RETURN TO HEALTH

Auto Accident Patient Information

Personal Information:

Last Name:		First Name:	Mid. Init.:
Address:		City, State, Zip:	
Cell Phone:	Work Phone:		Social Security No.:
Date of Birth:			

Emergency Contact: Contact Phone #:

Address

Town State ZIP

RETURN TO HEALTH

Responsible Party Auto Accident Insurance: Policy Number

Carrier

Address

City State ZIP Phone

Person To Contact… Claim #

Date of Accident Patient Relationship to the insured Self Spouse Child Other

Personal Injury Protection (PIP): Policy Number

Carrier

Address

City State ZIP Phone

Person To Contact… Claim #

Date of Accident Patient Relationship to the insured Self Spouse Child Other

Attorney Name:

Attorney Phone Number:

Address

City State ZIP Phone

Person To Contact… Claim #

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Automobile Accident Description

Please answer the questions below. If you do not know the answer to any of the questions, do not answer that question.

1. Your vehicle type	2. Your position in vehicle	3. What was your vehicle doing at the time of the accident?
Car Station Wagon Van Pickup Truck Large Truck Bus Other__________	Driver Front Passenger Left Rear Passenger Right Rear Passenger Other__________	Stopped at intersection Stopped in traffic Stopped at light king a right turn Making a left turn Parking Proceeding along Slowing down Accelerating Other

4. Time/Speed/Damage	5. Details of Accident Visibility at time of accident	6. Road conditions Road conditions at time of accident
Time of accident______ Your vehicle's ______mph Their vehicle's speed: ______mph **Damage to your vehicle** Mild Moderate Totaled	Poor Fair Good Icy **Who hit who/what?** You hit other vehicle Other vehicle hit you **You hit...(object)** __________	Wet Sandy Dark Clean and dry speed: **Point of impact** Head-On Left Front Right Front Rear-End Left Rear Right Rear

7. Body Position, etc.

Did you see the accident coming:	**Yes**	**No**
Were you braced for the impact?	**Yes**	**No**
Did you have a seat belt on?	**Yes**	**No**
Did you have a shoulder harness on?	**Yes**	**No**

Does your vehicle have headrests? Yes No

What was the position of your headrest at the time of the impact?

Even with top of head Even with bottom of head Middle of neck

What was the direction of your head at the time of the impact?

Facing straight forward Turned to the right Turned to the left

Did driver side air bags deploy? **Yes** **No** Did passenger side airbags deploy? **Yes** **No** Did side airbags deploy? **Yes** **No**

8. Additional accident information

In the case of a motor vehicle accident, enter any additional information here that is not covered by the above check offs.

9. During the accident:

Did your body strike the inside of your vehicle? **Yes** **No**
If yes, describe:____________________

Did you lose consciousness during the injury? **Yes** **No**
If yes, for how long? ____________________
Your vehicle's estimated damage? ____________________

Damage to their vehicle: Mild Moderate Totaled
Did police show up at the scene? **Yes** **No**

Was an accident report filled out? **Yes** **No**

10. After the accident:

Check off your symptoms right after and a few days following:

Headache	Dizziness	Mid back pain	Cold hands
Neck pain	Nausea	Low back pain	Cold feet
Neck stiffness	Confusion	Nervousness	Diarrhea
Fainting	Fatigue	Loss of taste	Depression
Ringing in ears	Tension	Toe numbness	Anxious
Loss of smell	Irritability	Constipation	Chest Pain
Pain behind eyes	Shortness of breath	Sleeping problems	

Others:____________________

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11. Emergency Room?

Where did you go after the accident?
Home Work Hospital ER Private Doctor
How did you get there?

Drove self Somebody else Ambulance Police
Were X-rays done? Yes No **Was lab work done?** Yes No
Body parts X-rayed?______________________
What lab work?______________________
The X-rays revealed: ______________________
Treatments: Cervical Collar Ice **Other:** ____________
Medications:______________________
Follow-up instructions: ______________________

12. Treatment History:

Fill in any other doctor(s) seen prior to your first visit to this office.
1. Dr. ______________ First visit date: ____/____/____
Specialty:______________ X-rays done? **Yes** **No**

Types of treatments received:______________________
How many treatments received? _____ Currently treating? **Yes** **No**
Did treatments benefit you? **Yes** **No**
Last visit date: ____/____/____
2. Dr. ______________ First visit date: ____/____/____
Types of treatments received:______________________
How many treatments received? _____ Currently treating: **Yes** **No**
Did treatments benefit you? **Yes** **No**
Last visit date: ____/____/____

Patient Signature:______________________ **Date:**______________________

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RETURN TO HEALTH
4474 Spring Valley Rd.
Farmers Branch, TX 75244
(P): (469) 677-0076
(F): (469) 677-0195

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of land-based and aquatic physiotherapy on me (or on the patient named below, for whom I am legally responsible) by Dr. Andrew Garrett, DC and/or other licensed doctors of chiropractic who now or in the future work at Return to Health, LLC.

I have had an opportunity to discuss with Dr. Andrew Garrett, DC and/or with other clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I 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 and sprains. I do not expect the health care providers at Return to Health, LLC to be able to anticipate and explain all risks and complications, and I wish to rely upon my healthcare providers to exercise reasonable judgment during the course of the procedure, based upon the information I have provided to them and the facts then known by my healthcare providers.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment at Return to Health, LLC.

Patient Signature_________________________ Date __________________

Witness Signature ________________________________ Date_____________

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HIPAA AUTHORIZATION FORM

I understand that under the Health and Portability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to plan and direct my treatment and follow-up care among the multiple healthcare providers who may be involved in that treatment directly or indirectly. Most specifically to: (1) obtain payment from designated third-party payers, (2) conduct normal health care operations such as quality assessments or evaluations, prior authorizations, and physician certifications.

By my signature below, I consent to, and acknowledge that the healthcare providers at Return to Health, LLC may use and disclose my Protected Healthcare Information (PHI) to carry out the following:

1. Plan and provide for my care and treatment
2. Communicate to other healthcare professionals who may contribute or participate in my care and treatment
3. Obtain authorization, confirm service provided and collect payment from third-party payers
4. Perform routine healthcare operations such as the review of records from healthcare professionals

I also consent to Return to Health, LLC to:

1. Leave a message at my phone number on file to assist the practice in carrying out routine healthcare operations such as appointment reminders, insurance items and call pertaining to my clinical care
2. Mail to my address on file any items that assist the practice in carrying out routine healthcare operations such as appointment reminders, test results, patient information forms and patient statements.

INITIALS: ________________

I understand that I have the right:

1. To request restrictions as to how my Protected Health Information (PHI) may be used or disclosed to carry out treatment, payment or healthcare operations, and that the healthcare providers at Return to Health, LLC is not required to agree to the restrictions requested
2. To review the Return to Health, LLC's Notice of Privacy Practices and acknowledge that a copy has been given to me
3. To revoke this consent in writing, except to the extent that Return to Health, LLC may have already made PHI available to obtain payment from designated third-party payers or conduct normal health care operations prior to this request.

I acknowledge that I have read and understand all the above information and have answered the questions with complete and up-to-date information.

Signature____ Date________________________

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Authorization to Release Medical Records Acknowledgement

I Understand that:

- This Authorization is voluntary, and I have the right to refuse to sign it.
- This Authorization will remain in effect for one year from the date of the signature below unless you specify a different date here: __________ (date).
- If I sign this Authorization, I may revoke it later by sending a written notice of revocation to the privacy office at the practice. Note: The only exception to your right to revoke is if the practice has already acted in reliance upon the Authorization.
- The information disclosed pursuant to this Authorization, except information protected by Federal and/or State regulations about confidentiality of drug and alcohol abuse records, HIV and Mental Health, may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations or other applicable state or federal laws.
- Once signed, the Practice will provide me with a copy of this Authorization.

Signature of patient/guardian ______________________________ Date____________

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Authorization to Release Medical Records

TITLE 22 EXAMINING BOARDS
PART 9 TEXAS MEDICAL BOARD
CHAPTER 165 MEDICAL RECORDS
RULE §165.2 Medical Record Release and Charges

Deadline for Release of Records. The requested copies of medical and/or billing records or a summary or narrative of the records shall be furnished by the physician within 15 business days after the date of receipt of the request for furnishing the information

Patient Name ______________________________ Date of Birth ____________

Claim Number(s)/DOI: ____

This information is to be REQUESTED FROM:

Agency/Business Name ____

Street Address ________________________ City _______________ State _____ Zip _______

Phone Number ____________________ Fax Number _____________________

This information is to be DISCLOSED TO:

Return to Health, LLC
4474 Spring Valley Rd.
Dallas, TX 75254
(P): (469) 677-0076
(F): (469) 677-0195

For the purpose of (please check one): θ Moving θ Changing provider θ At the request of the individual θ Consultation θ Insurance change θ Other (please describe) ______________________________

Information to be disclosed:

θ Office notes for date(s) of service ______________

θ X-ray reports of __________________for date(s) of service ______________

θ MRI reports of __________________for date(s) of service ______________

θ CD(s) containing images of above marked studies θ Photographs or other images

θ Complete healthcare record θ Other (please describe) ___________________________

Special instructions: ____

Signature of patient/guardian _____________________________ Date____________________