Valued practice member,

Thank you for trusting our team to take care of you. In order for us to properly bill your case please provide us with the information below.

Separate Documents Needed

- Drivers License
- Your Auto Insurance Card
- Your Auto Declaration Page listing coverage
- Accident/Incident Report (Police Report)
- Your Health Insurance Card

Billing information needed for submitting your claims

- Your Auto Policy Information (if applicable)
    - Medical Adjusters Name
    - Medical Adjusters Phone number and extension
    - Medical Claim Number
    - Insurance companies Name, Claims Mailing Address & fax Number
- At-Fault Party Insurance Information
    - Medical Adjusters Name
    - Medical Adjusters Phone number and extension
    - Medical Claim Number
    - Insurance companies Name, Claims Mailing Address & fax Number
- Attorney Information (If applicable)
    - Attorney Name
    - Firm
    - Phone number
    - Fax Number

Thank you in advance for providing all of the above information so we can properly serve you.

Yours in Health,
Team Vero

VERO CHIROPRACTIC
Automobile/PI Accident or Work Comp Questionnaire

Dear Patient:
This information is considered confidential. Your answers will help us 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. Thank you.

Please answer all questions completely.

Name____ Date of Birth____ /_____ /_______ Age______ Male/Female

Address____ City____________________ State______ Zip___________

Phone: Cell_______________________ Home_____________________ Email ____________________________________

Occupation______________________________________ Employer's Name______________________________________

Single / Married / Divorced / Widowed Spouse's Name____

Number of Children______ Names, Ages, & Gender____

How did you hear about us?____

Please explain in detail how your accident happened(list details of the crash):

____

____

____

CRASH DIAGRAM (From your memory)

You were heading North/ East/ South/ West on ____ (street or highway)

Other vehicle was heading North/ East/ South/ West on ____ (street or highway)

What was the time and date of present injury? ____

Where did you feel pain immediately after the accident? ____

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

____

____

Were you employed at the time of the crash? ☐ Yes ☐ No Are you currently employed? ☐ Yes ☐ No
If no, is your unemployment status due to the crash? ☐ Yes ☐ No
Type of work: ☐Office/Clerical ☐Light Labor ☐Moderate Labor ☐Heavy Labor

INJURY HISTORY:

Was the crash on the job? ☐ Yes ☐ No

You were: ☐Driver ☐Front seat passenger ☐Rear seat passenger ☐Motorcycle operator ☐Motorcycle passenger

☐ Other: ________________________

Vehicle driven by: ________________________________ Ins Company_____________________ Policy #___________

Your vehicle year/make/model: _____________________________

Your estimated speed at the moment of the crash:___________ ☐Stopped ☐Slowing ☐Accelerating

Other vehicle year/make/model: _____________________________

Time of day: ☐Daylight ☐Dawn ☐Dusk ☐Dark

Road conditions: ☐Dry ☐Damp ☐Wet ☐Snow ☐Ice ☐Other: _______________

Head restraints: ☐None ☐Integral type ☐Adjustable ☐Up ☐Down ☐Don't Know

If adjustable, was the position altered by the crash? ☐ Yes ☐ No

Was the seat back adjustment altered by the crash?☐ Yes ☐ No Was the seat broken? ☐ Yes ☐ No

Seat belt: ☐Wearing ☐Not wearing ☐Don't Know

Did the airbag deploy? ☐ Yes ☐ No If yes, were you struck? ☐ Yes ☐ No

Body position: ☐Good ☐Forward lean ☐Other: ______________________________

Head position: ☐Forward ☐Left ☐Right ☐Up

Down Hand position: ☐One on the wheel ☐Two on the wheel ☐N/A

Brakes applied? ☐ Yes ☐ No Were you aware of the impending crash? ☐ Yes ☐ No

DURING THE CRASH:

Did you strike any parts of the vehicle? ☐ Yes ☐ No

If yes, describe: ____

Did the vehicle strike any objects after impact? ☐ Yes ☐ No

If yes, describe: ____

Were you wearing a hat or glasses? ☐ Yes ☐ No If yes, were they still on after the crash? ☐ Yes ☐ No

Did you lose consciousness? ☐ Yes ☐ No If yes, for how long? ___________________

Estimated property damage to your vehicle: $___________

Estimated damage to other vehicle(s): ☐ None ☐ Minimal ☐ Moderate ☐ Major

Were the police on-scene? ☐ Yes ☐ No Were police notified? ☐ Yes ☐ No

If yes, was a report made? ☐ Yes ☐ No

Check symptoms you have noticed since the accident:

___ Headache	___ Dizziness	___ Depression	___ Fatigue
___ Light Bothers Eyes	___ Buzzing in Ears	___ Diarrhea	___ Neck Pain
___ Head Seems to Heavy	___ Memory Loss	___ Feet Cold	___ Neck Stiff
___ Pins and Needles in Arms	___ Ears Ring	___ Hands Cold	___ Fainting
___ Sleeping Problems	___ Back Pain (Mid/Low)	___ Face Flushed	___ 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	___ Stomach Upset		

Symptoms other than above: ____

____

Where were you taken after the accident? ____

Hospitalized? ☐ Yes ☐ No If yes, admitted? _____ How long? _____

Name of Hospital: ____

Name of Doctor(s): ____

What treatment was given? ____

Was any other doctor consulted after your accident? ☐ Yes ☐ No

If so, what was the doctor's name? ____ D.C., M.D., D.O., D.D.S.

What was the diagnosis? ____

What treatment was given? ____

How often and for how long did you see the doctor? ____

Have you ever had any complaints in the involved area before? ☐ Yes ☐ No

If so, what were the complaints? ____

Please list any other health concerns you have had now, or in the past that are **NOT** related to the accident/injury:

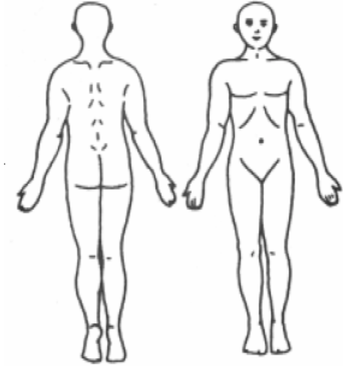
____

____

Before the 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 this injury are your symptoms … ☐ Improving? ☐ Getting worse? ☐ Same?



***PLEASE MARK** the areas on the Diagram with the following letters to describe your symptoms: **R = R**adiating **B = B**urning **D = D**ull **A = A**ching **N = N**umbness **S = S**harp/ **S**tabbing **T= T**ingling

Outcome Assessment Tool

Please **circle** the number that best describes the question asked. If you have more than one complaint, please answer each question for each individual complaint and indicate the score of each complaint.

EXAMPLE:

No pain Worst possible pain

0 1 2 3 (4) 5 6 7 (8) 9 10

1. How would you rate your pain **RIGHT NOW?**

   0 1 2 3 4 5 6 7 8 9 10

2. What is your typical or **AVERAGE** pain?

   0 1 2 3 4 5 6 7 8 9 10

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

   0 1 2 3 4 5 6 7 8 9 10

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

   0 1 2 3 4 5 6 7 8 9 10

Activities of Life

Please mark any areas where your current condition(s) is/are affecting your ability to carry out activities that are a part of your life:

□ Carrying Groceries	□ Sit to Stand	□ Climbing Stairs	□ Pet Care
□ Driving	□ Extended Computer Use	□ Household Chores	□ Lifting Objects
□ Dressing	□ Shaving	□ Sexual Activities	□ Sleep
□ Sitting for Long Periods	□ Standing for Long Periods	□ Walking	□Washing/Bathing
□ Sweeping/Vacuuming	□ Dishes	□ Laundry	□ Yard work
□ Garbage	□ Concentration (Reading)	□ Other: _________	□ Other: _______

Patient Signature ___________________________ Date of Birth___________Date ____________

Doctor Signature ___________________________ Date ____________

Informed Consent for Chiropractic Care

Chiropractic care, like all forms of health care while offering considerable benefits may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases, injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include: sprain/strain injuries, irritation of a disc condition, and rarely, fractures. One of the rarest complications associated with chiropractic care occurring at a rate between one instance per one million to one per two million cervical spine (neck) adjustments may be a vertebral injury that could lead to a stroke.

Prior to receiving chiropractic care in the chiropractic office, a health history and physical examination will be completed. These procedures are performed to assess your specific conditions, your overall health and in particular your spinal health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies are needed. In addition, this will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan prior to beginning care.

- I understand and accept that there are risks associated with chiropractic care, and give consent to the examination and chiropractic care that the doctor deems necessary, including spinal adjustments, as reported following my assessment.

- I authorize and request payment of insurance benefits directly to Vero Chiropractic. I agree that this authorization will cover all services rendered until I revoke the authorization. I agree that a photocopy of this form may be used in place of the original. All professional services rendered are charged to the practice member. It is customary to pay for services when rendered unless other arrangements have been made in advance. I understand that I am financially responsible for all charges not covered.

Print Name: ____

Signature: ____ Date: __________________

If This Health Profile Is for A Minor/Child, Please Fill Out and Sign Below

Written Consent for A Child

Name of Practice Member who is a Minor/Child: ____

I authorize Dr. Josiah Fitzsimmons and any and all Vero Chiropractic staff to perform diagnostic procedures, radiographic evaluations, render chiropractic care and perform chiropractic adjustments to my minor/child. As of this date, I have the legal right to select and authorize health care services for my minor/child. If my authority to select and authorize care is revoked or altered, I will immediately notify Vero Chiropractic.

Guardian Signature: ____ Date: _____________________

Relationship to Minor/Child: __________________________________

Notice of Privacy Practices Acknowledgement

I understand that I have certain rights of privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA). I understand that this information can and will be used to:

1. Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations, such as quality assessments and physicians certifications.

I acknowledge that I may request your NOTICE OF PRIVACY PRACTICES containing a more complete description of the uses and disclosures of my health information. I also understand that I may request, in writing, that you restrict how my private information is disclosed to carry out treatment, payment, or healthcare operation.

Release of Information:

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse ____

[ ] Child(ren)____

[ ] Other ____

[ ] Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing.

Signature: ____Date: ______________________

X-Ray Authorization

As your healthcare provider, we are legally responsible for your chiropractic records. We must maintain a record of your x-rays in our files. At your request, we will provide you with a copy of your x-rays. Digital x-rays on a CD will be available within 72 hours of any regular practice hour day. Please note**:** X-rays are utilized in this office to help locate and analyze vertebral subluxations. The doctor of Vero Chiropractic does not diagnose or treat medical conditions; however, if any abnormalities are found, we will bring it to your attention so that you can seek proper medical advice.

By signing below you are agreeing to the above terms and conditions.

Full Legal Name: ____ Date of Birth: ______________

Signature: ____ Date: ________________________

FEMALE PRACTICE MEMBERS ONLY: To the best of my knowledge, **I BELIEVE I AM NOT PREGNANT** at the time the x-rays are taken at Vero Chiropractic.

Signature: ____ Date: ________________________

Office Name: **Vero Chiropractic**

Date of Accident: __________ Time of Accident:____________ City:____________________ State:__________

Practice Members Medical Pay Information

Do you have Medical Pay on your Policy? YES NO
If Yes, coverage amount: $1,000 $1,500 $2,000 $2,500 $5,000 $10,000 Other $____________

Personal Injury Claim #: ____

Personal Injury Adjuster's Name:____

Adjusters Phone Number: ________________________________Extension______________________________

Insurance Company Name, Address & Fax Number:

____

____

____

Fax Number: ____

Attorney Information

Have you retained an attorney? YES NO

Attorney Name: _______Firm: ____________________________________

Phone Number: _____________________________________Fax: ____________________________________

Lien On File? YES NO Did the attorney confirm they will pay the provider directly? YES NO

Other Driver (At Fault Driver) Insurance Information

Name: ____ Claim #: _____________________________

At Fault Driver's Insurance Company Name & Address

____

____

____

Personal Injury Adjuster's Name:____

Adjusters Phone Number: ________________________________Extension______________________________

At Fault States: Alabama, Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, Georgia, Idaho, Illinois, Indiana, Iowa, Louisiana, Maine, Maryland, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Mexico, North Carolina, Ohio, Oklahoma, Oregon, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Vermont, Virginia, Washington, West Virginia, Wisconsin & Wyoming

Financial Policy
Vero Chiropractic
5525 Mills Civic Pkwy. Suite 120
West Des Moines, IA 50266
Phone: 515-422-9552 Fax: 515-528-0141

It is the goal of this office to provide you with the finest quality chiropractic care available. We are committed to your care at this office. It is our desire to assist our practice members whenever possible. The following allows you, our valued practice member, to receive the care you need without undue financial strain. Below is a statement of our Financial Policy which we require you to read, initial and sign prior to services. **All practice members must complete our information and insurance form before seeing the doctor.**

________ **(Initial here)** The privilege of insurance assignment begins when our office has qualified your insurance coverage. For your convenience, we will bill your insurance company directly and accept assignment. As always, you have the option of billing your own insurance if necessary. In a case in which you receive payment from your insurance carrier you must bring the check to the office within 5 business days of receipt and endorse it over to this office to be applied to your account. If you do not bring in payments you received directly you will receive an invoice from our office.

________ **(Initial here)** This office does not promise that an insurance company will reimburse you for the usual and customary charges submitted by this office nor will we enter into any dispute with an insurance company over the amount of reimbursement. In the event the insurance company denies the claim, it is your responsibility to pay the charges and seek reimbursement from your insurance company.

________ **(Initial here**) Ultimately the practice member is responsible for all services rendered including those not reimbursed by third party payors.

________ **(Initial here)** All copayments and deductibles must be paid when services are rendered as this office has adopted a zero balance policy. For your convenience, advance payment plans are available.

________ **(Initial here)** Since we do not own your insurance policy and occasionally we experience difficulty in collecting from the carrier, we may ask for your active assistance in rectifying this situation after 60 days.

________ **(Initial here** You will be sent an email, text message or US Mail for any balances over 30 days old, if this office does not hear from you within 5 days of the email, text message or US Mail you authorize this office to run your credit card that is on file for the balance on your account. If your credit card denies you understand that your account will be subject to a 1.5% interest charge per month until the balance is collected. All accounts not paid within 90 days will receive final notification and be turned over to a collection agency for further action.

I have read the above, understand it fully, and agree to adhere to these policies.

Practice Members Signature ____ Date______________________

Witness (Team Member's sign)____ Date______________________

Vero Chiropractic
5525 Mills Civic Pkwy Suite 120
West Des Moines, IA 50266
(515)-422-9552

NOTICE OF DOCTOR'S LIEN

I hereby authorize and instruct my attorney &/or insurance carrier,________________________ to pay Vero Chiropractic directly for the full amount of services rendered by Vero Chiropractic in relation to my personal injury treatment arising from my accident on or about __________________ once a settlement or verdict is reached and those funds are made available or disbursed.

I understand that I am directly and fully responsible for all medical bills incurred at Vero Chiropractic for services rendered to me with respect to any personal injury treatment. Further, I understand that I am responsible for the payment of all services rendered by Vero Chiropractic, regardless of whether or not I receive any proceeds from any insurance company or third party, and that my obligation and liability to Vero Chiropractic is in no way conditioned upon any settlement of verdict.

I agree to promptly notify Vero Chiropractic of any changes in my representation or attorney for this accident.

By signing below I acknowledge and agree to this lien in favor of Vero Chiropractic the full amount owed for any and all services rendered to me by Vero Chiropractic.

I acknowledge that Vero Chiropractic is not required to permit me the option to postpone or make payments toward services rendered, and that it is being done solely as a courtesy. As such, Vero Chiropractic may, at any time, seek payment for any and all amounts owed by me while this lien is in force. Additionally, if my attorney fails to acknowledge this lien in favor of Vero Chiropractic, the entire balance related to this personal injury treatment is my sole responsibility, and Vero Chiropractic may demand payment immediately.

______________________________________Print Practice Members Name

______________________________________Practice Member Signature

__________________Date

Acknowledged by Attorney this _________________ day of ________________, 20____

___________________________________Attorney Signature