**Crossroads Chiropractic & Acupuncture**
9320 Olde Eight Road, Northfield Center, OH 44067
(330) 467-0508 (p) ~ (330) 467-0140 (f)

# ASSIGNMENT

I was involved in an accident on or around _______________(date) in which I was injured for which I have or may have a claim against another person(s) for causing my injuries (including ________________) (referenced as "My Claim"), who is insured by ____________________________.
(Name of Person at Fault)
In consideration of the agreement of Crossroads Chiropractic Center, LLC to delay billing me personally for medical treatment rendered until resolution of My Claim:

1. I now assign, without any right to later revoke, a part of any proceeds from my claim equal to the fees incurred by me to Crossroads Chiropractic Center, LLC for all treatment and other services rendered by Crossroads Chiropractic Center, LLC. I am <u>not</u> assigning any legal cause of action in My Claim above, but only prospective proceeds. I also assign to Crossroads Chiropractic Center, LLC my right to enforce the obligation of any insurance company to pay settlement proceeds for **any** settlement agreement made by or for me in exchange for **my signing such insurance company's release of claim. Prior to settlement or other** disposition of My Claim, I understand and permit Crossroads Chiropractic Center, LLC to pursue payment from any other source but me personally, including medical payments coverage in an automobile liability policy.

2. **This Assignment and related documents which I have signed in connection with it states the entire agreement and my complete understanding regarding Crossroads Chiropractic Center, LLC 's fees. I have not relied on any statements by the Clinic or the Doctor or other information before making this Assignment. I understand that I remain responsible for any Clinic fees not paid out of My Claim.**

   ____________________________
   *(Signature of Patient)*

3. **I understand that it is my responsibility during treatment to remain aware of my cumulative account balance for services rendered. I have received a schedule of treatment fees for this Clinic, or if I have not, will request this Clinic for one in writing.**

4. I understand that this is an express contract to pay for the services rendered by **Crossroads Chiropractic Center, LLC**. I agree to pay my account balance in full and/or direct its payment from My Claim proceeds regardless of whether any other person or entity attempts to or fails to fully reimburse me for it. If I dispute my account balance or treatment rendered, I agree that my remedy will be to resolve it with a separate action from My Claim.

5. **<u>NOTICE:</u> I DIRECT <u>ANY INSURANCE COMPANY, ATTORNEY, OR OTHER PERSON WHO SOLDS OR LATER HOLDS ANY PROCEEDS FROM MY CLAIM</u> TO APPLY ANY PROCEEDS FROM MY CLAIM TO MY TOTAL ACCOUNT BALANCE OUT OF THE <u>TOTAL</u> PROCEEDS HELD IN MY BEHALF, UNLESS THE CLINIC CONFIRMS PRIOR PAYMENT OF IT IN WRITING. "TOTAL PROCEEDS" HELD BY AN ATTORNEY FOR MY CLAIM SHALL MEAN PROCEEDS AFTER DEDUCTION OF ATTORNEY FEES.**

6. Ohio law governs this Assignment. Jurisdiction shall be in Ohio, and venue shall lie in the county in which the Clinic is located, unless required by applicable law to lie in a different county in which I reside.

7. **I REALIZE THAT <u>I HAVE NOW GIVEN AWAY A PART OF ANY PROCEEDS FROM MY CLAIM</u>. IF I RECEIVE ANY PROCEEDS FROM MY CLAIM, I AGREE TO IMMEDIATELY DETERMINE IF THIS CLINIC HAS BEEN SEPARATELY PAID IN FULL. UNLESS THE CLINIC CONFIRMS FULL PAYMENT IN WRITING, <u>I REALIZE THAT ANY USE BY ME OF THESE PROCEEDS IS TAKING OR CONVERTING MONEY THAT IS THE PROPERTY OF CROSSROADS CHIROPRACTIC CENTER, LLC</u> .**

8. I HAVE READ THIS DOCUMENT AND I FULLY UNDERSTAND IT.

____________________________ (SIGNATURE OF PATIENT)

____________________________ (DATE)

This Assignment has been signed on the Clinic Premises:

____________________________ (PRINT OR TYPE PATIENT NAME)

____________________________ **(SIGNATURE OF PARENT OR LEGAL GUARDIAN)**

____________________________ **(STAFF WITNESS)**

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# AUTOMOBILE ACCIDENT HISTORY

Insurance Company_________________________ Policy Number_________________________________

Address ___________________________________Name of Adjuster__________________________________

Adjusters Phone Number________________________ Claim Number________________________________

Patients Insurance Company________________________ Patients Insurance Phone Number___________________________

Have you retained an attorney? **Yes** **No**

Name and Address of Attorney:________________________________________________________________________________

**General Symptoms:**

Did you hit part of your body during the collision, for example: head on dash, chest on steering wheel? **Yes** **No**

If yes, which part and how? ____________________________________________________________________________________

Where were you taken after the accident? ___________________________________________________

Were you hospitalized? **Yes** **No** If yes, for how long? _______________________________________

**Accident History:**

Date of Accident: ___________________________ Time of Accident: __________________ A.M. P.M.

State how the Accident happened in your own words:

____________________________________________________________________________________________________

____________________________________________________________________________________________________

What type of vehicle were you in? Make: ________________________Year: ________________________

Were you driving? **Yes** **No** Was it your car? **Yes** **No** If not, whose? __________________________

Passenger? **Front** **Back** **Right Side** **Left Side** Were you rotated in seat? **Yes** **No**

Were you reclined? **Yes** **No** Other: __________________________________________________

Other people in car? **Yes** **No**

Names and Addresses:

____________________________________________________________________________________________________

____________________________________________________________________________________________________

Were they injured? **Yes** **No**

If yes, please explain: ____________________________________________________________________________________________

____________________________________________________________________________________________________

Seat belts on? **Yes** **No** Shoulder harness on? **Yes** **No** Position of headrest __________________

Was it? **Daylight** **Night** **Dark** **Dawn** What were the weather conditions? ____________________

How long had you been in the car? ________ What were you doing prior to the Accident? __________________

What were the traffic conditions? _________________________ What was the posted speed limit? __________

How fast were you going? _________ Type of road: **2 Lane** **4 Lane** **Gravel** **Tar**

Did it happen at a/an: **Stop Sign** **Traffic Light** **Intersection** **Highway**

Was your car hit? **Front** **Back** **Left Side** **Right Side**

What damage was done to your car?

Inside: ____________________________________________________________________

Outside: ___________________________________________________________________

Other: _____________________________________________________________________

If you struck another car, did you strike it: **Front** **Back** **Side**

What was the damage to the other car?

Inside: ____________________________________________________________________

Outside: ___________________________________________________________________

In what condition was the vehicle prior to the Accident? _____________________________________________

Do you have pictures of the involved automobile? **Yes** **No**

What type of vehicle was involved in the accident?

**Car** **Truck** **Motorcycle** **SUV** **Other:** ____________________ **Size and Type**: __________________________

Was accident report made? **Yes** **No** Police of: **City:** _____________ **County:** ______________ **State:** _____

Who was ticketed? _______________________ For what? _________________________________

Did your vehicle strike anything? **Yes** **No** If yes: **Another Car** **Sign** **Tree**

**Other:** ____________________________ **Size and Type**: _____________________________________

Were you completely conscious after the impact? **Yes** **No** Do you remember the impact? **Yes** **No**

Did your vehicle go off the road? **Yes** **No**

State any strange events that happened during or immediately after the Accident:

______________________________________________________________________________________________

______________________________________________________________________________________________

Have you had any time loss from work? **Yes** **No** If yes, from __________________to __________________

Have you ever had to have any outside help? **Yes** **No** What type? _______________________________________

***The above information is accurate and has been completed to the best of my knowledge:***

Patient Signature: _________________________________________________ Date: ______________________

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## Confidential Patient Information

Date: ____________________

Patient Name: ________________________________ Chief Complaint: ______________________________

Address: ____________________________________ Primary Phone: ______________________________

City: ________________________ Zip:__________ Email: ______________________________________

Date of Birth: ________________________________ Marital Status: M S W D

Occupation: _________________________________ Employer: ___________________________________

Insurance Policy Holder (if different than above): _________________________ Policy Holder Birthdate: __________

**Is your present condition the result of an auto collision, work-related injury or other personal injury?** ___ Yes ___No Name of attorney if applicable: ________________________________

Primary Care Physician: ________________________________________ (Note: May we send your health information to this provider **Y / N**)

Emergency Contact: Name ____________________ Phone # ____________________ Relationship ________________________

Have you ever been under Chiropractic Care? **Y** **N** If so, please provide name of doctor:________________________________

Have you had any **SPINAL** X-Rays / MRI's / CT's taken in the last year? **Y** **N** If so, where? ____________________________

Spinal surgeries? **Y** **N** Year ________________ Describe: ___________________________________________

Do you have a pacemaker or defibrillator? **Y** **N** Have you ever had any Hip or Knee Replacements? **Y** **N**

What medications are you taking? (Check ALL that apply): Pain Killers ____ Insulin ___ Cholesterol Meds ___
Blood Pressure Meds ___ Muscle Relaxers ___ Birth Control ___ Supplements ___ Other: _________________________________

### LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign at clinic's request, and convey directly to Crossroads Chiropractic & Acupuncture all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer, and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I hereby authorize the doctor to release all medical information to other healthcare providers involved in my care including but not limited to my primary care physician. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under the any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and clinic's expenses.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

________________________________________ ________________________
Signature of Insured / Guardian Date

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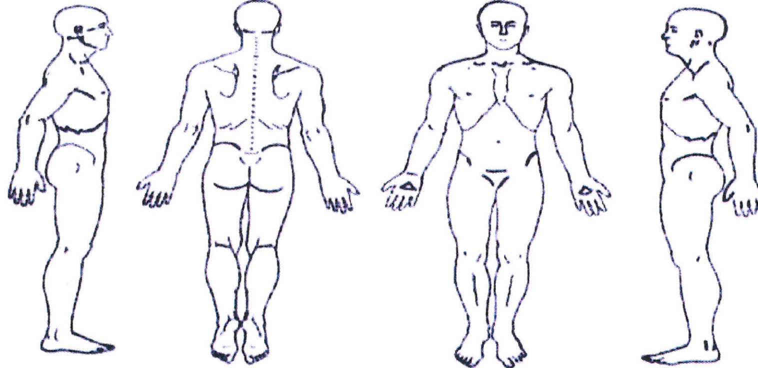
# CASE HISTORY

**Name:** ____________________

1. Indicate with a **CIRCLE** or **X** on the drawings below where you have pain/symptoms.



2. How often do you experience your symptoms?
   - ☐ Constantly (80-100% of the time)
   - ☐ Frequently (50-79% of the time)
   - ☐ Occasionally (25-49% of the time)
   - ☐ Intermittently (1-24% of the time)

3. How would you describe the type of pain?
   - ☐ Sharp
   - ☐ Tingly
   - ☐ Shooting w/motion
   - ☐ Throbbing
   - ☐ Numb
   - ☐ Achy
   - ☐ Stiff/Tight
   - ☐ Stabbing w/motion
   - ☐ Dull
   - ☐ Burning
   - ☐ Diffuse (spread out)
   - ☐ Other: ____________________

4. How are your symptoms changing with time?
   ____ Improved ____ Gotten Worse ____ Stayed the same since it began

5. Using a scale from 0-10 (10 being the worst), how would you rate your problem?
   0 1 2 3 4 5 6 7 8 9 10 (Please circle)

6. How much has the problem interfered with your work?
   ☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely ☐ N/A

7. How much has the problem interfered with your social activities?
   ☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely ☐ N/A

8. How long have you had this problem? ________________________________

9. How do you think your problem began? ________________________________

10. Who else have you seen for this problem? ________________________________

11. What makes your problem WORSE? ________________________________

12. What makes your problem BETTER? ________________________________

13. Were you referred to our office by anyone? ________________________________

14. Any other Musculoskeletal problems? ____No ____Yes Neurological problems? ____No ____ Yes

I certify that the above information is accurate to the best of my knowledge.

Patient/Guardian Signature ________________________________ Date: ______________

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www.crossroads-chiro.com

# Electronic Health Records Intake Form

*In compliance with requirements for the government EHR incentive program*

**First Name:**_______________________ **Last Name:**_______________________

**Email address:** _______________@_______________

**Preferred method of communication for patient reminders** (Circle one): Email / Phone / Mail

**DOB:** __/__/____ **Gender (Circle one):** Male / Female **Preferred Language:** ________________

**Smoking Status (Circle one):** Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

*CMS requires providers to report both race and ethnicity*

**Race (Circle one):** American Indian or Alaska Native / Asian / Black or African American / White (Caucasian)
Native Hawaiian or Pacific Islander / Other / I Decline to Answer

**Ethnicity (Circle one):** Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

**Are you currently taking any medications?** (Please include regularly used over the counter medications)

| Medication Name | Dosage and Frequency (i.e. 5mg once a day, etc.) |
|---|---|
| | |
| | |
| | |

**Do you have any medication allergies?**

| Medication Name | Reaction | Onset Date | Additional Comments |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

☐ **I choose to decline receipt of my clinical summary after every visit** *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

Patient Signature: ________________________________________ Date:______________

***For office use only***

Height: ________ Weight:__________ Blood Pressure:_____/_____

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**Patient Name:** ______________________________ **Date:** ______________________

# TermsofAcceptance

The goal of our office is to enable patients to gain control of their health. To attain this, we believe communication is the key. There are often topics that are hard to understand, and we hope this document will clarify those issues for you. Please read the following, and if you have any questions, please feel free to ask one of our staff members.

**Informed Consent:**

A patient, in coming to the chiropractic doctor, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or care if he/she is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known, or to learn through healthcare procedures what he/she is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the chiropractic physician. The chiropractic doctor provides a specialized, non-duplicating health care service. Your doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regimen. I understand that if I am accepted as a patient by a physician at Crossroads Chiropractic & Acupuncture, I am authorizing them to proceed with any treatment that they deem necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

- **Women Only:**

To the best of my knowledge I **am / am NOT** pregnant and (**give my permission / don't give permission**) to x-ray me for diagnostic interpretation. *(Circle one above)* *(Circle one above)*

- **Missed Appointments:** Please call the office as soon as possible if you will need to reschedule your appointment.

Any **MASSAGE APPOINTMENT** that is not canceled **24 hours prior** to scheduled appointment will be charged **$35**.
Three (3) late cancellations for massage in 1 calendar year will result in a suspension of those services.

- **Outstanding Balances:**

There will be an **annual 18% interest fee** charged to any balance **30 or more days outstanding**.

- **Consent to Evaluate and Treat a Minor:**

I, ______________________________ being the parent or legal guardian of ______________________________, have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

- **Communications:**

In the event we would need to communicate your healthcare information, to whom may we do so?

Spouse/Partner: ______________________________________________

Children: ______________________________________________

Others: ______________________________________________ No one: ______

May we leave messages regarding your personal healthcare information on any answering device? Yes [ ] No [ ]
May we contact you via email? Yes [ ] No [ ]

- **Acknowledgement**

I have read and fully understand the above statements. I have reviewed the notice of privacy practices (HIPAA) and have been provided an opportunity to discuss my right to privacy. Upon request I will be given a copy.

Print Name: ______________________________________ Signature: ______________________________________
Date: ______________________________