEMENT
By signing this contract, you are agreeing to have any issue of medical malpractice decided by neutral arbitration and you are giving up your right to a jury or court trial. See Article 1 of this contract for more details.

Article 1. Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, this is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by state and federal law, and not by a lawsuit or resort to court process except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering is, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.
A complete copy of the arbitration agreement is available upon request.

Signature _____ Date _____