JONES CHIROPRACTIC CLINIC, INC.
6547 E. 71st. Street, Tulsa, OK 74133-2755 (918) 481-6535 FAX (918) 481-6537
7841-A E. 134th Street, Bixby, OK 74008 (918) 369-8500 FAX (918) 369-8500

PERSONAL INJURY QUESTIONNAIRE

Name _____ Home Phone _____ Work Phone _____

Address _____ City _____ State _____ Zip _____

Social Security # _____ Birthdate _____ Age _____ Male _____ Female _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed Number of Children _____

Occupation _____ Employer _____ Employer Address _____

City _____ State _____ Zip _____ Name of Spouse _____ Work Phone _____

Patient's Nearest Relative _____ Phone _____

Referred By: _____ Have You Had Chiropractic Care Before? _____

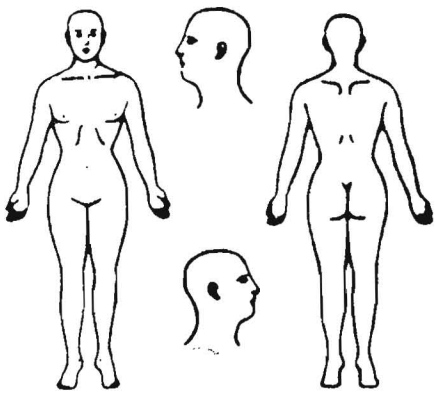
List Your Chief Symptoms In Order of Severity: Date of Last Physical _____

(1) _____ For How Long? _____

(2) _____ For How Long? _____

(3) _____ For How Long? _____

Please mark your areas of pain on the figures below.



What functions are you unable to perform or induce pain upon performance? List in order of severity (Example: sitting, walking, bending, laying, etc.)

1. _____
2. _____
3. _____
4. _____

Other Doctors seen for this condition _____

When did symptoms start? _____

How frequent is the pain? _____

Where is it located? _____

Describe the pain _____

What makes it worse? _____ What makes it better? _____

Is it worse in the morning or evening? _____

Does it radiate to any other parts of your body? _____

Do you experience nausea? _____ Numbness? _____

How does this affect you at home/work? _____

_____

Did you have normal pregnancies? (If applicable) _____

What types of medication have you taken for this? _____

_____

FAMILY HISTORY

Name of Wife or Husband _____ Ages of Children _____

Spouse's Employer _____ Business Phone _____

Your Nearest Relative _____ Relative's Address _____

Do you have a history of back problems in your family? _____

_____

If female are you pregnant? _____ Are you/Have you been diagnosed with cancer? _____

In your own words, please describe accident: _____

_____

_____

_____

Name _____ Insurance Company _____ Policy # _____
Driver of vehicle in which you were injured (if applicable)

Name _____ Insurance Company _____ Policy # _____
Driver of other vehicle (if any)

Attorney ☐ Yes ☐ No Name _____ Address _____

Phone _____ Were there any witnesses? ☐ Yes ☐ No Names _____

_____

Date of Accident _____ Time of Day _____ Number of People in Your Vehicle _____

Were you the: ☐ Driver ☐ Passenger ☐ Front Seat ☐ Back Seat

Were you wearing your seat belt? _____ What direction were you headed? _____

On (Name of Street) _____ Were you struck from: ☐ Behind ☐ Front ☐ Left Side ☐ Right Side

Approximate Speed of Your Car _____ mph Other Car _____ mph

Were you knocked unconscious? ☐ Yes ☐ No If yes, for how long? _____

Were the police notified? ☐ Yes ☐ No Have you ever been involved in an accident before? _____

If yes, describe, including dates and type of injury received: _____

_____

Did you have any physical complaints before the accident? _____ If yes, describe: _____

_____

Please describe how you felt:: During the Accident _____

Immediately After the Accident _____

Later that Day _____ The Next Day _____

Where were you taken after the accident? _____

Since this injury, are your symptoms: ☐ Improving ☐ Getting Worse ☐ Same

☐ Headache	☐ Irritability	☐ Shortness of Breath	☐ Pins & Needles in Arms
☐ Neck Pain	☐ Chest Pain	☐ Sleeping Problems	☐ Pins & Needles in Legs
☐ Neck Stiff	☐ Dizziness	☐ Head Seems Heavy	☐ Numbness in Fingers
☐ Numbness in Toes	☐ Loss of Balance	☐ Other _____	

Have you lost time from work as a result of this accident? _____ If yes, last day worked: _____

Do you notice any activity restriction as a result of this injury? _____

_____

INSURANCE INFORMATION

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this chiropractic office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this chiropractic office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

Signature: _____

CONSENT OF PROFESSIONAL SERVICES AND RELEASE OF INFORMATION

I hereby authorize Jones Chiropractic and whomever they may designate as their assistants to administer treatment, physical examination, X-ray studies, laboratory procedures, chiropractic care or any clinic services that he deems necessary in my case; and I further authorize him to disclose all or any part of my (patient's) record to any person or corporation which is or may be liable under a contract to the clinic or to the patient or a family member or employer of the patient for all or part of the clinic's charge, including, and not limited to, hospital or medical services companies, insurance companies, workers' compensation carriers, welfare funds, or the patient's employer.

Patient's or Guardian's Signature: _____

Date _____ Patient Signature _____

NAME: _____
DATE: _____
Crt#. _____

Please circle current conditions - check former conditions

GENERAL SYMPTOMS
- ☐ Headache
- ☐ Fever
- ☐ Chills
- ☐ Sweats
- ☐ Fainting
- ☐ Dizziness
- ☐ Convulsions
- ☐ Loss of Sleep
- ☐ Fatigue
- ☐ Nervousness
- ☐ Gain/Loss of Weight
- ☐ Numbness/pain in arms, hands, legs
- ☐ Allergy
- ☐ Wheezing
- ☐ Neuralgia/neuritis
- ☐ Depression

E.E.N.T.
- ☐ Failing vision
- ☐ Near sightedness
- ☐ Far sightedness
- ☐ Crossed eyes
- ☐ Eye pain
- ☐ Deafness
- ☐ Earache
- ☐ Ear discharge
- ☐ Nose bleeds
- ☐ Nasal obstruction
- ☐ Sore throat
- ☐ Hoarseness
- ☐ Hay fever

E.E.N.T. continued
- ☐ Tinnitus
- ☐ Asthma
- ☐ Gum trouble
- ☐ Frequent colds
- ☐ Enlarged thyroid
- ☐ Tonsillitis
- ☐ Sinus infection
- ☐ Nasal drainage
- ☐ Enlarged glands

SKIN
- ☐ Skin eruptions
- ☐ Itching
- ☐ Bruises easily
- ☐ Dryness
- ☐ Boils
- ☐ Varicose veins
- ☐ Sensitive skin
- ☐ Hive or allergy

RESPIRATORY
- ☐ Chronic cough
- ☐ Spitting up phlegm
- ☐ Spitting up blood
- ☐ Chest pain
- ☐ Difficult breathing

CARDIO VASCULAR
- ☐ Rapid beating heart
- ☐ Slow beating heart
- ☐ High blood pressure
- ☐ Low blood pressure

CARDIO VASCULAR cont'd
- ☐ Pain over heart
- ☐ Previous heart attack
- ☐ Hardening of arteries
- ☐ Swelling of ankles
- ☐ Poor circulation
- ☐ Paralytic stroke
- ☐ Aneurysm

MUSCLE & JOINT
- ☐ Stiff neck
- ☐ Backache
- ☐ Swollen joints
- ☐ Painful tailbone
- ☐ Foot trouble
- ☐ Pain in shoulders
- ☐ Hernia
- ☐ Spinal curvature
- ☐ Faulty posture
- ☐ Arthritis

GENITOURINARY
- ☐ Frequent urination
- ☐ Painful urination
- ☐ Blood in urine
- ☐ Pus in urine
- ☐ Kidney infection
- ☐ Kidney stones
- ☐ Bed wetting
- ☐ Inability to control urine
- ☐ Prostate trouble

GASTROINTESTINAL
- ☐ Poor appetite
- ☐ Difficult digestion
- ☐ Excessive hunger
- ☐ Belching or gas
- ☐ Nausea
- ☐ Vomiting
- ☐ Vomiting of blood
- ☐ Pain over stomach
- ☐ Constipation
- ☐ Colon trouble
- ☐ Hemorrhoids (piles)
- ☐ Intestinal worms
- ☐ Liver trouble
- ☐ Gall bladder trouble
- ☐ Jaundice
- ☐ Colitis

FOR WOMEN ONLY
- ☐ Painful menstruation
- ☐ Excessive flow
- ☐ Hot flashes
- ☐ Irregular cycle
- ☐ Cramps or backache
- ☐ Previous miscarriage
- ☐ Vaginal discharge
- ☐ Congested breast
- ☐ Lumps in breast
- ☐ Menopausal symptoms
- ☐ Pregnancy

HAVE YOU HAD ANY OF THE FOLLOWING DISEASES?
- ☐ Appendicitis
- ☐ Scarlet fever
- ☐ Diphtheria
- ☐ Typhoid fever
- ☐ Pneumonia
- ☐ Rheumatic fever
- ☐ Polio
- ☐ Malaria
- ☐ Tuberculosis
- ☐ Whooping cough
- ☐ Anemia
- ☐ Measles
- ☐ Mumps
- ☐ Small pox
- ☐ Chicken pox
- ☐ Diabetes
- ☐ Cancer
- ☐ Heart disease
- ☐ Goiter
- ☐ Influenza
- ☐ Pleurisy
- ☐ Alcoholism
- ☐ Venereal infection
- ☐ Epilepsy
- ☐ Mental disorder
- ☐ Eczema
- ☐ Drug dependency
- ☐ Emphysema
- ☐ Asthma

Coffee, tea, caffeinated soft drinks (cups per day) _____

Tobacco (packs per day) _____

DO YOU HAVE A PERMANENT DISABILITY RATING? _____ Location _____ Date received _____

rating percentage _____

COMMENTS: _____

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(Next to Daily YMCA)
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Unravel your bones with Dr. Jones!

Dear Patient:

Please read the information marked by the checked box. This will be applicable in your case. Please sign and date on the next page.

❒ CASH PATIENT

1. We request that 100% of the first visit be paid at the time of service.
2. We are happy to accept cash, check, Visa, MasterCard and Discover.

❒ GROUP OR INDIVIDUAL INSURANCE

Your insurance is an agreement between you and your insurance company, not between your insurance company and this office. It is to be understood that services rendered are charged to you directly and you are personally responsible. We do not file secondary insurance, however we will print insurance receipts for you and you can file to your secondary carrier for reimbursement.

Your insurance company may cover chiropractic. The amount they pay varies from one policy to another. Because of this difference between policies, we expect that each patient who wishes to file insurance claims through this office pay the policy deductible and the percentage/copay as stated in your policy.

❒ MEDICARE

We do accept assignment from Medicare and Medicare sends their payment to us for covered services. Services covered by Medicare in a chiropractic office are for spinal manipulations only. Medicare does not cover exams, x-rays, therapies, supports or supplements. Medicare pays 80% of the spinal adjustment once the deductible has been met. You are responsible for the 20% balance and for payment in full of all non-covered services. We do not file secondary insurance, however we will print insurance receipts for you and you can file to your secondary carrier for reimbursement.

(continued on next page)

❒ **"ON THE JOB" INJURY**

Worker's Compensation pays in full for chiropractic care. Upon being released from care, a three month time period is allowed for settlement of your claim. If settlement has not been reached within this time period, or you have suspended or terminated your care without your doctor's approval, payment for services is due immediately. I understand that I am being treated under the assumption that this injury is work-related. In the event that this case proves not to be work-related or denied , then I am fully aware of the charges incurred to me and I am also aware that I am fully responsible for the charges.

❒ **PERSONAL INJURY OR AUTOMOBILE ACCIDENTS**

Please present your auto insurance forms as soon as possible along with a copy of the police report (for auto accidents). If an attorney is handling your case, please notify our insurance department right away. Although you are ultimately responsible for your bill, our office will wait for settlement to be paid as long as you are an active patient. If you suspend or terminate care, any fees for services are due immediately. **Upon being released from care, a three month time period is allowed for settlement of your claim. If settlement has not been reached within this time period, or you have suspended or terminated your care without your doctor's approval, payment for services is due immediately.**

I understand and agree that health and accident policies are an arrangement between an insurance company and myself. Furthermore, I understand that Jones Chiropractic Clinic will prepare any necessary reports and forms necessary to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Jones Chiropractic Clinic will be credited to my account on receipt. However, I clearly understand the total charges for professional services rendered to me by this clinic and I am personally responsible for payment. I also understand that Jones Chiropractic Clinic will file a lien against myself and the insurance company(s) involved.

Your Motor Vehicle Ins Co. _____
Policy #: _____ Claim#: _____
Adjustor's Name: _____
Phone: _____ ext _____

Other Motor Vehicle Ins Co. _____
Policy #: _____Claim #: _____
Adjustor's Name: _____
Phone: _____ ext _____

I have read and understand the above terms.

Patient Name (Printed): _____

Patient Signature: _____

Date: _____Witness: _____

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NOTICE OF PRIVACY PRACTICES

OUR PLEDGE REGARDING MEDICAL INFORMATION

This notice is to inform you that your personal health information will only be used for purposes of treatment in our facility and will not be misused or disclosed by / to anyone outside of our practice. You may gain access to this information if you desire.

Please review is carefully. The privacy of your health information is important to us.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this notice about our privacy practices, our legal duties and your rights concerning your health information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect April 14, 2003 and will remain in effect.

We reserve the right to change our privacy practices and the terms of this notice at any time provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this notice and make the new notice available upon request.

You may request a copy of our notice at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the information listed at the end of this notice.

USES AND DICLOSERS OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

> **Treatment:** We may use or disclose your health information to a physician or other healthcare provider who is currently providing treatment to you.
> **Payment:** We may use and disclose your health information to obtain payment for services we provide to you (i.e. insurance companies).
> **Healthcare Operations:** We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization
In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclose permitted by your authorization while it was in effect. Unless you give written authorization, we cannot use or disclose your health information for any reason except those described in this notice.

To Your Family and Friends
We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved in Care
We may use or disclose health information to notify or assist in the notification of (included identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses of disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to that person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Relation Services: Our chiropractic office does not use patient information for any marketing purposes. We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when it is required by law to do so (i.e. missing person, etc.).

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to lawfully authorize federal officials health information required by lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institutions or law enforcement officials having lawful custody of protected health information of inmate or patient under certain circumstances.

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this notice. We may charge you a reasonable cost-based fee for expenses such as copies and staff time. You may request access by sending us a letter to the address at the end of this notice. If you request an alternative format, we will charge a cost-based fee for providing your health information in the format. If you prefer, we will prepare a summary or an explanation of your health information for a fee.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for any purpose, other than treatment, payment, healthcare operations, and certain other activities for the last 6 years by not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions of our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing) Your request must specify that alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing. It must explain why the information should be amended.) We may deny your request under certain circumstances.

QUESTIONS AND COMPLAINTS

If you desire further information about our privacy practices or if you have questions, please contact us. If you are concerned that we may have violated your privacy rights, you may complain to us using the contact information listed at the end of this notice. You also may submit a written complaint to the U.S Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

Contact : Privacy Officer, Dr. Todd A. Jones, Owner, 6547 East 71st Street, Tulsa, OK 74133-2755, phone (918) 481-6535

PRIVACY PRACTICES ACKNOWLEDGEMENT

I have received the **Notice of Privacy Practices** and I have been provided an opportunity to review it.

Name _____ **Date:** _____

Signature: _____

If you would like us to disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for your healthcare, please list their names below:

_____ _____

_____ _____

_____ _____

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Informed Consent to Chiropractic Treatment

Patient: Please discuss any questions or concerns with the Doctor **before** signing this consent.

The nature of chiropractic treatment: The doctor will use his/her hands or a mechanical device in order to move your joints. You may feel a "click" or "pop", such as the noise when a knuckle is "cracked", and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electrical muscle stimulation, intersegmental traction or therapeutic ultrasound may also be used.

Possible Risks: As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or minor complications.

Probability of risks occurring: The risks of complications due to chiropractic treatment have been described as ***"rare",*** about as often as complications are seen from the taking of ***a single aspirin tablet*.** The risk of cerebrovascular injury or stroke, has been estimated at ***one in one million to one in twenty million***, and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered ***"rare".***

If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

Other treatment options which could be considered may include the following:

- Over-the-counter analgesics
- Medical care
- Hospitalization
- Surgery

I understand that chiropractic is not an exact science and that, therefore, reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the chiropractic treatment that I have requested and authorized. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction. I consent to the proposed treatment for my present condition and for any future condition(s) for which I seek treatment.

Printed name: _____ Date: _____

Patient or Parent/Guardian (if minor) Signature:_____

Doctor's Signature: _____

Pregnancy Release:

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual cycle: _____

Signature: _____ Date: _____

SIGN-IN SHEET

Patient Name: _____

1. Date: _____ Signature: _____
2. Date: _____ Signature: _____
3. Date: _____ Signature: _____
4. Date: _____ Signature: _____
5. Date: _____ Signature: _____
6. Date: _____ Signature: _____
7. Date: _____ Signature: _____
8. Date: _____ Signature: _____
9. Date: _____ Signature: _____
10. Date: _____ Signature: _____
11. Date: _____ Signature: _____
12. Date: _____ Signature: _____
13. Date: _____ Signature: _____
14. Date: _____ Signature: _____
15. Date: _____ Signature: _____
16. Date: _____ Signature: _____
17. Date: _____ Signature: _____
18. Date: _____ Signature: _____
19. Date: _____ Signature: _____
20. Date: _____ Signature: _____