PERSONAL INJURY QUESTIONNAIRE

Name _____ Phone ( ) _____

Address _____ City _____ State _____ Zip _____

Age _____ Birthdate _____ Sex _____ S/S# _____

Employer's Name _____ Employer's Address _____

Your Ins. Co. _____ Policy # _____ Agent's Name _____

Name on Policy (If other than self) _____ Policy # _____

Responsible Party's Name _____

Address _____ City _____ State _____ Zip _____

Policy Holder's Name _____ Policy # _____

ATTORNEY

Name _____ Phone ( ) _____

Address _____ City _____ State _____ Zip _____

Were there any witnesses? ( ) Yes ( ) No Name(s) _____

NATURE OF ACCIDENT:

1. Date of Accident _____ Time of Day _____
2. Were you: ( ) Driver ( ) Passenger ( ) Front Seat ( ) Back Seat
3. Number of people in your vehicle? _____ Were you wearing seat belts? _____
4. What direction were you headed? ( ) North ( ) East ( ) South ( ) West
   on (name of street) _____
5. What direction was other vehicle headed? ( ) North ( ) East ( ) South ( ) West
   on (name of street) _____
6. Were you struck from: ( ) Behind ( ) Front ( ) Left side ( ) Right side
7. Approximate speed of your car _____ mph Other car _____ mph
8. Were you knocked unconscious? ( ) Yes ( ) No If yes, for how long? _____
9. Were police notified? ( ) Yes ( ) No
10. In your own words, please describe accident: _____

    _____

    _____

    _____
11. Did you have any physical complaints BEFORE THE ACCIDENT? ( ) Yes ( ) No If yes, please describe in detail:

    _____

    _____

    _____
12. Please describe how you felt:
    a. DURING the accident: _____
    b. IMMEDIATELY AFTER the accident: _____
    c. LATER THAT DAY: _____
    d. THE NEXT DAY _____

13. What are your PRESENT complaints and symptoms? _____

_____

_____

14. Do you have any congenital (from birth) factors which relate to this problem? ( ) Yes ( ) No If yes, please descri

_____

15. Do you have any previous illnesses which relate to this case? ( ) Yes ( ) No If yes, please descri

_____

16. Have you ever been involved in an accident before? ( ) Yes ( ) No If yes, please describe, including date and type(s) of accidents, as well as injury(ies) received _____

_____

_____

17. Where were you taken after the accident? _____

18. Have you been treated by another doctor since the accident? ( ) Yes ( ) No If yes, please list doctor's na and address: _____

What type of treatment did you receive? _____

_____

19. Since this injury occurred, are your symptoms: ( ) Improving ( ) Getting Worse ( ) Same

20. CHECK SYMPTOMS YOU HAVE NOTICED SINCE ACCIDENT:

☐ Headache	☐ Irritability	☐ Numbness in Toes	☐ Face Flushed	☐ Feet Cold
☐ Neck Pain	☐ Chest Pain	☐ Shortness of Breath	☐ Buzzing in Ears	☐ Hands Cold
☐ Neck Stiff	☐ Dizziness	☐ Fatigue	☐ Loss of Balance	☐ Stomach Upset
☐ Sleeping Problems	☐ Head Seems Too Heavy	☐ Depression	☐ Fainting	☐ Constipation
☐ Back Pain	☐ Pins & Needles in Arms	☐ Lights Bother Eyes	☐ Loss of Smell	☐ Cold Sweats
☐ Nervousness	☐ Pins & Needles in Legs	☐ Loss of Memory	☐ Loss of Taste	☐ Fever
☐ Tension	☐ Numbness in Fingers	☐ Ears Ring	☐ Diarrhea	☐ _____

Symptoms Other Than Above _____

21. Have you lost time from work as a result of this accident? ( ) Yes ( ) No If yes, please complete this questi

a. Last Day Worked: _____

b. Type of Employment: _____

c. Present Salary: _____

d. Are you being compensated for time lost from work? ( ) Yes ( ) No If yes, please state type of compensa you are receiving: _____

22. Do you notice any activity restrictions as a result of this injury? ( ) Yes ( ) No If yes, please describe in det

_____

_____

_____

23. Other pertinent information: _____

_____

_____

_____

_____ _____

Date Patient's Signature

HUMBER-KIRK-UMBERGER-HOWELL CHIROPRACTIC CLINICS

PATIENT CONSENT FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I, _____, hereby state that by signing this Consent, I acknowledge and agree as follows:

1. The Practice's Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out is health care operations. The Practice explained to me that the Privacy Notice will be available to me in the future at my request. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.

2. The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.

3. I understand that, and consent to, the following appointment reminders or communications that will be used by the Practice:
   a) Any postal correspondent to me at the address provided by me; and
   b) Telephoning my home and leaving a message on my answering machine or with the individual answering the phone.
   c) It is the policy of HKUH to use electronic mail (email) to correspond and/or communicate necessary billing or personal information.

4. The Practice may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the Practice to treat me and obtain payment for that treatment, and as necessary for the Practice to conduct its specific health care operations.

5. I understand that I have a right to request that the Practice restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, the Practice is not required to agree to any restrictions that I have requested. If the Practice agrees to a requested restriction, then the restriction is binding on the Practice.

6. I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing, at any time for all future transactions, with the understanding that any such revocation shall not apply to the extent that the Practice has already taken action in reliance on this consent.

7. I understand that if I revoke this consent at any time, the Practice has the right to refuse to treat me.

8. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then the Practice will not treat me.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

_____ _____

Name of Individual (Printed) **Signature of Individual**

_____ _____

Signature of Legal Representative **Relationship**

Date Signed ____/____/____ Witness: _____

CONFIDENTIAL

AUTHORIZATION AND AGREEMENT TO PAY FEES TO
HUMBER-KIRK-UMBERGER-HOWELL CHIROPRACTIC CLINIC

820 Ebenezer Church Road
Suite 100
Sharpsburg, GA. 30277
TEL (770) 251-4345
FAX (770)251-8072

5640 Old National Hwy.
College Park, GA. 30049
TEL (404) 768-8008
FAX (404) 768-9303

I,_____ hereby authorize and direct my attorney or the responsible Insurance Company,_____, to pay promptly to Humber-Kirk-Umberger-Howell Chiropractic Clinic, from any portions of any recovery which may be paid to me through my attorney as a result of the injuries sustained on_____, the unpaid balance of charges for professional services to include those for treatment heretofore or hereafter rendered to the time of the medical reports , consultations, depositions, and court appearances on my behalf. I understand that this does not relieve me of my personal responsibility for all such charges in the event that there in no recovery or if the recovery is insufficient to satisfy such charges.

I further said, Humber-Kirk-Umberger-Howell Chiropractic Clinic to furnish said attorney or the responsible Insurance Company with any report that may request in reference to said injuries.

_____ _____ _____
Patient Signature Date Social Security Number

_____ _____
Attorney's Signature of Acceptance Date Signed

At Fault Insurance Company Information
Insurance Company: _____
Name Of Contact: _____
Telephone Number: _____
Address: _____

Humber-Kirk-Umberger-Howell Chiropractic Clinic

Insurance Authorization and Assignment

Patients Name: _____ Date: _____

Authorization to Release Information

I authorize the Doctor and their staff named below to release any information deemed appropriate concerning my physical condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred by me as a result of professional services rendered and hereby release him/her of consequence thereof. I agree that Photostatic copy of agreement shall serve as the original.

_____

Signature

Notice of Assignment

I hereby authorize and direct payment of any medical expense benefits allowable to the doctors named below as payment toward the charges for professional services rendered. This payment will not exceed my indebtedness to the assignee. I agree that a Photostatic copy of this agreement shall serve as the original.

_____

Signature

Notice of Insurance Payments

I understand that all insurance will be verified and billed directly from this office, although this is not a guarantee of payment. I also understand that if I should receive a check from my insurance company for services rendered in this office, I am to bring the check with a copy of the original explanation of benefits to our office so that my account will be accurate.

_____ _____

Signature Witness

Assignment and/or release authorization is granted to:
Humber-Kirk-Umberger-Howell Chiropractic Clinic

CONFIDENTIAL

STATEMENT OF OFFICE POLICIES

Welcome to Atlas Integrative Medicine and Spine Center. Please read and sign this policy statement below. Our staff will be happy to assist you with any questions or concerns you may have. We believe that a clear definition of our office policies will allow you, the patient, and Atlas Integrative Medicine and Spine Center to concentrate on the big issue—**REGAINING AND MAINTAINING YOUR HEALTH.**

APPOINTMENT CANCELLATION POLICY AND APPOINTMENT REMINDERS

Appointments have been scheduled for your convenience, to minimize waiting and to facilitate incorporating these appointments into your daily routine. Regardless of how many appointments are scheduled for you each week, please note that it is the frequency of visits that counts, and not the days. We attempt to honor all appointments at the scheduled time. If you are late, you may have to wait for the next available appointment. If you have any questions regarding our offiee policy or your appointments, please do not hesitate to speak to the front desk assistant. We require a notice for any canceled or re-scheduled appointment. **Failure to show for an appointment without notification will result in a $40.00 charge payable by YOU, not your insurance company.** You are expected to re-schedule missed appointment in order to comply with your prescribed treatment plan. Please keep in mind that re-scheduling an appointment is always subject to availability.

FINANCIAL RESPONSIBILITY

INSURANCE:

Charges for treatment are due at the time the service is provided or a product is ordered.

Financial responsibility for services rendered rests with the patient regardless of any insurance coverage. It must be understood that your medieal insurance is a contract between you and your insurance carrier. The benefits quoted by your insurance carrier is not a guarantee of payment and are subject to review based on the terms of you individual contract. Please note that you are responsible for knowing the limitations of your coverage. Your treatment plan is based on medical necessity as deemed appropriate by the Doctor of Chiropractic Specialists or your referring Physician. It is not our policy to enter into a dispute between you and your insurance carrier over any unpaid portion of your bill. Most insurance company's process claims within 15 days of receipt.

STATEMENTS:

It is the policy of ATLAS to mail as few statements as possible. If a patient balance (due from patient) is incurred, responsible parties are encouraged to mail the payment directly to ATLAS upon reeeiving the EOB (explanation of benefits) from their insurance company. If 30 days after the generation of the first statement it is necessary for ATLAS to mail a second statement because no payment has been received an interest charge of a flat 12% of the balance, but not less than $5.00 will be added to the account. If no payment is received within 10 business days after the mail date of the second statement, the account will be reviewed and tumed over to the collection agency. **ALL ACOUNTS TURNED OVER TO THE COLLECTION AGENCY WILL ALSO BE RESPONSIBLE FOR THE COLLECTIONS AGENCY FEES OF 40% OF THE BALANCE OWED.** ATLAS will send statements via postal service as well as via email.

COPYING FEES:

Our office will be happy to produce copies of your medical records. A coping fee will be accessed based on the number of pages and you may also be responsible for any retrieval, mailing and eertification fees. The fees are based on the State of Georgia's Office of Planning and Budget.

RETURN CHECKS

There will be a $35.00 fee imposed for all checks returned to this office. All returned check must be taken care of within 10 days of receipt. Any unpaid amount after 10 days will be referred to our collection agency unless specific payment arrangements have been made with our staff.

VOLUNTARY TERMINATION OF CARE

It is the policy of this office that if you should choose to suspend or terminate your care and treatment, any outstanding fees for professional services rendered to you will be immediately due and payable.

I, the undersigned, have read the statement of office policies listed above and I agree to abide by these policies.

Print name: _____ Date: _____

Sign name: _____

ATLAS INTEGRATIVE MEDICINE

AND SPINE CENTER

THIRD PARTY MEDICAL LIEN AND ASSIGNMENT

PATIENT: _____
CLAIM #: _____
DATE OF INJURY: _____

I hereby authorize and direct _____ Insurance Company to pay to **HUMBER-KIRK-UMBERGER-HOWELL CHIROPRACTIC CLINIC** such sums as may be due and owing for chiropractic services rendered me by reason of the accident and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect and fully compensate said doctor. And I hereby further request that payment be made directly to **HUMBER-KIRK-UMBERGER-HOWELL CHIROPRACTIC CLINIC** which would otherwise be paid to myself, as the result of the treatment charges injured for injuries in connection therewith. This is a direct assignment of my rights and benefits.

I fully understand that I am directly and fully responsible to said **HUMBER-KIRK-UMBERGER-HOWELL CHIROPRACTIC CLINIC** for all medical bill submitted by him/her for services rendered me and that this agreement is made solely for said doctor's protection and in consideration of his/her awaiting payment. And I further understand that such payments are not contingent on any settlement, judgment or verdict which I may eventually recover.

Please acknowledge your agreement to this request by signing below and returning to **HUMBER-KIRK-UMBERGER-HOWELL CHIROPRACTIC CLINIC** below. I have been advised that if you do not wish to cooperate in protecting the doctor's interest, the doctor will not await payment, but may declare the entire balance due and payable by me.

Date_____
Patient's Signature_____

The undersigned Insurance company does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment or verdict, as may be necessary to adequately protect and fully compensate said doctor above and below named and make payment payable directly to said doctor.

Date_____

Signature of Insurance Company
Representative_____

Print First and Last Name_____

Insurance Company Name_____

ATLAS INTEGRATIVE MEDICINE

AND SPINE CENTER

NOTICE OF LIEN

PATIENT: _____

DATE OF ACCIDENT: _____

I do hereby authorize_____ to furnish you and the insurance company with his/her examination, diagnosis, treatment, prognosis, etc. of myself in regard to the accident in which I was involved.

I hereby authorize and direct you and the insurance company to pay directly to **HUMBER-KIRK-UMBERGER-HOWELL CHIROPRACTIC CLINIC** such sums as may be due and owing for medical service rendered to me both by reason of this accident and by reason of any other bills that are due the doctor's office and to withhold such sums from any settlement, judgment, or verdict which may be necessary to adequately protect and fully compensate **HUMBER-KIRK-UMBERGER-HOWELL CHIROPRACTIC CLINIC.** And, I hereby further give a lien on my case to **HUMBER-KIRK-UMBERGER-HOWELL CHIROPRATIC CLINIC** against any and all proceeds of my settlement, judgment or verdict which may be paid to you, the insurance company, or myself, as a result of the injuries for which I have been treated or injuries in connection therewith. _____

I fully understand that I am fully responsible to **HUMBER-KIRK-HUMBER-HOWELL CHIROPRACTIC CLINIC** for all medical bills submitted by this office for service rendered me and that this agreement is made solely for said **HUMBER-KIRK-UMBERGER-HOWELL CHIROPRACTIC CLINIC** additional protection and in consideration of **HUMBER-KIRK-UMBERGER-HOWELL CHIROPRACTIC CLINIC awaiting** payment. And I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

_____

Please acknowledge this letter by signing below and returning it to **HUMBER-KIRK-UMBERGER-HOWELL CHIROPRACTIC CLINIC.** I have been advised that if the insurance company does not wish to cooperate in protecting **HUMBER-KIRK-UMBERGER-HOWELL CHIROPRACTIC CLINIC** interest, Humber-Kirk-Umberger-Howell Chiropractic Clinic will not await payment and will declare the entire balance due and payable. _____

DATE: _____

PATIENT: _____