## Notice for Patients Involved in a Motor Vehicle Accident

As treatment of injuries sustained in a motor vehicle accident involves auto insurance companies and/or attorneys, there is a significant amount of paperwork required. This extra paperwork has been added to your intake paperwork and must be completed prior to your examination with the doctor.

We will also require copies of the following:

- Photo Identification
- Police Report
- Accident Info Sheet (given by police at the scene)
- Card for Your Auto Insurance

Thank you for your understanding, and we look forward to being of service.

## APPLICATION FOR CARE AT CROSSROADS CHIROPRACTIC

Today's Date:____________________ Whom may we thank for referring you? _________________________

### PATIENT DEMOGRAPHICS

Name: ______________________________ Birth Date: _______________ Age: ________ ☐ Male ☐ Female

Address: _____________________________ Apt:_____ City: ________________________ State: ___ Zip:_______

Email: _______________________________ Home Phone: ___________________ Mobile Phone: _____________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Do you have insurance? ☐ Yes ☐ No

Social Security #: _______________________ Driver's License #: ________________________________________

Employer: ____________________________ Occupation: ____________________________________________

Spouse's Name: ________________________ # of Children: _______ Ages of Children: _________________

Name & Number of Emergency Contact: _____________________________________Relationship: _____________

### HISTORY OF COMPLAINT

Please identify the condition(s) that brought you to our office: **Primary**: _____________________________________

**Secondary**: ____________________ **Third**: ________________________ **Fourth**: _______________________

On a scale of 1 to 10, with 10 being the worst pain and 1 being the least, rate your above complaints by circling a number:

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Primary** or chief complaint: | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| **Secondary** complaint: | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| **Third** Complaint: | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| **Fourth** Complaint: | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

When did the problem(s) begin? __________________ When is it at its worst? ☐ AM ☐ PM ☐ Overnight

How long does it last? ☐ Constant ☐ On and off throughout the day ☐ Comes and goes throughout the week

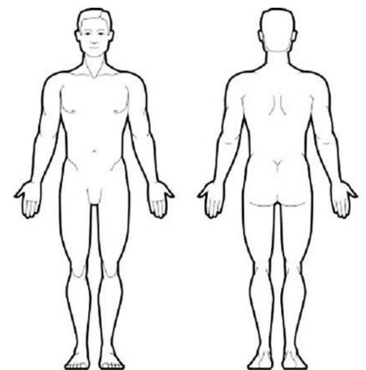
How did this injury happen? __________________________________________________________________

Has this condition been treated by anyone in the past? ☐ Yes ☐ No If yes, when? _______________________

By whom? _______________________ How long under care? ________ Outcome? ____________________________

Please mark the areas on the diagram with the following letters to describe your symptoms:

**R** = Radiating **B** = Burning **D** = Dull **A** = Aching **N**= Numbness **S** = Sharp/Stabbing **T** = Tingling



What relieves your symptoms? _______________________________________

What makes them feel worse? ________________________________________

| List of Restricted Activities: | Normal Activity Level: | Current Activity Level: |
|---|---|---|
| ____________________ | ____________________ | ____________________ |
| ____________________ | ____________________ | ____________________ |
| ____________________ | ____________________ | ____________________ |

Are there any other injuries to your spine, minor or major, that the doctor should know about? ☐ Yes ☐ No

If yes, please explain:________________________________________________

**HISTORY**

Have you suffered with this or similar problems in the past? ☐ Yes ☐ No If yes, how many times? __________

When was the last episode? ____________________ Did you try treatment? ☐ Yes ☐ No

If yes, what kind? ____________________ For how long? __________ Results? ☐ Favorable ☐ Not Favorable

Explain: ________________________________________________

Please list any allergies you have to medications:

________________________________________________

If you have been diagnosed with any of the following, please indicate with a **P** for "in the Past" or a **C** for "currently have"

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| ☐ | Broken Bone | ☐ | Dislocations | ☐ | Tumors | ☐ | Rheumatoid Arthritis |
| ☐ | Fracture | ☐ | Disability | ☐ | Cancer | ☐ | Osteoarthritis |
| ☐ | Heart Attack | ☐ | Diabetes | ☐ | Cerebral Vascular | ☐ | Other Serious Condition: |

Surgeries:____________________ How long ago?________ Type of care received:____________________

Injuries: ____________________ How long ago?________ Type of care received:____________________

Childhood Disease:____________________ How long ago?________ Type of care received:____________________

Adult Disease: ____________________ How long ago?________ Type of care received:____________________

**SOCIAL HISTORY**

Smoking ☐ Cigars ☐ Cigarettes ☐ Pipe How often? ☐ Daily ☐ Occasionally ☐ Never

Alcohol Consumption How often? ☐ Daily ☐ Occasionally ☐ Never

Recreational Drug Use: How often? ☐ Daily ☐ Occasionally ☐ Never

**FAMILY HISTORY**

Does anyone in your family suffer from the same condition(s)? ☐ Yes ☐ No

If yes, who? ☐ Grandfather ☐ Grandmother ☐ Father ☐ Mother ☐ Brother ☐ Sister ☐ Son ☐ Daughter

Any other hereditary conditions the doctor should be aware of? ________________________________________________

I, the undersigned, attest that the answers given are true and accurate to the best of my knowledge. I hereby authorize payment to be made directly to Crossroads Chiropractic and Wellness Center for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize use of this application or copies thereof for the purpose of processing claims and effecting payments. I further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to Crossroads Chiropractic and Wellness Center for any and all services I receive at this office. I also understand and agree that my email address will be added to the provider's newsletter list and that I may unsubscribe at any time.

Patient Name (Please Print): ______________________________

Patient or Authorized Person's Signature:______________________________ Date:____________

**ACTIVITIES OF LIFE**

Please identify with an "x" how your current condition is affecting your ability to carry out routine activities.

| Activity | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Carrying Groceries | ☐ | No Effect | ☐ | Painful (can do) | ☐ | Painful (limits) | ☐ | Can Not Perform |
| Sit-to-Stand | ☐ | No Effect | ☐ | Painful (can do) | ☐ | Painful (limits) | ☐ | Can Not Perform |
| Climbing Stairs | ☐ | No Effect | ☐ | Painful (can do) | ☐ | Painful (limits) | ☐ | Can Not Perform |
| Pet Care | ☐ | No Effect | ☐ | Painful (can do) | ☐ | Painful (limits) | ☐ | Can Not Perform |
| Driving | ☐ | No Effect | ☐ | Painful (can do) | ☐ | Painful (limits) | ☐ | Can Not Perform |
| Extended Computer Use | ☐ | No Effect | ☐ | Painful (can do) | ☐ | Painful (limits) | ☐ | Can Not Perform |
| Household Chores | ☐ | No Effect | ☐ | Painful (can do) | ☐ | Painful (limits) | ☐ | Can Not Perform |
| Lifting Children | ☐ | No Effect | ☐ | Painful (can do) | ☐ | Painful (limits) | ☐ | Can Not Perform |
| Reading/Concentration | ☐ | No Effect | ☐ | Painful (can do) | ☐ | Painful (limits) | ☐ | Can Not Perform |
| Bathing | ☐ | No Effect | ☐ | Painful (can do) | ☐ | Painful (limits) | ☐ | Can Not Perform |
| Dressing | ☐ | No Effect | ☐ | Painful (can do) | ☐ | Painful (limits) | ☐ | Can Not Perform |
| Shaving | ☐ | No Effect | ☐ | Painful (can do) | ☐ | Painful (limits) | ☐ | Can Not Perform |
| Sexual Activities | ☐ | No Effect | ☐ | Painful (can do) | ☐ | Painful (limits) | ☐ | Can Not Perform |
| Sleep | ☐ | No Effect | ☐ | Painful (can do) | ☐ | Painful (limits) | ☐ | Can Not Perform |
| Static Sitting | ☐ | No Effect | ☐ | Painful (can do) | ☐ | Painful (limits) | ☐ | Can Not Perform |
| Static Standing | ☐ | No Effect | ☐ | Painful (can do) | ☐ | Painful (limits) | ☐ | Can Not Perform |
| Yard Work | ☐ | No Effect | ☐ | Painful (can do) | ☐ | Painful (limits) | ☐ | Can Not Perform |
| Walking | ☐ | No Effect | ☐ | Painful (can do) | ☐ | Painful (limits) | ☐ | Can Not Perform |

If you have experienced any of the below, please mark them with a "**P**" for "in the **past**" or a "**C**" for "**currently** have":

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| ☐ | Headache | ☐ | Pregnant | ☐ | Painful Joints | ☐ | Mood Changes |
| ☐ | Neck Pain | ☐ | Frequent Colds | ☐ | Skin Problems | ☐ | High Blood Pressure |
| ☐ | Jaw Pain (TMJ) | ☐ | Frequent Flus | ☐ | Dizziness | ☐ | Low Blood Pressure |
| ☐ | Shoulder Pain | ☐ | Epilepsy | ☐ | Loss of Balance | ☐ | Prostrate Problems |
| ☐ | Upper Back Pain | ☐ | Tremors | ☐ | Fainting | ☐ | Impotence |
| ☐ | Mid Back Pain | ☐ | Chest Pain | ☐ | Blurred Vision | ☐ | Sexual Disfunction |
| ☐ | Low Back Pain | ☐ | Pain w/ Cough | ☐ | Ringing in Ears | ☐ | Digestive Problems |
| ☐ | Hip Pain | ☐ | Foot Problems | ☐ | Hearing Loss | ☐ | Menopausal Problems |
| ☐ | Back Curvature | ☐ | Knee Problems | ☐ | Depression | ☐ | Menstruation Problems |
| ☐ | Scoliosis | ☐ | Sinus Problems | ☐ | Irritable | ☐ | PMS |
| ☐ | Learning Disability | ☐ | Eating Disorder | ☐ | Trouble Sleeping | ☐ | Numb/Tingling Arms |
| ☐ | Ulcers | ☐ | Heartburn | ☐ | Heart Problems | ☐ | Numb/Tingling Hands |
| ☐ | Asthma | ☐ | Difficulty Breathing | ☐ | Lung Problems | ☐ | Numb/Tingling Fingers |
| ☐ | Kidney Trouble | ☐ | Liver Trouble | ☐ | Hepatitis (A, B, C) | ☐ | Numb/Tingling Legs |
| ☐ | Allergies | ☐ | ADD / ADHD | ☐ | Bed Wetting | ☐ | Numb/Tingling Feet |
| ☐ | Colon Trouble | ☐ | Diarrhea | ☐ | Constipation | ☐ | Numb/Tingling Toes |

List any medications you take: ______________________________________________

______________________________________________

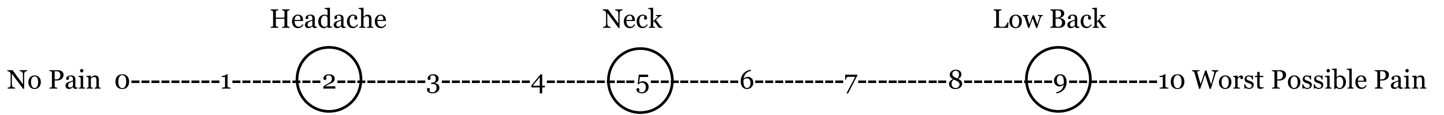
______________________________________________

______________________________________________

**Please Read Carefully:**

**Instructions:** Please circle the number that best describes the question being asked. If you have more than one complaint, please answer each question for each complaint, indicating the score for all complaints.

**Example:**




================================================================

1. **What is your pain RIGHT NOW?**

2. **What's your TYPICAL or AVERAGE pain?**

3. **What is your pain level at its BEST (How close to "0" does it get at its best)?**

4. **What is your pain level at its WORST (How close to "10" does it get at its worst)?**

OTHER COMMENTS:

______________________________________________

______________________________________________

______________________________________________

What are your **TOP 3 HEALTH GOALS**?

1. ______________________________________________
2. ______________________________________________
3. ______________________________________________

Crossroads Chiropractic and Wellness Center

# Informed Consent

**Regarding**: Chiropractic Adjustments, Modalities, and Therapeutic Procedures

Chiropractic care, like all forms of healthcare, holds certain risks. While the risks are most often very minimal, in rare cases complications such as sprain/strain injuries, irritation of disc condition and, although exceedingly rare, minor fractures and risk of stroke, which occurs at a rate of between 1 in 1 million to 1 in 2 million, have been associated with chiropractic adjustments.

I understand that the above list of items is not inclusive of all possible risks associated with chiropractic care and, after careful consideration, I do hereby consent to treatments by any means, method, and/or techniques the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care, and I voluntarily assume all risks. I acknowledge that, like in all forms of healthcare, results are not guaranteed.

______________________________________________ ____________________________

Patient or Authorized Person's Signature Today's Date

**Regarding**: X-Rays/Imaging Studies

During your examination, the doctor may feel that x-rays will be needed in order to provide your treatment. Diagnostic x-rays provide the doctor with valuable information that cannot be evaluated otherwise.

I understand that modern digital x-ray equipment exposes patients to a very low dose of radiation. After careful consideration, I hereby consent to have the x-ray examination the doctor has deemed necessary for my case.

______________________________________________ ____________________________

Patient or Authorized Person's Signature Today's Date

**FEMALES ONLY** regarding the possibility of pregnancy

☐ The first day of my last menstrual cycle was ________________________ (Date)

This is to certify that, to the best of my knowledge, I am **NOT** pregnant. The doctor and staff of Crossroads Chiropractic and Wellness Center have permission to perform diagnostic x-rays. I am aware that taking x-rays, particularly those involving the pelvis, can be hazardous to an unborn child.

______________________________________________ ____________________________

Female Patient or Authorized Person's Signature Today's Date

**ASSIGNMENT OF BENEFITS, ASSIGNMENT OF RIGHTS TO PERSUE PERSONAL INJURY, WORK COMP, ERISA, AND OTHER LEGAL CLAIMS ASSOCIATED WITH MY HEALTH INSURANCE AND/OR HEALTH BENEFIT PLAN (INCLUDING BREACH OF FIDUCIARY DUTY) AND DESIGNATION OF AUTHORIZED REPRESENTATIVE.**

Provider Name: Dr. Mark Domanski
Clinic Name: Crossroads Chiropractic and Wellness Center
Clinic Address: 320 East Montgomery Crossroad, Suite 30, Savannah, GA 31406

I hereby assign to the above-named provider, hereinafter referred to as “my provider,” my designated authorized representative, all medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance, and any other health/medical plan, to issue payment directly to my provider for services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered and paid by insurance. I understand that I maintain responsibility for obtaining any required referrals, preauthorization, or any other applicable insurance coverage requirements.

Should I involve an attorney in my case, I hereby authorize and direct my attorney and/or representative to provide Provider with any proceeds, judgement, verdict and/or thing of value, or any portion thereof, prior to dissemination of said proceeds, judgement, verdict and/or thing of value to any other person or entity, to compensate Provider in full for any services rendered to me and/or my dependents.

I authorize the use of my signature on all insurance submissions and payments. In the event that any attorney, insurance company, or any other third party is obligated to make payment to me or to my provider, I hereby assign and transfer to my provider any cause of action or other legal right(s) which may exist on my behalf and expressly authorize my provider to litigate, compromise, settle or otherwise resolve such claim as my provider exclusively deems appropriate.

I hereby authorize my provider to release healthcare information to any attorney, insurance company, or any applicable third party which is necessary to facilitate payment under the terms of this agreement. I further authorize any such applicable party to release any information relevant to the processing of a claim for reimbursement directly to my provider or its authorized representative. Such information can include, but is not limited to, insurance contracts, plans, booklets, summaries or any other materials which I am legally entitled to receive.

I acknowledge and agree that this assignment of benefits and/or right to compensation for treatment shall not be rescinded or revoked by myself, my attorney or anyone who claims to represent me. I understand that I am responsible for all charges submitted for services rendered to me by my provider, and that payment by me is not contingent upon any settlement, judgment, or verdict which I may eventually obtain for payment of outstanding charges.

A photocopy of this assignment/agreement shall be considered as valid as the original. A photocopy of any insurance claim(s) shall also be valid and have the same effect as the original.

______________________________________________ ____________________________

Patient or Authorized Person’s Signature Today’s Date

**Authorization to Release Medical Records**

I hereby authorize Crossroads Chiropractic and Wellness Center to release my medical records, including but not limited to medical history, laboratory reports, x-rays, and any other material regarding medical consultations and/or treatment I received, along with statements of account, to the attorney and/or insurance company handling my claim. I understand that it is my responsibility to immediately inform Crossroads Chiropractic and Wellness Center should there be any change in representation.

______________________________________________ ____________________________

Patient or Authorized Person’s Signature Today’s Date

Crossroads Chiropractic and Wellness Center

**NOTICE OF PRIVACY PRACTICE AND POLICIES**

This office is required to notify you in writing that, by law, we must maintain the privacy and confidentiality of your Personal Health Information. In addition, we must provide you with written notice concerning your rights to gain access to your health information and the potential circumstances under which, by law or as dictated by our office policy, we are permitted to disclose information about you to a third party without your authorization. Once you have read this notice and signed the following page, you are welcome to tear out this page and keep it for your records. Should you choose not to take this page, please review it thoroughly before leaving. The signature page following must be turned into the reception desk along with the rest of your paperwork

**Permitted Disclosures:**

1. Treatment purposed – discussion with other healthcare providers involved in your care
2. Inadvertent Disclosures – open treating areas mean open discussion. If you need to speak privately to the doctor, please let our staff know so that we can place you in a private consultation room.
3. For payment purposes – to obtain payment from your insurance company or any other collateral source
4. For workers compensation purposes – to process a claim or aid in investigation
5. Emergency – in the event of a medical emergency, we may notify a family member
6. For public health and safety – in order to prevent or lessen a serious or imminent threat to the health or safety of a person or persons or the general public.
7. To government agencies or law enforcement – to identify or locate a suspect, fugitive, material witness, or missing person.
8. For military, national security, prisoner and government benefits purposes
9. Deceased persons – discussions with coroners and medical examiners in the event of a patient's death
10. Telephone calls or emails and appointment reminders – we may call your home and leave messages regarding missed appointments or apprise you of changes in practice hours or upcoming events.
11. Change of ownership – in the event this practice is sold, the new owners would have access to your PHI

**Your rights:**

1. To receive an accounting of disclosures
2. To request mailings to an address different than residence
3. To request restrictions on certain uses and disclosures and to whom we release information, although we are not required to comply. If we agree, the restriction will be in place until we receive written notice of your intent to remove the restriction.
4. To request amendments to information. However, like restrictions, we are not required to agree to them.
5. To obtain one (1) copy of your records, timely notice (72 hours) is required. Copying and postage fees may apply.

**Refunds and Cancellation Policy:**

Requests for refunds must be submitted in writing and will be reviewed upon receipt. If a refund is payable, it will be processed and a credit will be applied to your credit card or paid by check within 30 days of request.

In situations where insurance has been applied: A quote of benefits is not a guarantee of payment. Your claim will process according to your plan. If your claim processes differently from the benefits we were quoted, the insurance company will side with the plan and will not honor the benefit quote we received. Once processed and applied, any refund will be issued in accordance with our refund policy.

Cancellation of a care plan negates extended discounts, and our standard office fee schedule will be applied to all services rendered. You are expected to do therapies (traction, rehab, wobble chair, vibration plate, etc.) when and as instructed. Should you choose to skip any or all therapies during a visit to the office, you must inform the front desk receptionist before leaving the office.

**Returns and Exchanges:**

Home Care Kits will not be eligible for refund, exchange, or credit.

**Complaints:**

If you wish to make a formal complaint about how we handle your health information, please call the office at 912-353-7611 to make an appointment to speak to the appropriate person.

Crossroads Chiropractic and Wellness Center

**NOTICE OF PRIVACY PRACTICE AND POLICIES continued**

I have received a copy of Crossroads Chiropractic and Wellness Center's NOTICE OF PRIVACY PRACTICE AND POLICIES. I understand my rights as well as the practice's duty to protect my health information and have conveyed my understanding of these rights to the doctor. I further understand that this office reserves the right to amend this NOTICE OF PRIVACY PRACTICE AND POLICIES at any time in the future and will make the provisions effective for all information that it maintains, past and present.

I understand that I have been given the opportunity to discuss any of my concerns and questions about this notice and the privacy of my healthcare information.

Patient Name (Please Print Clearly): ______________________________________________

Patient Date of Birth: _____________________________

_______________________________________________ _____________________________

Patient or Authorized Person's Signature Today's Date

Crossroads Chiropractic and Wellness Center

**Automobile Accident or Work Comp Questionnaire**

Patient Name: ______________________________ Date of Birth: ____________________

This information is considered confidential. Your answers will help us to determine if chiropractic care can help your condition. We will not accept your case if we do not believe your condition will respond satisfactorily to care. In order for us to understand your condition properly, please be as neat and accurate as possible while completing this form.

Date of Accident: ______________ Time of Accident: ______________

Were you the driver or passenger? ________________ Were you Wearing Seatbelt? ☐ Yes ☐ No

What road were you on? ______________________ Were you at a complete stop? ☐ Yes ☐ No

Describe what happened: ____________________________________________

____________________________________________

____________________________________________

Did you lose consciousness? ☐ Yes ☐ No Did your airbags deploy? ☐ Yes ☐ No

Did you go to the ER? ☐ Yes ☐ No

If yes: Which hospital? ______________ By Ambulance? ☐ Yes ☐ No

Did they take X-Rays? ☐ Yes ☐ No CT Scan? ☐ Yes ☐ No

What meds, if any, did they prescribe? ______________________________

Have you seen any other doctors for this condition? ☐ Yes ☐ No If yes, who? ____________________

Where did you feel pain immediately following the accident? ____________________________

List the extent of your injuries as you know them: ______________________________

____________________________________________

Have you ever had any problems in the involved areas prior to this accident? ☐ Yes ☐ No

If yes, what were your prior symptoms? ______________________________________

Before this injury, were you capable of working on an equal basis with others your age? ☐ Yes ☐ No

Are your work activities restricted as a result of this accident? ☐ Yes ☐ No

Since the accident, are your symptoms ... ☐ Improving? ☐ Getting Worse? ☐ Same?

Crossroads Chiropractic and Wellness Center

**Automobile Accident or Work Comp Questionnaire continued**

Patient Name: ______________________ Date of Birth: ______________________

Please mark any symptoms you've noticed since the accident that were not present prior to the accident:

| | | | |
|---|---|---|---|
| ☐ Headache | ☐ Dizziness | ☐ Depression | ☐ Fatigue |
| ☐ Light bothers eyes | ☐ Buzzing in ears | ☐ Diarrhea | ☐ Neck pain |
| ☐ Head feels heavy | ☐ Memory loss | ☐ Cold Feet | ☐ Neck stiff |
| ☐ Pins and Needles in arms | ☐ Ringing in ears | ☐ Cold hands | ☐ Fainting |
| ☐ Sleeping problems | ☐ Back pain | ☐ Flushed face | ☐ Loss of balance |
| ☐ Pins and needles in legs | ☐ Constipation | ☐ Tension | ☐ Nervousness |
| ☐ Numbness in fingers | ☐ Loss of smell | ☐ Fever | ☐ Irritability |
| ☐ Numbness in toes | ☐ Loss of taste | ☐ Chest pain | ☐ Cold sweats |
| ☐ Shortness of breath | ☐ Upset stomach | ☐ Other (specify): | ______________________ |
| | | | ______________________ |
| | | | ______________________ |

**Attorney Involvement:**

With regard to this accident, have you retained an attorney? ☐ Yes ☐ No

If yes: Attorney's Name: ______________________ Phone #: ______________________

Law Firm Name: ______________________

Attorney's Address: ______________________

**Driver of the vehicle in which you were injured:**

Name: ______________________ Relationship (circle one): Self Family Friend Other

Insurance Company: ______________________ Policy #: ______________________

Name of Adjuster: ______________________ Phone #: ______________________

**Driver of other vehicle:**

Name: ______________________ Claim #: ______________________

Insurance Company: ______________________ Policy #: ______________________

Name of Adjuster: ______________________ Phone #: ______________________

______________________ ______________________

Patient or Authorized Person's Signature Today's Date