ELK RIDGE
Chiropractic & Wellness Center

NEW PATIENT INFORMATION

Motor Vehicle Accident Packet

Please answer every question to the best of your ability.

_____
Patient Full Name

Street Address:_____City:_____State:_____Zip:_____

Mailing Address:_____City:_____State:_____Zip:_____

Birthdate:_____E-mail:_____

Social #_____Home #:_____Cell #: _____

Marital Status: ☐ Married ☐ Partnership ☐ Single Are you a student? Yes / No ☐ Part-Time ☐ Full-Time

Who referred you:_____(We want to thank them for referring you)

Emergency Contact:_____#:_____

Your Occupation:_____☐ Part-Time ☐ Full-Time

Your Employer/ Business Name: _____

Most Recent Chiropractor:_____City:_____State:_____

Date of the Last visit to your previous Chiropractor (approximate): _____

Reason for leaving last Chiropractor: _____

Primary Care Physician or Naturopath: _____

Are you currently under Doctor Supervision? YES NO Who: _____

Insurance Company:_____Customer Service #:_____

Primary Policy Holder:_____Primary's Birthday: _____

Consent to Treatment:

I_____hereby give my permission to the examining physician to order x-rays, routine tests, and Chiropractic treatment for my condition. I understand that I will be presented in this packet a "Terms of Acceptance" which explains Chiropractic, "Our Fee Structure" that shows the cost, and "HIPPA" that explains my records privacy.

PATIENT/ GUARDIAN SIGNATURE:_____**TODAY'S DATE**: _____

FINANCIAL AGREEEMENT

This agreement deals solely with financial obligations. There is no guarantee that any illness, injury, or disease can be prevented or cured by participation in this program. Any balance due for services and products already received are due, regardless of results.

Please read and sign below.

Insurance: A portion of my care provided may be covered by my insurance. I understand that payments made are applied to my deductible, co-pay, and/ or co-insurance, as well as non-covered products/ services that may receive. The benefits quoted above are an estimate based on the information received from my insurance. I am financially responsible for all services/ products I received that my insurance doesn't cover.

SERVICES & PRODUCTS	**INS COST**
Adjustment (each visit)	$70.00
Extremity Adjustment (each visit)	$38.00
Manual Therapy (each visit)	$50.00
Therapeutic Rehab (each visit)	$65.00
Examination	Varies
Laser Light Therapy	$30.00
E-stim (15 minutes)	$27.00
Balance & Posture Kit	$55.00

SSN#: In order for my insurance to be billed, I understand that Elk Ridge Chiropractic & Wellness Center must have a copy of my ID and insurance card. Until my insurance pays their portion, I understand that Elk Ridge Chiropractic & Wellness Center is extending credit to me. For this reason, I must have my Social # on file.

Financial Responsibility: Payment is always due at the time of service or paid in advance. These policies in no way obligates the patient to continue the course of treatment recommended. If care is discontinued, the debt balance for services/ products already received, that balance is due in full.

Collections & Other Fees: Should my account go to collections, for any amount owed on services and products already received; I agree to pay ALL costs, late fees, collection fees, and any expenses, including attorney fees. Fees: Bounced Check $25 Credit Card Charge Back $25 per incident. Account late fee is 5% of my account balance per 30 day increment past the due date, per month.

Fee Structure: Please note that if you become involved in a motor vehicle accident or work injury, our fee structure may differ due to the complexity of your needs in such cases. All fees are subject to change.

Billing Insurance: Should I have Chiropractic coverage through my insurance carrier; I authorize Elk Ridge Chiropractic & Wellness Center to bill my insurance and send the documents required for reimbursement. I understand that I am financially responsible for all service, products, deductibles, co-pays, and co-insurances not paid by my insurance to Elk Ridge Chiropractic & Wellness Center. Should my insurance reimburse me rather than the clinic, I understand that I must notify the clinic immediately, and that I am financially responsible to reimburse the clinic for the amount that the insurance was to pay the clinic.

Time Of Service Payment: I understand that any deductible, co-pay, and/ or co-insurance are due at the time of service. I also understand that any natural supplements and any supports that I receive will not be covered by insurance and therefore I will pay in full at the time of receipt. Payment for services and products received is due in full at the time of service.

Agreement: I understand and agree to the terms of the agreement outlined above.

PATIENT/ GUARDIAN SIGNATURE:_____ **TODAY'S DATE**: _____

HIPAA

Certificate of Privacy Assurance to Patients

In the course of your care as a patient at Elk Ridge Chiropractic & Wellness Center, we may use or disclose personal information about you in the following ways:

- Your personal health information, including your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment, or treatment.
- Your healthcare records as well as your billing records may be disclosed to another party, such as an insurance carrier, a HMO, or a PPO, if they are or may be responsible for payment of services.
- Your name, address, phone number, and your health records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or other health related information that may be of interest to you.
- If you are not at home to receive an appointment reminder, a message may be left on your answering machine.
- Further, you have the right to inspect or obtain a copy of the information we will use for these purposes. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization it will not affect the care provided to you or the reimbursement avenues associated with your care.

Under federal law, we are also permitted/required to use or disclose your health information without your consent or authorization in these following circumstances:

- If we are providing health care services to you based on the orders of another health care provider.
- If we provide health care services to you in an emergency.
- If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
- If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.
- If we are ordered by the courts or another appropriate agency.

Any use or disclosure of your protected health information, other than as outlined above, will only be made upon your written authorization.

We normally provide information about your health care to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your health care or about the status of your account. If you would like to receive this information at another address other than your home or if you would like the information in a different form please advise us in writing as to your preferences.

This office utilizes an "*Open Adjusting*" environment for our ongoing patient care. "*Open Adjusting*" involves several patients being seen in the same adjusting room at the same time. Patients are within sight of one another and some ongoing routine details of care are discussed within earshot of other patients and staff. This environment is used for ongoing care and this is NOT the environment used for taking patient histories, providing examinations, or presenting reports of findings. These procedures are completed in a private and confidential setting. The use of this format is intended to make your experience with our office more efficient and productive as well as to enhance your experience with our office and to enhance your access to quality health care and health information. If you choose not to be adjusted in an "*Open Adjusting*" environment, other arrangements will be made for you.

You have the right to inspect and/or copy your health information with a signed records release for seven (7) years from the date that the record was created or as long as the information remains in our files. In addition you have the right to an amendment to your health information. Requests to inspect, copy, or amend your health related information should be provided to us in writing. We are required by state and federal law to maintain the privacy of our patient file and protect your health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information. We are further required by law to abide by the terms of this notice while it is in effect.

We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice we will notify you in writing as soon as possible following the changes. Any change in our privacy policy will apply to all of your health information in our files. Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

I have read and agree to the above.

PATIENT/ GUARDIAN SIGNATURE:_____**TODAY'S DATE**: _____

CONSULTATION & HEALTH HISTORY

HOW ARE YOU FEELING TODAY?

Primary Complaint/ Symptom: _____

When did this originally happen (date)?_____Is this a flare-up? When did the flare-up start: _____

What were you doing when you first noticed this pain? _____

Was this an: ☐ Auto Accident or ☐ Work Related Injury Date of Incident: _____

How often do you experience this pain/discomfort? ☐ Constantly ☐ Intermittently (comes & goes) ☐ Occasionally (infrequent)

This pain occurs_____times per ☐ Day ☐ Week ☐ Month ☐ Year

When does this pain occur or feel worse? ☐ In the Morning ☐ At Work ☐ After Work ☐ Sitting ☐ Standing ☐ Bending

☐ Exercising ☐ Sneezing ☐ Other:_____

Please CIRCLE all that apply describing how you feel:

Aching Burning Cramping Dull Numb Pain Pins & Needles Sharp Shooting Sore Stabbing Throbbing Tight Tingling

At its worst - Pain Scale (1=no pain/discomfort, 10=worst pain ever) Pick ONE: **1 2 3 4 5 6 7 8 9 10**

Does your Primary Complaint: ☐ **MOVE** ☐ **RADIATE** ☐ **STAY** | Where does it move/radiate to?_____

Other Complaints/ Symptoms: _____

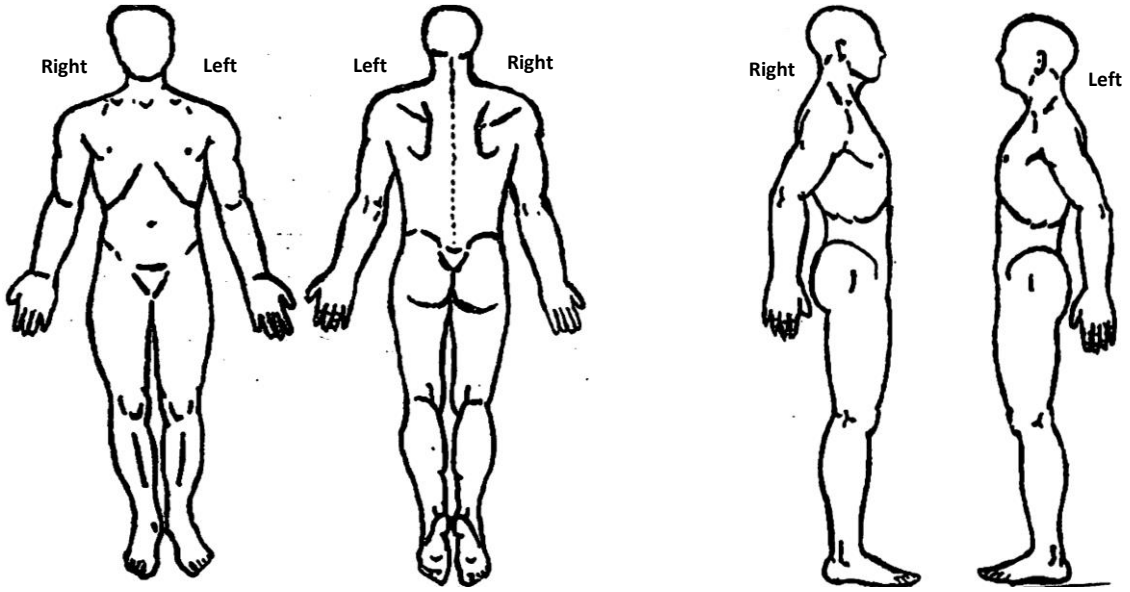
_____

What makes this pain better? ☐ Ice ☐ Heat ☐ Stretching/PT ☐ Exercise ☐ Acupuncture ☐ Massage ☐ Anti-Inflammatories

☐ Other:_____

PAIN SITES

Circle on the image below where you feel any pain or discomfort. It can be the main reason you're here or anything else.



PRIOR AUTO ACCIDENTS

Have you ever been involved in an Auto Accident (even fender benders and little bumps)? **Yes No**

When?_____Injured? **Yes No** Explain injuries: _____

Explain the accident: _____

When?_____Injured? **Yes No** Explain injuries: _____

Explain the accident: _____

SLEEPING HABITS

I have trouble: Falling Asleep / Staying Asleep / Waking Up Frequently

Hours of sleep per night:_____ Typical times sleep & awake:_____am/pm to_____am/pm

Wake_____x per night at_____am / pm Do you wake feeling unrested? **Yes** | **No**

Reason: ☐ Waking to Urinate ☐ Difficulty Falling Asleep ☐ Restless Sleep ☐ Waking Up Early ☐ Disturbing Dreams

MEDICAL HISTORY

MAJOR SURGERIES, BROKEN BONES, INJURIES, HOSPITALIZATIONS (INCLUDING CANCER, C-SECTIONS, ETC):

Year	Type	Outcome

MEDICATIONS, SUPPLEMENTS AND HERBS. Please list what you are taking:

Start Date	Item	Amount	Frequency

Circle **EVERYTHING** you have experienced in the **PAST** and the **PRESENT** or anything your family has experienced.

☐ A.D.H.D./A.D.D.	Past	Present |	Mother	Father	Sibling | Other:_____
☐ Alcohol/Drug Abuse	Past	Present |	Mother	Father	Sibling | Other:_____
☐ Anemic/Blood issue	Past	Present |	Mother	Father	Sibling | Other:_____
☐ Arthritis/Joint Degeneration	Past	Present |	Mother	Father	Sibling | Other:_____
☐ Blood Pressure: Low or High	Past	Present |	Mother	Father	Sibling | Other:_____
☐ Cancer/ Pre-Cancer	Past	Present |	Mother	Father	Sibling | Other:_____
☐ Diabetic: Which Type 1 2	Past	Present |	Mother	Father	Sibling | Other:_____
☐ Emotional/Psychiatric Issues	Past	Present |	Mother	Father	Sibling | Other:_____
☐ Epilepsy	Past	Present |	Mother	Father	Sibling | Other:_____
☐ Scoliosis/Spondylosis	Past	Present |	Mother	Father	Sibling | Other:_____

FITNESS & HEALTH HABITS

Do you exercise regularly (excludes work)? **Yes** | **No** How much? ☐ Weekly ☐ _____days/week ☐ Everyday

How do you exercise? ☐ Yoga ☐ Weights ☐ Cardio Machines ☐ Run ☐ Bike ☐ Walk ☐ Ski/Snowboard ☐ _____

Are you on a special diet now or have you had one in the past?_____

	Yes	No	Amount per Day/Week	Age Started	Age Quit
☐ Coffee/Tea	_____	_____	_____	_____	_____
☐ Caffeine Drinks:	_____	_____	_____	_____	_____
☐ Alcohol	_____	_____	_____	_____	_____
☐ Cigarettes	_____	_____	_____	_____	_____
☐ Marijuana	_____	_____	_____	_____	_____
☐ Chew Tobacco:	_____	_____	_____	_____	_____

ACKNOWLEDGEMENT

When a patient seeks Chiropractic healthcare and Elk Ridge Chiropractic & Wellness Center accepts a patient for such care, it is essential for both parties to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understands both the objective and the method that will be used to obtain it. This will prevent any confusion or disappointment.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column, which causes alterations of nerve function and interference to the transmission of mental impulses, resulting in lessening of the body's innate (in born) ability to express its maximum health potential (reduce the body's function).

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our Chiropractic method of correction is by specific adjustments of the spine.

Health: A state of physical, mental, and social well-being, not merely the absence of disease or infirmity.

We primarily treat and diagnose neuromusculoskeletal disorders. If during the course of Chiropractic spinal examination, we encounter non-Chiropractic unusual findings, we will advise you. If you desire advice, diagnosis, or treatment for those non-Chiropractic unusual findings, we will recommend that you seek the services of another healthcare provider. Though we work to treat and eliminate the primary complaint, we cannot guarantee outcomes or results.

We utilize a Postural Screening Analysis to identify structural anatomical issues by analyzing your posture, using a program meant specifically for this purpose. In order to create this screening, photographs will be taken using 2-4 views of your body standing in a neutral position. For the best results, we ask that you wear shorts and a tank top. These photos will be used for the practitioner to assess your posture and will be viewed only by office staff. The screening will be saved to your patient file and email to the email address you provided.

I **(Print Your Name)**_____ have read and fully understand the above statements. All questions regarding the Doctor's objectives pertaining to my care, in this office, have been answered to my complete satisfaction. I therefore consent to Chiropractic care and treatment on this basis.

PATIENT/ GUARDIAN SIGNATURE:_____ **DATE:** _____

MVA Required Insurance Info

PATIENT & ACCIDENT INFORMATION

Patient Name: (First)_____(MI)_____(Last)_____

Today's Date:_____/_____/_____ Date of Injury:_____/_____/_____Time:_____:_____am / pm

Copy of MVA Ins Card: Yes / No **Copy of Major Medical Ins Card:** Yes / No

Is there PIP coverage? Yes / No How many people in the vehicle? # _____

Please list all people in vehicle:

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Drivers Name: (First)_____(MI)_____(Last)_____

Name of Insured: (First)_____(MI)_____(Last)_____

Insured's Address: (Street)_____

(City)_____(State)_____(Zip)_____

Insured's Phone Number: (_____) _____

YOUR AUTO POLICY INFORMATION (Please fill out the below information, regardless of whether or not you were at fault)

Auto Insurance Policy #:_____MVA Claim #:_____

MVA Insurance Co: _____

MVA Billing Address: (Street)_____

(City)_____(State)_____(Zip)_____

MVA Ins Main Phone: (_____)_____Ext._____

Drivers Name: (First)_____(Last)_____

MVA Adjuster Phone: (_____)_____Ext. _____

THIRD PARTY INSURANCE INFORMATION (Please fill out if you were NOT AT FAULT - All info below is on the Driver At Fault)

Drivers Name: (First)_____(Last)_____

Drivers Phone: (_____)_____Drivers Vehicle (Make/Model)_____

Auto Insurance Policy #:_____MVA Claim #:_____

MVA Insurance Co: _____

MVA Billing Address: (Street)_____

City)_____(State)_____(Zip)_____

MVA Ins Main Phone: (_____)_____Ext. _____

MVA Adjuster Phone: (_____)_____Ext. _____

PERSONAL INJURY RECOVERY AGREEMENT

_____(The "Patient") does hereby authorize Dr. Natasha Ruegsegger (The "Doctor") to furnish Patient's attorney of record (The "Attorney") with a full report of the Doctor's examination, diagnosis treatment, prognosis, etc., of Patient in regard to the accident in which Patient was involved on_____, 20_____.
Patient hereby authorizes and directs Attorney to pay directly to Doctor such sums as may be owing Doctor for medical services rendered to Patient as a result of the above-referenced accident and/or owing by reason of any other bills that are due by Patient to Doctor, and to withhold such sums from any settlement, judgement or verdict as may be necessary to fully compensate Doctor. Patient further gives lien on Patient lawsuit arising from the above-referenced accident to Doctor against any and all proceeds of any settlement, judgement or verdict which may paid to Attorney or to patient in connection with the lawsuit.

Patient understands and acknowledges that Patient is directly and fully responsible to Doctor for all bills submitted by Doctor for healthcare services rendered to Patient and that this agreement is solely for Doctor's additional protection and in consideration of Doctor's agreement to postpone demand for payment. Patient further understands and acknowledges that such payment is not contingent on any settlement, judgement or verdict by which Patient may eventually recover all or any portion of the sums owed by Patient to Doctor.

Patient directs that Attorney shall not withhold any portion of the amount due to the Doctor under this lien to offset Attorney's fees which Attorney now or hereafter may claim to be owning by Doctor to Attorney in connection with this lien.
Patient agrees to promptly notify Doctor of any change or addition of Attorney(s) used by the Patient in connection with the lawsuit described above, and instructs Attorney to the same and to also promptly deliver a copy of this lien to any such substituted or added Attorney(s).

Attorney shall promptly notify Doctor if and when Attorney ceases to represent Patient in the lawsuit described above or when Patient retains additional Attorney(s) to represent Patient in that lawsuit. Attorney shall also promptly deliver a copy of the lien to any additional or substitute Attorney(s) retained by Patient in connection with that lawsuit.

Attorney does hereby agree to observe all terms of this lien stated above and agrees to withhold, without deduction for any Attorney's fees, such sums from any settlement, judgement or verdict as may be necessary to adequately protect and fully compensate Doctor.

PATIENT/ GUARDIAN SIGNATURE:_____**DATE:** _____

POWER OF ATTORNEY TO ENDORSE CHECKS

I,_____(Patient/Principle Name), hereby appoint **Natasha Ruegsegger, D.C.,** and her employees, to act as a representative on my behalf, to sign/endorse any check, drafts or money orders to pay for chiropractic services or the like, which have been performed by Ruegsegger Chiropractic (DBA Elk Ridge Chiropractic & Wellness Center).

This appointment shall extend to the endorsement of any and all payments for services rendered by above referenced Chiropractic office in order to pay for the care I have received since the date of my motor vehicle accident.

It is my intent that my attorney, family, physician and all legal authorities be bound by the decisions that are made by the representative appointed by this document, in regard to payment for services rendered.

PATIENT/ GUARDIAN SIGNATURE:_____**DATE:** _____