West Valley Auto Injury Disc and Spine

Dr.William Bucur --16995 W Greenway Rd. Suite 102/ Surprise, Az. 85388/ 623-433-8895

Motor Vehicle Collision Intake Form

HOW DID YOU HEAR ABOUT OUR OFFICE? Please Circle One.

Walk In, Community Event, Mailing, Postcard, Internet/Facebook, Banner, Patient Referral - Name: _____
Other: _____

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: _____ Medical Practitioner: _____

Employer_____ Address: _____ City: _____

State: _____Spouse Name: _____ DOB: _____/_____/_____ Age: _____

Patient Auto Insurance Information:

Subscriber Name: _____Relationship: _____

Insurance Carrier:_____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

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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MOTOR VEHICLE COLLISION QUESTIONNAIRE
Please answer all questions completely:

Where did the collision occur? **City/Town: _____** **State: _____**

Date of collision: _____ **Time: _____ AM PM**

Were you the: driver passenger pedestrian

If passenger, were you in the front seat right rear seat left rear seat

What type of accident were you in?
Front-End Collision **Rear-End Collision** **Side-Impact Collision** **Other: _____**

What type of vehicle were you in? _____

What type was the other vehicle? _____

What was the weather at the time of the collision? dry wet icy

Was your vehicle in: park neutral in gear moving stopped

What was the estimated speed of your vehicle? _____MPH

Were your brakes being applied? yes no

Was your vehicle shoved: forward backward sideways

Were you shoved: forward whipped backward sideways

Did your seat have a head restraint (headrest?) yes no

Which way was your head rotated immediately before impact? left forward right behind your shoulder

Did any other part of your body hit the interior of the vehicle? yes no

If yes, please specify: steering wheel dashboard windshield side door side window

Which part of your body? chest head chin face R L knee R L shoulder R L hand other_____

Were you holding on to the steering wheel? yes no

Did you brace your legs against the floorboard? yes no

Did the vehicle go into a spin or roll as a result of the impact? yes no

If yes, explain: _____

Describe how you felt immediately following impact? (Physically and emotionally)

_____

How much damage was there to the outside of the vehicle? none some a lot

Was your car totaled? yes no Car evaluation amount? $_____

How much damage was there to the inside of the vehicle? none some a lot

Were you wearing a seat belt? yes no

Did the seat break as a result of the impact? yes no

Were you braced for the impact? yes no

Were you surprised by the impact? yes no

Did the airbag deploy? yes no

Any burns cuts bruises stitches? Area(s): _____

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Were you unconscious? Y / N **Did you go to the hospital?** Y / N **If yes, When** ? __/__/_____

Name of hospital _____

If you went to the hospital, please answer the following:
Were you taken in an ambulance? Y / N Other: _____

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

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

Treatment Received _____
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 On

Have you lost any days of work from this injury? yes no If yes, give dates: _____

Are you experiencing loss of enjoyment of life since the accident? yes no

Loss of Enjoyment Summary

Complete the following summary as it relates to your lifestyle, work environment, and activities which you normally would be enjoying, but are currently not enjoying as a result of the motor vehicle collision.

Work/ Job Description

Increased pain when: Lifting Bending Sitting for long periods Walking for long periods Computer Duties
Finger/ wrist movement other:_____
Unable to perform: Lifting Bending Sitting for long periods Walking for long periods Computer Duties
Finger/ wrist movement other:_____

Domestic/Household Duties

Increased pain when: Vacuuming Cleaning Taking care of Kids Drive car Preparing Meals Yardwork
Shopping Taking out Trash other:_____
Unable to perform: Vacuuming Cleaning Taking care of Kids Drive car Preparing Meals Yardwork
Shopping Taking out Trash other:_____

Sports/ Fitness

How many days per week do you enjoy exercising? : _____**Days per week**

Increased pain when: Running Lifting Bending Swimming Kicking Swinging Jumping
other:_____
Unable to perform: Running Lifting Bending Swimming Kicking Swinging Jumping
other: _____

PTSD Questionnaire

Are you experiencing any of the following? : Anxiety when driving Depression Problems sleeping from pain
Loss of concentration Anger Dizziness Nausea/vomiting Sadness Paranoia Nightmares

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WHIPLASH DISABILITY QUESTIONNAIRE

This questionnaire has been designed to provide information on the impact that your whiplash injury and symptoms have upon your lifestyle. Please circle the number in each section to indicate how you have been affected by the whiplash injury and symptoms. If one or more questions are not relevant to you, please leave that section blank.

1. How much **pain** do you have today?

0 1 2 3 4 5 6 7 8 9 10
No pain — Worst pain imaginable

2. How much do your whiplash symptoms interfere with your **personal care** (washing, dressing, etc)?

0 1 2 3 4 5 6 7 8 9 10
Not at all — Unable to perform

3. How much do your whiplash symptoms interfere with your **work/home/study duties**?

0 1 2 3 4 5 6 7 8 9 10
Not at all — Unable to perform

4. How much have your whiplash symptoms interfered with **driving or using public transport**?

0 1 2 3 4 5 6 7 8 9 10
Not at all — Unable to travel in car/use public transportation

5. How much do your whiplash symptoms interfere with **sleep**?

0 1 2 3 4 5 6 7 8 9 10
Not at all — Cannot sleep

6. How often do you experience **tiredness/fatigue** as a result of your whiplash injury/symptoms?

0 1 2 3 4 5 6 7 8 9 10
Not at all — Always

7. How much do your whiplash symptoms interfere with **social activity**?

0 1 2 3 4 5 6 7 8 9 10
Not at all — Unable to socialize

8. How much do your whiplash symptoms interfere with **sporting activity**?

0 1 2 3 4 5 6 7 8 9 10
Not at all — Unable to participate

9. How much do your whiplash symptoms interfere with **non-sporting leisure activity**?

0 1 2 3 4 5 6 7 8 9 10
Not at all — Unable to participate

10. How often do you experience **sadness/depression** as a result of your whiplash injury/symptoms?

0 1 2 3 4 5 6 7 8 9 10
Not at all — Always

11. How often do you experience **anger** as a result of your whiplash injury/symptoms?

0 1 2 3 4 5 6 7 8 9 10
Not at all — Always

12. How often do you experience **anxiety** as a result of your whiplash injury/symptoms?

0 1 2 3 4 5 6 7 8 9 10
Not at all — Always

13. How much difficulty do you have **concentrating** as a result of your whiplash injury/symptoms?

0 1 2 3 4 5 6 7 8 9 10
No difficulty — Unable to concentrate

14. How has your condition **changed** over the past month?

-5 -4 -3 -2 -1 0 1 2 3 4 5
Very much wore — No Change — Very much better

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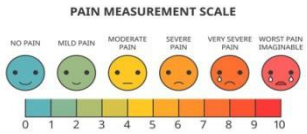
Please check mark all symptoms that have occurred since the accident:

□ Headaches	Muscle Spasms	Sensitivity to Light	Numbness/tingling
□ Neck Pain	Dizziness	□ Upper Arm Pain	Problems concentrating
□ Neck Stiffness	Middle Back Pain	Lower Leg Pain	Pain in Hands
□ Sleeping Problems	Bruising	Lower Back Pain	Pain in Feet
□ Depression	Cuts/Abrasions	□ Decreased Grip Strength	□ Lack of Coordination
Anxiety	Burns	Radiating Pain into arms	□ Anger
Fainting	Blurred Vision	Radiating Pain into legs	□ Other: _____

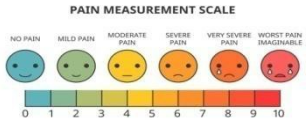
DESCRIBE AREA OF COMPLAINT - Begin with the area causing the most distress. (circle the words that apply)

Area #1 _____ **Tone - (Circle) - Dull Sharp Achy/Soreness Stiff/Tightness Numbness/Tingling**



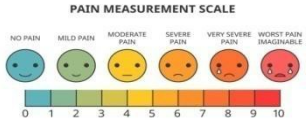
Rate - _____ **Frequency – (Circle) - Constant Intermittent Occasional**

Area #2 _____ **Tone - (Circle) - Dull Sharp Achy/Soreness Stiff/Tightness Numbness/Tingling**



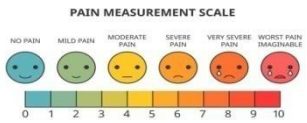
Rate - _____ **Frequency – (Circle) - Constant Intermittent Occasional**

Area #3 _____ **Tone - (Circle) - Dull Sharp Achy/Soreness Stiff/Tightness Numbness/Tingling**



Rate - _____ **Frequency – (Circle) - Constant Intermittent Occasional**

Area #4 _____ **Tone - (Circle) - Dull Sharp Achy/Soreness Stiff/Tightness Numbness/Tingling**



Rate - _____ **Frequency – (Circle) - Constant Intermittent Occasional**

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

2. Have you seen any other doctors for this condition? If yes, who? _____ Results: **Yes No**

3. Are you currently under drug/medical care? **Yes No** Condition _____ Results: **Yes No**

4. Previous Chiropractic Care: _____ Approx. date of last visit: _____/_____/_____

5. Previous Spinal Injuries? **YES NO** _____ Automobile Accidents? **YES NO**

6. How many & when _____ Exercise Problems or Injuries? **YES NO**

7. Exercise**:** **Often Occasionally** 8. Difficulty Sleeping? **YES NO** 9. Position that Relieves Tension? **Side Stomach Back**

10. Previous Injuries or Broken Bones: _____

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Please circle all that apply to you:

Allergies	Arthritis	Asthma	Blood Clots
High 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	Low Blood Pressure

Other:_____

Pregnancy: Due Date:_____# of weeks: _____

Medications: *(please list all medications and supplements that you currently take)*

_____ _____ _____
_____ _____ _____
_____ _____ _____

Allergies: *(please list all medications that cause allergic reaction)*

_____ _____ _____
_____ _____ _____
_____ _____ _____

Smoking: ___Yes ___No If yes, _____Packs per Day for _____years

Alcohol ___Yes ___No If yes, Number of drinks per week _____

Surgical History: Please list ALL previous surgery and the date on which it was performed:

Surgery _____ Date _____
_____ _____
_____ _____

Personal Medical History & Review of Systems:

Please indicate with an "X" any medical problems that you currently have or have had in the past.

□ **NO MEDICAL PROBLEMS** - no prior history of any significant medical problems

Cancer : any type -- please specify _____

Lungs / Pulmonary – breathing disorders
□ asthma □ pulmonary embolism □ respiratory arrest
□ COPD □ pneumonia □ sleep apnea
□ emphysema □ tuberculosis □ other: _____

Cardiac / Heart and peripheral vascular disease
□ chest pain / angina □ high blood pressure □ irregular heartbeat, arrhythmia
□ heart attack □ heart murmur, valve disorder □ peripheral vascular disease
□ congestive heart failure □ mitral valve prolapse □ deep vein thrombosis
□ other: _____ □ bleeding problems

Neurologic Disorders
□ stroke or TIA □ Parkinson's □ cerebral palsy
□ peripheral neuropathy □ MS □ polio
□ other: _____

Bone & Joint Disorders
□ osteoarthritis □ gout □ osteomyelitis
□ rheumatoid arthritis □ lupus □ ankylosing spondylitis
□ other: _____
Do you have arthritis or degenerative joint disease? yes no

Gastrointestinal Disorders
□ peptic ulcer or stomach ulcer □ diverticulitis □ hepatitis - Type _____
□ acid reflux, GERD □ irritable bowel □ liver disease
□ GI bleed □ inflammatory bowel disease
□ other: _____

Genitourinary Disorders
□ urinary tract infection □ kidney problems □ dialysis, kidney failure
□ bladder problems □ kidney stones □ other: _____

Metabolic & Other Disorders
□ Diabetes x _____years □ skin disorder _____ □ depression
□ thyroid problems □ psoriasis □ anxiety
□ sickle cell disease □ any skin ulcer □ alcohol or drug dependency
□ high cholesterol or lipids □ tooth abscess, gingivitis □ other: _____

Family History:
Please indicate with an "X" any significant family medical history or problems.
□ asthma □ tuberculosis □ sleep apnea
□ COPD or Emphysema □ other lung :_____
□ heart attack, myocardial infarction □ congestive heart failure
□ irregular heartbeat, arrhythmia □ bleeding problems □ Peripheral neuropathy □ MS or Parkinson's
□ other neuro :_____
□ osteoarthritis □ Lupus □ gout
□ rheumatoid arthritis □ Other bone & joint: _____
□ acid reflux, GERD □ inflammatory bowel disease □ hepatitis - Type _____
□ liver disease □ other GI :_____
□ kidney problems □ dialysis, failure
□ diabetes □ psoriasis □ high cholesterol or lipids
□ thyroid problems □ sickle cell disease □ any skin ulcer
□ Malignant hyperthermia

Patient Name: _____ Date: _____

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Financial Agreement

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 each return of payment.

_____ A fee will be charged for missed appointments and cancelled appointments inside of 24 hours.

- $30 charge for 1 Hour massage
- $15 charge for 30 min massage
- $10 charge for Chiropractic Adjustment
- $10 charge for Laser
- $10 charge for Spinal Decompression

All payments will be processed to the credit card on file that same day. Late arrivals to sessions may require to be shortened in order to accommodate others whose appointments follow yours. Depending upon how late you arrive, your therapist will then determine if there is enough time remaining to start a treatment. Regardless of the length of the treatment actually given, you will be responsible for "full cost" of the cost of that session. Out of respect and consideration for your therapist and other customers, please plan accordingly and be on time.

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 if my insurance policy contains Med Pay or PIP, Greenway Cotton Chiropractic will bill my policy for reimbursement and provide proof of payment to my attorney/the at fault party.

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.

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

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

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Informed Consent to Chiropractic Services

- You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.
- We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.
- Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.
- It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, dislocations, strains, and sprains. In addition, the literature recognizes an association between strokes and chiropractic manipulation of the cervical spine. With respect to strokes, there is a rare but serious condition known as an "arterial dissection" that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.
- Carotid and vertebral artery dissections are rare, with an annual incidence of 2.5 – 4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately, a percentage of these patients will experience a stroke.
- The reported association between visits to a chiropractor or a primary care physician and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million visits.
- It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.
- I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.
- Patient Name: _____ Signature: _____ Date:
- Parent or Guardian: _____ Signature: _____ Date:
- Witness Name: _____ Signature: _____ Date:

Consent to Treatment of a Minor: By my signature above, I hereby authorize the office and its therapists to provide massage and related services to my minor child or dependent as we deem necessary. Additionally, I have read, verified, and agree with all information on this form. I understand that I may be present during any massage received by child. This authorization is valid until and unless it is revoked by me in writing. Name of Parent or Guardian (please print):

_____

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Informed Consent to Massage Therapy Services

- I hereby consent to massage therapy to be performed by affiliate Massage Therapist within the office and acknowledge that if I experience any pain or discomfort within the massage session
- 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. I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort.
- I further understand that Massage Therapy should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment of which I am aware.
- Because Massage should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I fail to do so.
- Cupping/Gua Sha: I understand that cupping therapy will leave bruise-like marks that will last several days depending on the severity of my condition. While most marks fade and disappear after a few days, there are times when marks could take up to 15 days to clear and in rare cases, it has been reported that marks have taken up to 21 days to fully clear.
    - Contraindications: 1. Hemophilia or other bleeding/clotting disorders 2. Patients taking blood thinners 3. Weak patients or those who have been ill 4. Abdomen and lower back on pregnant women 5. Diabetics. Especially those with uncontrolled blood sugar as they may not be able to feel pain properly 6. Those who are unable to experience heat or pain properly 7. Those who have circulatory conditions *8. Those who are unsure if their condition is contraindicated should seek guidance from their primary care physician prior to receiving cupping therapy.*
    - I understand that bruising, discoloration and/or soreness will likely occur following this treatment and may take days or weeks to fully resolve. I further understand that the above-listed conditions are contraindicated for cupping therapy and I have informed my therapist/physician of any and all medical conditions, even those not listed as contraindications. I further understand that there is a potential for burns and/or blisters due to the fire/heat aspect of the treatment. This is a rare but not unexpected occurrence. (Initials) _____
- Improper Conduct: This is a Therapeutic Massage session and any sexual remarks or advances will terminate the session and understand I will be liable for payment of the scheduled treatment. I understand the Massage Therapist practitioner reserves the right to refuse services to me for any reason that the Therapist deems necessary. Male and *female* modest will be considered will not be exposed or touched at any time. Professional draping will be used for your privacy and comfort. Our policy requires therapists to leave the room prior to disrobing/undressing and use draping with sheets/ blankets at all times during every massage session.

(Initials) _____

Print Patient Name: _____

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

Informed Consent to Class 4 Laser Services
Consent and Contraindications

Contraindications and Cautions

Use Laser Therapy with extra care if you meet any of the following criteria:

- Sensitivity to light
- Pregnancy
- Cancerous tissues or tumors
- Taking light sensitive medications or are pre-treated with photo sensitizers
- **Are you are any medications that are heat sensitive? Yes or No**

I, _____, have fully read and understand the provided information about Class 4 Laser Therapy and the contraindications and cautions for treatment. I consent that I do not have any of the conditions listed under the contraindications segment of this form and agree to receive Class 4 Laser treatment from Greenway Cotton Chiropractic. **NO GUARANTEES** – Because all individuals are different it is not possible to completely predict the benefits from this treatment. By signing this form I acknowledge that guarantees as to the final results of my treatment have not been made. Some individuals will have a very noticeable improvement after their first treatment while others may have little or no improvement. I understand that additional treatments for additional fees may be required to achieve my desired end result.

Print Patient Name:_____

Patient Signature:_____ Date:_____

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Consensual Lien

Release of Information

AUTHORIZATION FOR RELEASE OF RECORDS & PHYSICIAN'S LIEN

TO: Attorney/Insurance Carrier

_____

_____

_____

_____

From: Greenway/303 Chiropractic P.C.

William M. Bucur D.C.

16995 W. Greenway Rd., Ste 102

Surprise, AZ, 85388

Patient Name: _____

RELEASE OF RECORDS: I do hereby authorize the above doctor to furnish you, my attorney/insurance carrier, with a full report of this case history, examination, diagnosis, treatment, and prognosis of myself in regard to my accident on record.

LIEN ON SETTLEMENT: I hereby give a Lien to the above doctor on any settlement, claim, judgment, or verdict as a result of said accident. I authorize and direct you, my attorney/Insurance Carrier, to pay directly to said doctor all sums that are due and owing, for services rendered me, by withholding such sums from any settlement, claim, judgment, or verdict as may be necessary to protect said doctor adequately. Prior to dispersing any such fees, it is the responsibility of the payer to verify with this office all outstanding balances.

ASSIGNMENT OF BENEFITS: I further assign my claim or right to compensation for treatment expenses incurred with the doctor/clinic named above arising from a tort or liability claim in connection with this accident or injury.

IRREVOCABLE LIEN: I understand that this Lien shall be irrevocable either by myself or any other agent that represents me; that in the event another attorney is substituted in this matter, the new attorney shall honor this lien as inherent to the settlement and enforceable upon the case as if it was executed by him.

RESPONSIBILITY FOR PAYMENT: I understand that I am directly and fully responsible to said doctor/clinic for chiropractic bills submitted for services rendered me, and that this agreement is made solely for said doctor's additional protection and in consideration of his awaiting payment. I further understand that such payment is not contingent on any settlement, claim, judgment, or verdict by which I may eventually recover said fee. In the event that there is a deductible or co-pay to be satisfied, I understand and agree to pay any deductible or co-pay required by any insurance company that is billed for me. I understand that if my insurance policy contains Med Pay, PIP, Underinsured/Uninsured Greenway Cotton Chiropractic will bill my policy for reimbursement and provide proof of payment to my attorney/the at fault party. I also understand and agree that I am responsible for any reasonable collection fees required to secure the doctor's payment.

Patient Signature: _____ Dated: _____

Receipt Verification

____ Sent by Certified US Mail

____ Sent by Fax with Receipt Confirmation

Staff Name (print) _____ Staff Name (sign) _____ Date: _____

Attorney Signature: _____ Dated: _____

West Valley Auto Injury Disc and Spine
Dr.William Bucur --16995 W Greenway Rd. Suite 102/ Surprise, Az. 85388/ 623-433-8895

NOTICE OF PRIVACY PRACTICES

Abridged Edition

Effective April 14, 2003, the Department of Health & Human Services has implemented protection for patient health care information. It outlines who we may disclose information to without your authorization and how we can disclose your protected health information with your authorization as well as how you can gain access to your personal health information or to make a complaint to the Department of Health & Human Services if you feel your protected health information was used in an improper way. This notice will give you a brief description of our entire privacy practices.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

So that this office can treat you, receive payment for that treatment and run our health care operation, we may use your protected health information without your authorization to send to third party payers, administrators, etc.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION THAT MAY BE MADE WITH YOUR WRITTEN AUTHORIZATION

With your signed authorization we may make communications with you to promote products and services that may not be for a specific purpose of providing treatment advice. You have the right to revoke this authorization. Other permitted and required uses and disclosures that may be made without your authorization or opportunity to object – we may disclose to a member of your family, a relative, a close friend or other person you identify, your protected health information that directly relates to that person's involvement in your health care. We may also disclose your protected health information to an authorized public or private entity as required by law.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES THAT MAY BE MADE WITHOUT YOUR CONSENT, AUTHORIZATION OR OPPORTUNITY TO OBJECT

We may use or disclose your protected health information in the following situations:

- Required by law
- Health Oversight
- Legal Proceedings
- Research

Your rights – You may inspect or obtain a copy of your protected health information for as long as we maintain that information unless protected by federal law.

RIGHT TO REQUEST A RESTRICTION OF YOUR PROTECTED HEALTH INFORMATION

You may ask us not to use or disclose any part of your protected health information for the purpose of treatment, payment or health care operation. Also, you may request that any part of your protected health information not be disclosed to your family members or friends who may be involved in your care. Your request must be in writing and state specific restrictions requested and to whom it applies.

RIGHT TO REQUEST TO RECEIVE CONFIDENTIAL COMMUNICATION FROM US BY ALTERNATIVE MEANS OR AT AN ALTERNATIVE LOCATION

You may request that you receive these communications from us at an alternative location or by alternative means than is normally provided to other patients.

RIGHT TO AMEND YOUR PROTECTED HEALTH INFORMATION

You may request an amendment to your protected health information for as long as we maintain your protected health information. In certain cases we may deny your request for an amendment.

RIGHT TO RECEIVE AN ACCOUNTING OF CERTAIN DISCLOSRUES WE HAVE MADE

You have the right to receive an accounting if we receive a request for disclosure of information for purposes other than treatment, payment and health care operations

RIGHT TO OBTAIN A PAPER COPY OF THIS NOTICE

You have the right to receive a complete copy of our privacy practices by paper or electronically.

COMPLAINTS

If you believe your privacy rights have been violated, you may complain to us or to the Secretary of Health & Human Services. This notice was published and becomes effective (updated) January 1st, 2018.

West Valley Auto Injury Disc and Spine
Dr.William Bucur --16995 W Greenway Rd. Suite 102/ Surprise, Az. 85388/ 623-433-8895

HIPAA 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

Authorization

I_____, give authorization to the following individuals listed below to:

Communicate with Greenway Cotton Chiropractic by way of text, email, or phone on my behalf to discuss my schedule, reschedule or cancel appointments. ( ) yes ( ) no

Communicate in regards to billing and results pertaining to my care with Greenway Cotton Chiropractic. ( ) yes ( ) no

Name: _____

Relationship: _____

Name:_____

Relationship: _____