Cornerstone Chiropractic Center

Confidential Patient Information

Name:_____ **Birth Date**:_____ **Gender:** ***M F***

Home Address:_____

City:_____ **State**:_____ **Zip**:_____

Circle your primary contact preference:

Home Phone:_____ **Cell Phone**:_____ **Work Phone**:_____

E-mail Address:_____ Nickname:_____

SSN:___ ___ ___ - ___ ___ - ___ ___ ___ ___ **Marital Status**: *M S W D* Number of Children:_____

Person to contact in case of an emergency:_____ **Phone**:_____

Your Occupation/Employer:_____ FULL TIME or PART TIME

Your Family Physician:_____ May We Contact? *Y N* Phone: _____

*Your Spouse/Parent:*_____ *Their SSN:*___ ___ ___ - ___ ___ - ___ ___ ___ ___

*Their Birth Date:*_____ *Address:*_____ *Phone:*_____

Whom may we thank for referring you to our office?_____ Relationship: _____

Who has your permission to receive information about your appointments, treatment, and/or billing info (usually family or significant other…)?_____

Race?

- ☐ I do not wish to provide this information.
- ☐ White
- ☐ Black or African American
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Native Hawaiian or Other Pacific Islander

Ethnicity?

- ☐ I do not wish to provide this information.
- ☐ Hispanic or Latino
- ☐ Non-Hispanic or Non-Latino

Preferred Language?

- ☐ English
- ☐ Spanish
- ☐ Other_____

Smoking Status?

- ☐ Current every day smoker _____ /day
- ☐ Current some days smoker ____ / week
- ☐ Former smoker – date quit: _____
- ☐ Never smoker

Family History? (Please list all major diseases such as cancer, diabetes, heart problems, bone/joint disorders, …)

Father:_____

Mother:_____

Sibling(s):_____

Grandparent(s):_____

Do you have any <u>MEDICATION</u> allergies?

- ☐ No known medication allergies
- ☐ Yes:_____
- ☐ Yes:_____

Are you <u>currently prescribed</u> any medications?

- ☐ Not currently prescribed any medications
- ☐ Yes.

Please provide medication name and condition it is prescribed for:

1._____ For:_____

2._____ For:_____

3._____ For:_____

4._____ For:_____

5._____ For:_____

What <u>ONE area of pain or dysfunction</u> brings you here today?_____**Left or Right**

When did it start hurting most recently?_____**What were you doing at that time?**_____

_____

Have you ever had anything like this in the past? *YES NO* If yes, when and how did that occur?_____

_____

<u>Worst pain or dysfunction level for THIS EPISODE</u>: (NONE) *0 1 2 3 4 5 6 7 8 9 10* (UNBEARABLE)
Aggravated by: (circle all that apply)
*Sitting Standing Coughing/Sneezing Walking Bending Twisting Sleeping Other:*_____

What activities of daily living is this condition affecting? _____

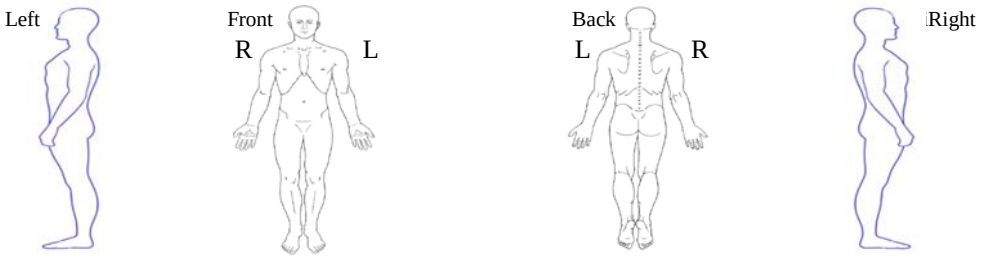
What other doctors/treatment/tests have you tried? _____

What was the outcome of the treatment or tests?_____
<u>Current pain or dysfunction level TODAY</u>: (NONE) *0 1 2 3 4 5 6 7 8 9 10* (UNBEARABLE)
Describe your pain / dysfunction: (circle all that apply)
*Achy Burning Numb Pinching Popping Sharp Sore Stabbing Stiff Throbbing Tight Tingling Other:*_____

How often do you experience symptoms? (0-100)_____**% of the time** *Radiating from*_____*to*_____

What makes it feel better? (circle all that apply) *Rest Ice Heat Medication Other:*_____

Indicate your area(s) of pain:



Any <u>additional area of pain or dysfunction</u>?_____**Left or Right**

When did it start hurting most recently?_____**What were you doing at that time?**_____

_____

Have you ever had anything like this in the past? *YES NO* If yes, when and how did that occur?_____

_____

<u>Worst pain or dysfunction level for THIS EPISODE</u>: (NONE) *0 1 2 3 4 5 6 7 8 9 10* (UNBEARABLE)
Aggravated by: (circle all that apply)
*Sitting Standing Coughing/Sneezing Walking Bending Twisting Sleeping Other:*_____

What activities of daily living is this condition affecting? _____

What other doctors/treatment/tests have you tried? _____

What was the outcome of the treatment or tests?_____
<u>Current pain or dysfunction level TODAY</u>: (NONE) *0 1 2 3 4 5 6 7 8 9 10* (UNBEARABLE)
Describe your pain / dysfunction: (circle all that apply)
*Achy Burning Numb Pinching Popping Sharp Sore Stabbing Stiff Throbbing Tight Tingling Other:*_____

How often do you experience symptoms? (0-100)_____**% of the time** *Radiating from*_____*to*_____

What makes it feel better? (circle all that apply) *Rest Ice Heat Medication Other:*_____

What types of exercise do you perform on a regular basis? _____

What do your daily work habits include? (Computer work, housework, light/heavy labor, travel, …)_____

_____

Check conditions which apply to ***your*** **Past medical history** or that you are **Currently under care** for:

P	**C**		**P**	**C**	
□	□	Arthritis:_____	□	□	High Blood Pressure
□	□	Asthma	□	□	High Cholesterol
□	□	Back Pain	□	□	HIV/AIDS
□	□	Bleeding Disorder:_____	□	□	Immune Disorder:_____
□	□	Broken Bones: _____	□	□	Menstrual Problems
□	□	Cancer:_____	□	□	Muscle Disorder:_____
□	□	Constipation and/or Diarrhea	□	□	Neck Pain
□	□	Depression	□	□	Neurological Disorder: _____
□	□	Diabetes:_____	□	□	Osteopenia or Osteoporosis
□	□	Digestive Problems	□	□	Pacemaker
□	□	Dizziness and/or Vertigo	□	□	Sinus Trouble
□	□	Epilepsy/Seizures	□	□	Sprains/Strains:_____
□	□	Headaches and/or Migraines	□	□	Stroke/TIA
□	□	Heart Problem:_____	□	□	Tinnitus
□	□	Hernia: _____	□	□	Other:_____

List any serious illnesses you have had or now have: _____

List any major accidents (auto, work, falls, …) you have had and the date each occurred: _____

_____

List all surgeries you have had and the approximate date each occurred: _____

_____

Special Diet (vegetarian, …)_____ **Alcohol:**_____/ week

Caffeine:_____/ day **Recreational Drug use:** Never Past Current

WOMEN ONLY: Taking birth control pills? *Y N* Are you pregnant? *Y N* (Due date:_____) Nursing? *Y N*

AUTHORIZATION: *I certify that all information I provide is thorough and accurate. I agree that I am responsible for full payment of all services rendered at this office to myself and/or my dependents. I understand and agree that health and accident insurance policies are an agreement between my insurance company and myself, not between my insurance company and this office. I authorize Cornerstone Chiropractic Center to release any medical information and to complete any usual and customary reports and forms to assist in collection from my insurance company and/or any third party payer. I authorize my insurance company and/or any third party payer to pay Cornerstone Chiropractic Center directly. I understand that all delinquent accounts are subject to 1.5% interest per month and may be turned over to a collection attorney. I agree to pay the additional 33⅓% attorney fee as well as all costs incurred in the recovery of my debt.*

MISSED APPOINTMENT POLICY: *It is the policy of Cornerstone Chiropractic Center to assess a $35.00 missed appointment fee to patients who either do not come to their appointment or cancel appointments with less than a 24-hour notice. One missed visit will not result in the assessment of a fee, however you will be charged for additional missed visits. We provide care for many individuals and missed visits result in time lost that could have been used to provide care for others.*

I have read, understand, and agree to the conditions of the above policies.

Patient / Guardian Signature:_____Date_____

Cornerstone Chiropractic Center

Dr. Donald P. Bresnahan

D.C., D.A.B.C.O., C.C.S.P., C.C.R.P.

Certified in Active Release Technique & Graston Technique

Patient Health Information, Treatment Consent, & Notice of Privacy Practices Acknowledgement

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 along with possible adverse effects associated with chiropractic treatment. 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 and that you understand the inherent risks associated with chiropractic treatment. 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 Notice of Privacy Practices that is available to you at the front desk before signing this consent. Additional information on the effects and effectiveness of spinal adjustments is available upon request.

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 privacy official 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 privacy official 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.
8. Chiropractic examination and therapeutic procedures (including spinal adjustment, ultrasound, heat and cold application, electrotherapy, stretches, exercises, and manual muscle therapies) are considered safe and effective methods of care. While the chances of experiencing adverse effects are small, it is our practice to inform our patients about the possibilities. Side effects include, but are not limited to, soreness, bruising, inflammation, soft tissue injury, dizziness, burns, and temporary worsening of symptoms. More serious complications are extremely rare and their association with spinal adjustment (manipulation) is debated.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures. A copy of the Notice of Privacy Practices has been made available to me. I have also read and understand the above statements regarding treatment side-effects. I also understand that there is no guarantee or warranty for a specific cure or result.

Signature of Patient Date

1917 Laskin Road, Suite 108, Virginia Beach, VA 23454 * Phone: (757) 491-4600 * Fax: (757) 491-0578

IRREVOCABLE ASSIGNMENT OF BENEFITS, AUTHORIZATION AND LIEN

To Whom It May Concern:

This Irrevocable Assignment of Benefits, Authorization and Lien (this "Assignment") is made by and between _____ ("Patient") and Donald P. Bresnahan, D.C. ("Health Care Provider"). With this Assignment, and in consideration of treatment without having to render concurrent payment, Patient, hereby irrevocably transfers sets over and assigns to Health Care Provider all insurance and/or litigation proceeds to which Patient is now or may hereafter become entitled, including those listed below, up to the total amount due and owing the Health Care Provider for services rendered to the Patient by reason of accident or illness, including interest thereon, as well as any other charges that are due or may become due the Health Care Provider, including, without limitation, requested reports, collection costs and expenses and attorney's fees, and Patient further hereby irrevocably authorizes and directs any insurance company and/or attorney to whom an original or copy of this Assignment is provided to withhold from Patient and pay directly to such Health Care Provider such amount(s) from (1) any insurance benefits payable to Patient or on Patients behalf, including, but not limited to, medical payments benefits, No Fault benefits, health and accident benefits, personal injury protection benefits, third-party liability coverage, foundation grants, governmental or agency benefits, worker's compensation benefits or any other insurance proceeds or benefits of any kind which are payable to or on behalf of the Patient, and (2) any litigation proceeds (which may include insurance proceeds) from any settlement, judgment or verdict in Patients favor as may be necessary to fully pay any and all financial obligations owed to the Health Care Provider by the Patient. This Assignment is to be a complete and current transfer of Patients right, title, and interest, separate from any statutory or contractual lien or claim to which the Health care Provider may also be entitled. Patient acknowledges that Health Care Provider has a substantial pecuniary interest in the enforcement of this Assignment.

The Patient further agrees that, in the event the insurance company and/or attorney obligated hereunder to make payments to the Health Care Provider fails or refuses to make payment for the full amount due as set forth above, this Assignment is a full, immediate and complete assignment of all the Patient's rights, title, interest, remedies and benefits in and to the assigned property to the extent of the Health Care Providers total claim amount; therefore, Patient hereby irrevocably and fully assigns and transfers to the Health Care Provider any and all causes of action that Patient might have or that might exist in Patients favor against such insurance company and/or attorney with respect to the assigned property. In addition to the foregoing assignment, Patient hereby authorizes, nominates and appoints as Patients attorney-in-fact any officer of Health Care Provider, to prosecute said causes(s) of action either in Patients name or in the Health Care Providers name and Patient further authorizes the Health Care Provider to compromise, settle or otherwise resolve said claim(s) or cause(s) of action as it sees fit.

In further consideration of the services provided by the Health Care Provider, Patient hereby grants a lien to said Health Care Provider against any and all insurance benefits and litigation proceeds outlined in the first paragraph above which may be payable to or on behalf of the Patient as a result of the injuries or illness for which Patient has been treated by said Health Care Provider. The Patient further agrees that the statute of limitations applicable to Health care Providers right to demand payment from the patient shall be tolled for all reasonable times that negotiations or litigation between third parties and the Patient are ongoing.

Patient hereby acknowledges that Virginia law imposes a lien in the amount of $750.00 upon Patients claim against the individual or entity whose negligence is alleged to have caused Patients injuries.

Notwithstanding the foregoing, the Patient agrees that until the Health Care Provider is paid in full, the Patient shall remain personally and fully responsible for and promises to pay the total amount due the Health Care Provider (including principal, interest, collection costs and attorney's fees of 35%) until fully paid. The Patient further understands and agrees that this Assignment does not constitute any agreement of or consideration for the Health Care Provider to await payments from any source, and in the event the Health Care Provider deems itself in its sole discretion insecure as to the prospect payment, it may demand payments from Patient immediately upon rendering services at its option and proceed to collect same through legal means if necessary.

Patient authorizes the Health Care Provider to release this Assignment and any information pertinent to Patients case to any insurance company, adjuster or attorney to facilitate collection under this Assignment. Patient hereby nominates and appoints any officer of the Health Care Provider as Patient's attorney-in-fact to endorse/sign Patient's name on any and all checks for payment of the services provided to Patient by said Health Care Provider.

In the event that any part or provision of this Assignment shall be determined to be invalid or unenforceable, the remaining parts and provisions of this Assignment which can be separated from the invalid, unenforceable provision shall continue in full force and effect.

AUTO ACCIDENT PATIENTS ONLY: Notice regarding the assignment of medical expense benefits is provided in a separate document. I have been presented with and had an opportunity to read the notice. Acknowledged:_____ (patient initials)

Witness the following signatures and seal as of the indicated date:

Patient	Health Care Provider
Patient's Signature_____	Cornerstone Chiropractic Center
Printed Name_____	By: Its Owner, Donald P. Bresnahan
Date_____ SS#_____	Provider's Signature_____
Witness_____	Date_____

Cornerstone Chiropractic Center
Dr. Donald P. Bresnahan
D.C., D.A.B.C.O., C.C.R.P., C.C.S.P.
Certified in Active Release and Graston Techniques

NOTICE: AUTOMOBILE ACCIDENT PATIENTS
(Addendum to Assignment of Benefits Form)

If you have been in an automobile accident, you may be entitled to payment from your automobile insurance if you have medical expense benefits coverage. By signing this assignment of benefits form, you are giving to your health care provider the right to receive some or all of the payment directly from your automobile insurance company.

If you have health insurance and your healthcare provider is in-network: As long as you provide information necessary to verify your health insurance coverage, the healthcare provider may only bill the amount you owe for any copayment, coinsurance, or deductibles to your automobile insurance and you may be entitled to any remainder of your automobile insurance benefit.

If you do not provide information necessary to verify your health insurance coverage, do not have health insurance, or your healthcare provider is not in your health insurer's provider network, your healthcare provider may bill its full charges to your automobile insurance.

You may want to consult your insurance agent or attorney before signing or initialing this form. **You are not required to sign/initial this form to receive care. However, if you do not sign this form, you will be required to (i) pay any applicable co-pays and deductibles at the time the services are provided and allow us to bill your health insurance company or (ii) pay for all care at the time of service.**

By signing below, I acknowledge that I have read or had the opportunity to read this notice.

Patient Signature:_____Date:_____

1917 Laskin Road, Suite 108, Virginia Beach, VA 23454 * Phone: (757)491-4600 * Fax: (757)491-0578
DrDon@CornerstoneChiropracticCenter.com * www.CornerstoneChiropracticCenter.com

Cornerstone Chiropractic Center

Automobile Accident Questionnaire

Name:_____ Date of Accident: _____ Time of Accident:_____

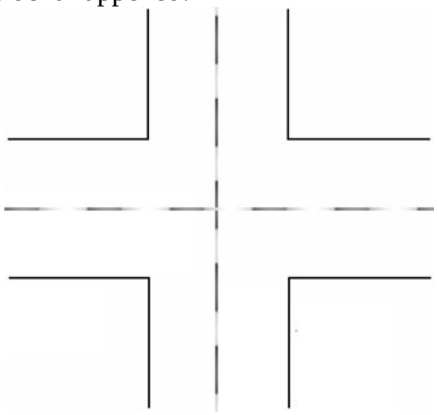
Were you wearing a seat belt? □ Yes □ No Year and Model of car:_____

Driver of car you were in: _____ Where you were seated:_____

Visibility at time of accident:_____ Road conditions at time of accident: _____

What road were you traveling on?_____

Indicate on the diagram below how the accident happened:



Describe the accident **in detail**: _____

_____

_____

_____

What Year and Model of vehicle did the other driver have?_____

Where was your car struck? _____ Was this a: □ Head-on collision □ Broad-side collision
□ Rear-end collision □ Front impact, rear-ended car in front □ Other: _____

What part of the car was damaged? _____ Estimated repair $:_____

At the time of the accident, was your car: □ Fully stopped □ Braking hard □ Slowing □ Changing lanes
□ Accelerating □ Driving at a steady rate □ Other:_____ Your estimated speed?_____

At the time of the accident was the other car: □ Fully stopped □ Braking hard □ Slowing □ Changing lanes
□ Accelerating □ Driving at a steady rate Other:_____ Their estimated speed? _____

What was the position of your head & body at the time of impact? □ Head turned left/right □ Head straight forward
□ Head looking back □ Body straight in sitting position Body rotated left/right Other:_____

Did you see the accident was about to happen? □ Yes □ No Did you brace for impact? □ Yes □ No

Did any air bags deploy?_____

Did any part of your body hit the inside of your vehicle? □ Yes □ No If so, what and where? _____

As a result of the accident were you: □ Rendered unconscious □ Dazed □ Other: _____

Could you move all parts of your body? □ Yes □ No If no, why not? _____

Were you able to get out of the car and walk unaided? □ Yes □ No If no, why not? _____

Did you have any cuts or bruises from this accident? □ Yes □ No If so, where? _____

Describe how you felt immediately after the accident: _____

How did you feel later that □ Day □ Night? _____

How do feel today? _____

Are any of your activities of daily living any different now compared to before the accident? □ Yes □ No

List anything you are unable to do: _____

List anything that is painful to do: _____

List anything that is difficult to do: _____

Check symptoms apparent **since the accident**:

□ headache	□ loss of smell	□ numbness in fingers	□ loss of taste
□ neck pain	□ cold hands	□ tension	□ cold feet
□ upper back pain	□ chest pain	□ fatigue	□ diarrhea
□ middle back pain	□ constipation	□ pain behind eyes	□ shortness of breath
□ lower back pain	□ dizziness	□ irritability	□ loss of memory
□ fainting	□ depression	□ cold sweats	□ anxious
□ sleeping problems	□ loss of balance	□ numbness in toes	□ ringing/buzzing in ears
□ confusion	□ hard to concentrate	□ eyes sensitive to light	□ other: _____

Have you ever had the same or similar conditions? □ Yes □ No If yes, please describe and give dates: _____

_____

_____

Did you seek medical help immediately/soon after the accident? □ Yes □ No

If yes, how did you get there? _____

Doctor/hospital/clinic(s) seen: _____ Date(s): _____

What was done? _____

Were x-rays/MRI/CT done? □ Yes □ No If yes, of what body part? _____

What treatments/prescriptions were given? □ Bed rest □ Brace Heat/ice □ Follow up with: _____

□ Medications: _____ □ Other: _____

Date of last treatment: _____ What benefit(s) did you receive from treatment(s)? _____

_____

Have you missed time from work? □ Yes □ No Work hours are: □ Full-time □ Part-time

If you have missed time from work, how much time have you missed? _____

Was the accident work related? _____

Additional Comments: _____

_____

ATTESTATION: *By my signature below, I attest that the information I have provided is true and accurate to the best of my knowledge.*

Patient / Guardian Signature: _____ Date _____

Cornerstone Chiropractic Center

Personal Injury Policy

Our Personal Injury Policy is designed to render you immediate care and keep your out of pocket expenses to a minimum. There are potentially several sources for payment of your chiropractic expenses for your personal injury care. Virginia State law has a "no subrogation" clause (Virginia Code § 38.2-3405). This means that you may bill and collect on the same services from more than one insurance company. This does not apply to Federally funded or self- insured policies, nor does it apply in a Worker's Compensation claim.

Primary Coverage (Med pay)

It is the policy of this office to consider YOUR car insurance as the primary coverage for this accident. The benefit is available through the "Medical Payments" portion of your policy. This is often referred to as med pay. Med pay will provide coverage for the policyholder and any passengers suffering from bodily injury as a direct result of the accident. They will reimburse for reasonable medical expenses regardless of who was at fault in the accident. We recommend that you use this coverage if it is available as it is a benefit that you pay for. If you do not have med pay, we will need a statement in writing from your auto insurance company.

Your car insurance information:

Name of Insured:_____

Insurance Company:_____ Fax Number:_____

Address to send claims:_____

Policy Number: _____ Claim Number:_____

Name of Adjuster: _____ Phone Number:_____

Med Pay Limit:_____ How much has been used?_____

Secondary Coverage (Person at fault/liability)

There is also coverage through the car insurance of the person at fault in the accident. This is referred to as "third-party liability" coverage. Our office considers this coverage secondary to med pay. Generally, the third-party insurance carrier will not pay your medical expenses until you have been released from the care of all providers regarding the accident. At that time you will need to advise them that you have completed care and wish to settle your case.

This is the information of the person at fault:

Name of Insured:_____

Insurance Company:_____ Fax Number:_____

Address to send claims:_____

Policy Number: _____ Claim Number:_____

Name of Adjuster: _____ Phone Number:_____

Have they accepted liability?_____

Attorney

Your Attorney's Name: _____ Phone Number:_____

Address, City, State, Zip:_____

Contact Person:_____

Attestation & Authorization

By my signature below, I attest that the information I have provided is true and accurate to the best of my knowledge. My attorney and/or insurance carrier are hereby requested and authorized to pay direct to Cornerstone Chiropractic Center any monies due on account, the same to be deducted from any settlement made on my behalf. Furthermore, I agree to pay Cornerstone Chiropractic Center the difference, if any, between the total amount of charges on my account and the amount paid by the attorney and/or insurance carrier. It is further understood that I, the undersigned agree to pay Cornerstone Chiropractic Center the full amount of charges on my account should it occur for any reason that the services I received here are not covered by my policy or if for any reason the insurance carrier refuses to pay my claim. I have read and understand the above policy and agree to abide by the terms.

Signature:_____ Date:_____

Witness:_____ Date:_____