GREENWAY/COTTON
CHIROPRACTIC
Body Harmony Massage and Advanced Body Works

William M. Bucur, D.C.
16995 West Greenway Road Ste# 102Surprise, AZ 85388
Office: (623) 433-8895 Fax: (623) 455-8759

Auto Intake Form

Patient Information

Last Name: _____ First Name: _____ M: _____ Male / Female

Address: _____Apt# _____ City: _____ State: _____ Zip:_____

Home : (_ __)_____-_____Cell: (_ __)_____-_____ Work: (__ _)____-_____DOB: _____/_____/_____

E-Mail: _____SSN:_____-_____-_____

Marital Status: Married Single Divorced Widowed

Occupation: _____How Long? _____ Years / Months

Employer_____Address: _____ City: _____

State: _____ Spouse Name: _____ DOB: _____/_____/_____ Age: _____

Patient Medical Insurance Information:

Subscriber Name: _____Relationship: _____

Primary Private Insurance: _____ Phone: _____

Address: _____Phone: _____

Policy #_____ Group #_____

Patient Auto Insurance Information:

Subscriber Name: _____ Relationship: _____

Primary Private Insurance:_____Phone:_____

Address: _____Phone: _____

Claim #_____ Policy #_____

Are you the "**At Fault Party**": Yes / No If no, please insert "At Fault Party" Insurance information below:

Date of Accident: _____ Was an Accident report made: Yes / No

City of _____ County of: _____ State: _____

At Fault Auto Insurance Information

Name of **"At Fault"** Party: _____ DOB: _____/____/____

Insurance Carrier: _____ Phone: _____ Address: _____

City: _____State: _____ Zip: _____ Policy _____

Claim #_____Representative Name: _____Ext: _____

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Accident Questionnaire:

In the car, were you: (circle one)

Driver Front Passenger Right Rear Passenger Left Rear Passenger

What type of accident were you in?

Front-End Collision Rear-End Collision Side-Impact Collision Other: _____

Did your vehicle strike another vehicle? Yes / No **Were you struck?** Yes / No

Were you wearing your seatbelt? Yes / No

At the time of impact were you: Looking ahead Looking to the right Looking to the Left

Did you strike anything in the vehicle? Yes / No Please specify: _____

Describe how you felt immediately following impact? _____

Were you unconscious? Y / N **In a daze?** Y / N

Did you go to the hospital? Y / N **If yes, When?** At time of Accident? **Or** Later in the day?

Were you taken in an ambulance? Y / N Other: _____

Did the EMT place you in: Neck Collar? Splints? Brace?

Which Hospital were you taken to? _____

Were X-rays taken? Y / N **If yes, what was the diagnosis?** _____

Have you seen any other doctor in regards to this incident? Y / N Dr.'s Name: _____

If no Immediate symptoms, how long until you felt symptoms? _____ Days _____Hours _____Weeks

Check One: Immediately Bad? _____ Gradually Bad? _____

I VERIFY AND ACKNOWLEDGE THAT ALL INFORMATION IS CURRENT AND CORRECT: (Please sign below)

Print Patient Name: _____

Signature of Patient: _____ Date: _____

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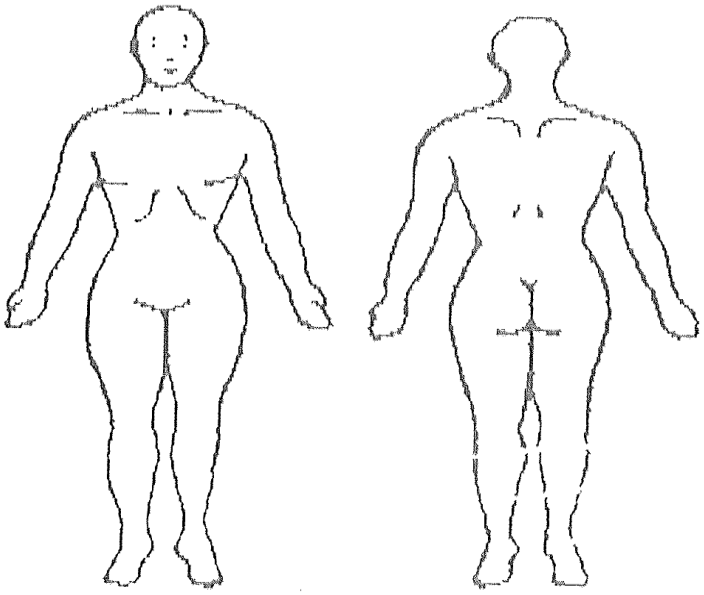
Please circle most affected areas below:



DESCRIBE AREA OF COMPLAINT

Begin with the area causing the most distress

Area #1 _____ **Dull Sharp Achy/Soreness Stiff/Tightness Numbness/Tingling**

Rate Pain on Scale of 1-10 (10 being most pain) _____ Frequency: **Constant Intermittent Occasional**

Area #2 _____ **Dull Sharp Achy/Soreness Stiff/Tightness Numbness/Tingling**

Rate Pain on Scale of 1-10 (10 being most pain) _____ Frequency**: Constant Intermittent Occasional**

Area #3 _____ **Dull Sharp Achy/Soreness Stiff/Tightness Numbness/Tingling**

Rate Pain on Scale of 1-10 (10 being most pain) _____ Frequency: **Constant Intermittent Occasional**

Area #4 _____ **Dull Sharp Achy/Soreness Stiff/Tightness Numbness/Tingling**

Rate Pain on Scale of 1-10 (10 being most pain) _____ Frequency: **Constant Intermittent Occasional**

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1. Have you tried anything to relieve the pain? If so, what? _____Results: **Yes** **No**

2. Are you currently under drug/medical care? **Yes** **No** Condition _____Results: **Yes** **No**

3. Previous Chiropractic Care: _____Approx. date of last visit: _____/_____/_____

4. Previous Spinal Injuries? **YES** **NO** _____

5. Exercise**:** **Often** **Occasionally** Exercise Problems or Injuries? **YES** **NO**

6. Difficulty Sleeping? **YES** **NO** Position that Relieves Tension? **Side** **Stomach** **Back**

7. Previous Injuries or Broken Bones: _____

8. Surgeries: When: _____ Area: _____

Please circle all that apply to you:

Allergies	Arthritis	Asthma	Blood Clots
Blood Pressure	Cholesterol	Chronic Pain	Depression
Diabetes	Digestion Issues	Eczema	Epilepsy
Hearing & Ear	Heart Disease	Heart Attack	HIV/AIDS
Hepatitis (A,B,C)	Infectious Disease	Joint Replacements	Lung Conditions
Menopause	Mental Health	Migraine	Neurological Issues
Shingles	Sleep Disorder	Thyroid	Other:_____

Pregnancy: Due Date:_____# of weeks: _____

I VERIFY AND ACKNOWLEDGE THAT ALL INFORMATION IS CURRENT AND CORRECT: (Please sign below)

Print Patient Name: _____

Signature of Patient: _____ Date: _____

Financial Agreement

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I will pay in full for services at the time of my appointment unless I have insurance coverage that requires another arrangement, or I make a different agreement with my provider.

My initials indicate that I have read and agree with each item below.

Professional Fees

Any co-payment or co-insurance will be due in full at the time of service.

All initial appointment fees are due upon first day of service. Special financial arrangements must be discussed by the second appointment.

A $25 processing fee will be charged for any NSF fees on any return of payment.

A $20 fee will be charged for missed appointments, $ 10 fee for canceled appoints with less than 24 hours notice., if rescheduled at time of the cancellation. This includes Auto cases, All payments will be processed to the credit card on file the same day. All fees will be donated to the Wounded Warriors Project.

Authorization of Release of Records

I authorize the release of any medical information necessary to process my claim and/or for better treatment in this office including x-rays, MRIs, Lab tests, etc.

Payment and Assignments of Services

It is my responsibility to know what services are covered by my insurance plan. I have reviewed carefully the section in my insurance coverage booklet that describes the coverage of benefits for the services that will be provided at this office. I will call my plan administrator with any questions. I will pay for any services I receive that are not covered or denied by my insurance plan.

I will provide full and accurate insurance information in advance of my appointment, or will pay for the appointment on a self-pay basis. I will present my insurance card at the time of my appointment. I will provide updated insurance information promptly in the case of any changes.

I understand that I, not my insurance company, am responsible for full payment of my fees. I understand that insurance billing is provided by my healthcare provider as a courtesy, but I remain the responsible party.

I understand that, if after 90 days my insurance company has not responded I will receive a statement. I agree to pay my balance in full at that time. I understand that I will be reimbursed promptly if and when the insurance payment arrives.

I understand that, if my account is referred to a collection specialist due to nonpayment, I will pay any applicable collection fees.

I understand that, "Authorization to Pay the Doctor" I hereby authorize payment directly to Greenway/Cotton Chiropractic of the insurance benefits otherwise payable to me.

I understand that, Personal Injury/Auto Claim_____ Non Personal Injury/Auto Claim _____ in the case that I choose Non Personal Injury/Auto Claim, I state that I was not involved in any auto accident or personal injury caused by any other party. I further state that my diagnostic test or treatment is not the result of an injury while on the job or by any other person related to my employment.

I understand that, In the case of auto carrier or workman's compensation claims, whether settled or unsettled, I understand that I am responsible for all costs of chiropractic care which become payable within 30 days after the end of treatment and am held to the same rules as mentioned in the balance held policy noted above.

I understand that I am solely responsible for any and all missed, canceled or reschedule appointment fees whether the charges are in relation to an auto case or otherwise. I understand that my credit card will be charged at the time of the occurrence, if I am unable to give proper notice of more than 24 hours prior to my schedule appointment.

Dispute Procedure

In the event of a dispute between myself and Greenway/Cotton Chiropractic whether for charges, procedures or balances I owe, I hereby waive the statute of limitations on collections and/or recovery. I also understand that litigation is certain once balances owed reaches 120 days past due, and I agree to pay all litigation costs incurred by Greenway/Cotton Chiropractic as a result of inaction to timely payment of my account. I understand and agree to pay a 50% collection fee on any outstanding balances due that are turned over to a collection agency.

By signing this document, I hereby agree to abide by all mentioned policies, authorizations, assignments, and procedures.

Print Patient Name: _____

Signature of Patient: _____ **Date:** _____

Witness/ Personnel: _____ **Date:** _____

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HIPPA Privacy Rule: Consent for Purposes of Treatment, Payment and Healthcare Operations

I acknowledge that Greenway/Cotton Chiropractic "Notice of Privacy Practices Abridged Edition" has been provided to me.

I understand I have a right to review the entire Greenway/Cotton Chiropractic Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Greenway/Cotton Chiropractic. The Notice of Privacy Practices for Greenway/Cotton Chiropractic also provided on request at the main administration desk of this practice. This Notice of Privacy Practices also describes my rights and Greenway/Cotton Chiropractic duties with respect to my protected health information.

Greenway/Cotton Chiropractic reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

PATIENT ACKNOWLEDGEMENT

By signing my name below, I acknowledge receipt of the above stated notice and my understanding and agreement to its terms.

_____ _____
Signature of Patient or Personal Representative **Date**

_____
Print Name of Patient or Personal Representative

_____
Description of Personal Representative's Authority

Informed Consent to Chiropractic Services

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays, on me (or on the patient named below, for whom I am legally responsible) by the licensed doctor of chiropractic who now or in the future work at the clinic or office listed below or any other office or clinic.

I consent to the opportunity to discuss with the doctor of chiropractic or with other office or 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 doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

I have read, or have had read to me, the above consent. I consent to the 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.

Patient Signature_____ Date _____

Release of Information

MUST BE FILLED OUT COMPLETELY

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Patients Name:_____ Date of Birth:_____

I give my consent to the staff of Greenway Cotton Chiropractic to relay my radiological testing, or any other pertinent information as follows.

Please provide my medical information to individuals other than myself or circle: **NONE**

Name: _____ (Relationship)_____

Name:_____ (Relationship)_____

Please Check the following:

YES	NO	Leave information on my answering machine at home Home Telephone:
		On answering machine
		With anyone answering the phone
		With designated person listed above
		Leave message with call-back number only
YES	NO	Leave information on my **work phone:**
		On answering machine
		With anyone answering the phone
		Leave message with call back number only
YES	NO	Leave information on my **cell phone**:
		On answering machine
		With anyone answering the phone
		Leave message with call back number only

Signature: _____Date:_____

IRREVOCABLE HEALTHCARE POWER OF ATTORNEY

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TO: Attorney / Insurance Carrier

_____

_____

_____

_____

From: Greenway/303 Chiropractic P.C.,
dba Greenway/Cotton Chiropractic,
16995 W. Greenway Rd., Ste 102
Surprise, AZ, 85388

I, _____ (HEREAFTER, "PRINCIPAL") OF GREENWAY/303 CHIROPRACTIC P.C., COUNTY OF MARICOPA, IN THE STATE OF ARIZONA, do appoint above doctor (hereafter, "Attorney"), as my true and lawful attorney in fact. In Principal's name, and for Principal's use and benefit, said Attorney is hereby authorized to:

1. Endorse any and all checks or other forms of reimbursement made payable to Principle (or members of Principal's family) by and health insurance companies which relate to medical treatment provided by Attorney to Principal (or members of Principal's family) over to Attorney.

2. Demand and direct any and all health insurance companies, during the course of Principal's (or members of Principal's family) medical treatment with Attorney on personal injury cases or major medical matters, to make all reimbursement checks for such treatment payable to Attorney and to send such checks directly to Attorney.

This Special Power of Attorney is created for Attorney's benefit to secure Attorney's right to payment for healthcare services provided and shall be irrevocable throughout the duration of the healthcare services provided by Attorney to Principle arising from any injury or major medical conditions sustained either by Principal or members of Principal's family.

Giving and Granting to said attorney full power and authority to do all and every act and thing whatsoever requisite and necessary to be done relative to any of the foregoing as fully to all intents and purposes as Principal might or could do if personally present.

All that said attorney shall lawfully do or cause to be done under the authority of this power of attorney is expressly approved.

_____ _____
Signature Date

Sworn to or Affirmed before me this: _____, 20_____
(Date)

My Commission Expires: _____ _____
(Notary Public)