

Patient's Name _____ Date of Birth _____

NOVO CHIROPRACTIC Automobile/PI Accident or Work Comp Questionnaire

Dear Patient:

This information is considered confidential. Your answers will help us determine if chiropractic care can help your condition. We will not accept your case if we do not believe your condition will respond satisfactorily to care. In order for us to understand your condition properly, please be as neat and accurate as possible while completing this form. Thank you.

Please answer all questions completely.

Please explain in detail how your accident happened: _____

What was the time and date of present injury? _____

Where did you feel pain immediately after the accident? _____

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

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

INJURY HISTORY:

Was the crash on the job? Yes No
You were: Driver Front seat passenger Rear seat passenger Motorcycle operator Motorcycle passenger
 Other: _____
Vehicle driven by: _____
Your vehicle year/make/model: _____
Your estimated speed at the moment of the crash: _____ Stopped Slowing Accelerating
Other vehicle year/make/model: _____
Time of day: Daylight Dawn Dusk Dark
Road conditions: Dry Damp Wet Snow Ice Other: _____
Head restraints: None Integral type Adjustable Up Down Don't Know
If adjustable, was the position altered by the crash? Yes No
Was the seat back adjustment altered by the crash? Yes No
Was the seat broken? Yes No
Seat belt: Wearing Not wearing Don't Know
Did the airbag deploy? Yes No If yes, were you struck? Yes No
Body position: Good Forward lean Other: _____
Head position: Forward Left Right Up
Down Hand position: One on the wheel Two on the wheel N/A
Brakes applied? Yes No
Were you aware of impending crash? Yes No

Patient's Name _____ Date of Birth _____

DURING THE CRASH:

Did you strike any parts of the vehicle? Yes No

If yes, describe: _____

Did the vehicle strike any objects after impact? Yes No

If yes, describe: _____

Wearing hat or glasses? Yes No If yes, were they still on after the crash? Yes No

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

Estimated property damage to your vehicle: \$ _____

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

Were the police on-scene? Yes No

If yes, was a report made? Yes No

Check symptoms you have noticed since the accident:

- | | | | |
|---|--|---------------------------------------|--|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Depression | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Light Bothers Eyes | <input type="checkbox"/> Buzzing in Ears | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Neck Pain |
| <input type="checkbox"/> Head Seems too Heavy | <input type="checkbox"/> Memory Loss | <input type="checkbox"/> Feet Cold | <input type="checkbox"/> Neck Stiff |
| <input type="checkbox"/> Pins and Needles in Arms | <input type="checkbox"/> Ears Ring | <input type="checkbox"/> Hands Cold | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Back Pain | <input type="checkbox"/> Face Flushed | <input type="checkbox"/> Loss of Balance |
| <input type="checkbox"/> Pins and Needles in Legs | <input type="checkbox"/> Constipation | <input type="checkbox"/> Tension | <input type="checkbox"/> Nervousness |
| <input type="checkbox"/> Numbness in Fingers | <input type="checkbox"/> Loss of Smell | <input type="checkbox"/> Fever | <input type="checkbox"/> Irritability |
| <input type="checkbox"/> Numbness in Toes | <input type="checkbox"/> Loss of Taste | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Cold Sweats |
| <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Stomach Upset | | |

Symptoms other than above: _____

Where were you taken after the accident? _____

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

Name of Hospital: _____

Name of Doctor(s) : _____

What treatment was given? _____

Was any other doctor consulted after your accident? Yes No

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

What was the diagnosis? _____

What treatment was given? _____

How often did you see the doctor? _____

How long did you see the doctor? _____

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

If so, what were the complaints? _____

Patient's Name _____ **Date of Birth** _____

Before the injury, were you capable of working on an equal basis with others your age? Yes No

Are your work activities restricted as a result of this accident? Yes No

Since this injury, are your symptoms ... Improving? Getting worse? Same?

Driver of other vehicle (if any):

Name _____ Insurance Company _____ Policy No. _____

Driver of vehicle in which you were injured (if applicable):

Name _____ Insurance Company _____ Policy No. _____

Name of your insurance adjuster _____

Have you retained an attorney? Yes No

If so, his/her name and address _____

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

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

Were police notified? Yes No

CRASH DETAILS (In your own words)

CRASH DIAGRAM (From your memory)

Patient Signature _____ Date of Birth _____ Date _____

Doctor Signature _____ Date _____

Patient's Name _____ Date of Birth _____

Office Name: **Novo Chiropractic**

Date of Accident: _____ Time of Accident: _____ City: _____ State: _____

Practice Member's Medical Pay Information

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

Personal Injury Claim #: _____

Personal Injury Adjuster's Name: _____

Adjuster's Phone Number: _____ Extension _____

Insurance Company Name, Address & Fax Number:

Fax Number: _____

Attorney Information

Have you retained an attorney? YES NO

Attorney Name: _____ Firm: _____

Phone Number: _____ Fax: _____

Lien On File? _____ Did attorney confirm they will pay provider directly? _____

Other Driver (At Fault Driver) Insurance Information

Name: _____ Claim #: _____

At Fault Driver's Insurance Company Name & Address

Personal Injury Adjuster's Name: _____

Adjuster's Phone Number: _____ Extension _____

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

**ASSIGNMENT OF BENEFITS, ASSIGNMENT OF RIGHTS TO PURSUE PERSONAL INJURY, WORK COMP, ERISA,
AND OTHER LEGAL AND ADMINISTRATIVE CLAIMS ASSOCIATED WITH MY HEALTH INSURANCE AND /OR
HEALTH BENEFIT PLAN (INCLUDING BREACH OF FIDUCIARY DUTY) AND
DESIGNATION OF AUTHORIZED REPRESENTATIVE**

Provider Name: Dr. Shane Davidson, D.C.
Clinic: Novo Chiropractic
Address: 8601 S. 30th St. Ste 108, Lincoln, NE 68516

I hereby assign and convey directly to the above-named health care provider, as my designated authorized representative, any and all medical benefits and/or any insurance reimbursement, if any, otherwise payable to me for services, treatments, therapies, and/or medications rendered or provided by the above-named health care provider, regardless of its managed care network participation status. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the above-named health care provider to release all medical information necessary to process my claims. Further, I hereby authorize my plan administrator fiduciary, insurer, and/or attorney to release to the above-named health care provider any and all Plan documents, summary benefit description, insurance policy, and/or settlement information upon written request from the above-named health care provider or its attorneys in order to claim such medical benefits.

In addition to the assignment of all medical benefits and/or insurance reimbursement above, I also assign and/or convey to the above named health care provider any legal or administrative claim or chose an action arising under any group health plan, employee benefits plan, health insurance or tort feasor insurance concerning medical expenses incurred as a result of the medical services, treatments, therapies, and/or medications I receive from the above-named health care provider (including any right to pursue those legal or administrative claims or chose an action). This constitutes an express and knowing assignment of ERISA breach or fiduciary duty claims and other legal and/or administrative claims.

I intend by this assignment and designation of authorized representative to convey to the above-named provider all of my rights to claim (or place a lien on) the medical benefits related to the services, treatments, therapies, and/or mediations provided by the above-named health care provider, including rights to any settlement, insurance or applicable legal or administrative remedies (including damages arising from ERISA breach of fiduciary duty claims). The assignee and/or designated representative (above-named provider) is given the right by me to (1) obtain information regarding the claim to the same extent as me; (2) submit evidence; (3) make statements about facts or law; (4) make any request including providing or receiving notice of appeal proceedings; (5) participate in any administrative and judicial actions and pursue claims or chose in action or right against any liable party, insurance company, employee benefit plan, health care benefit plan, or plan administrator. The above-named provider as my assignee and my designated authorized representative may bring suit against any such health care benefit plan, employee benefit plan, plan administrator or insurance company in my name with derivative standing at provider's expense.

Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA (health care reform legislation), ERISA, Medicare and applicable federal and state laws. A photocopy of this assignment is to be considered valid, the same as if it was the original.

I HAVE READ AND FULLY UNDERSTAND THIS AGREEMENT.

Patient Signature

Date

PERSONAL INJURY LIEN

Patient Name: _____

Date of Accident: _____

I hereby authorize and direct:

Name of Attorney: _____

Attorney's Address: _____

Attorney's Phone: _____

and/or

Insurance Company: _____

to pay directly to Novo Chiropractic, LLC such sums that may be due and owing this office for services rendered to me, both by reason of this accident and by reason of any other bills that are due to this office, and to withhold such sums from any disability benefits, medical payment benefits, liability benefits, health and accident benefits, workmens' compensation benefits, or any other insurance benefits, or from any settlement, judgment or verdict on my behalf, as may be necessary to adequately protect said office.

I hereby further give a lien to said office against any and all insurance named herein, and any and all proceeds of any settlement, judgment, or verdict that may be paid to me as a result of the injuries for which I have been treated by said office. This is to act as an assignment of my rights and benefits to the extent of the office's services provided.

I understand that I remain personally responsible for the total amounts due the office for their services. I further understand and agree that this assignment, lien and authorization does not contribute any consideration for the office to await payments and they may demand payment from me upon rendering services at their option. I authorize this office to release any information pertinent to my case to any insurance company or attorney to facilitate collection under this assignment, lien, and authorization.

I further understand and agree, that if this office must take any action to collect an outstanding balance on my account, I will be responsible for payment of and reimburse this office for all costs of such collection efforts including, but not limited to, all courts costs and attorney fees.

I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment, but will require me to make payments on my current balance.

Patient's Signature

Date

Countersigned/Witnessed by Staff

Date

APPLICATION FOR CARE AT NOVO CHIROPRACTIC

Today's Date: _____

Claim #: _____

PATIENT DEMOGRAPHICS

Name: _____ Birthdate: ____-____-____ Age: _____ Male Female

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Mobile Phone: _____

E-mail Address: _____ Marital Status: Single Married Do you have insurance? Yes No

Social Security #: _____ Driver's License #: _____

Employer: _____ Occupation: _____

Spouse's Name _____ Spouse's Employer _____

Number of children and ages: _____

Name & Number of Emergency Contact: _____ Relationship: _____

HISTORY OF COMPLAINT

Please identify the condition(s) that brought you to this office: Primary: _____

Secondary: _____ Third: _____ Fourth: _____

On a scale of **0** to **10** with **10** being the worst pain and **zero** being no pain, rate your above complaints by ***circling the number***:

Primary or chief complaint is:	0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10
Second complaint is:	0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10
Third complaint is:	0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10
Fourth complaint is:	0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

When did the problem(s) begin? _____ When is the problem at its worst? AM PM mid-day late PM

How long does it last? It is constant **OR** I experience it on and off during the day **OR** It comes and goes throughout the week

How did the injury happen? _____

Condition(s) ever been treated by anyone in the past? No Yes **If yes**, when? _____ by whom? _____

How long were you under care? _____ What were the results? _____

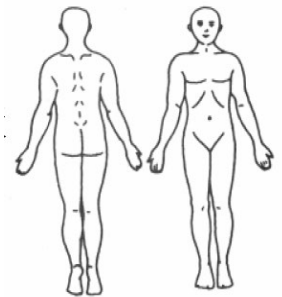
Name of previous chiropractor: _____ N/A

PLEASE MARK the areas on the body diagram with the following **letters** to describe your symptoms:

R = Radiating **B** = Burning **D** = Dull **A** = Aching **N** = Numbness **S** = Sharp/Stabbing **T** = Tingling

What relieves your symptoms? _____

What makes your symptoms feel worse? _____



LIST RESTRICTED ACTIVITY	CURRENT ACTIVITY LEVEL	USUAL ACTIVITY LEVEL
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

PATIENT'S NAME: _____ Claim #: _____ TODAY'S DATE: _____

Is your problem the result of ANY type of accident? Yes No

Identify any other injury(s) to your spine, minor or major, that the doctor should know about:

PAST HISTORY

Have you suffered with any of this or a similar problem in the past? No Yes **If yes**, how many times? _____ When was the last episode? _____ How did the injury happen? _____

Other forms of treatment tried: No Yes **If yes**, please state what type of treatment: _____, and who provided it? _____ How long ago? _____ What were the results. Favorable Unfavorable
Please explain: _____

Please identify any and all types of jobs you have had in the past that have imposed any physical stress on you or your body:

If you have ever been diagnosed with any of the following conditions, please indicate with:

P for in the **Past** **C** for **Currently** have **N** for **Never** have had

___ Broken Bone ___ Dislocations ___ Tumors ___ Rheumatoid Arthritis ___ Fracture ___ Disability ___ Cancer
___ Heart Attack ___ Osteo Arthritis ___ Diabetes ___ Cerebral Vascular ___ Other serious conditions: _____

PLEASE IDENTIFY ALL PAST and any **CURRENT** conditions you feel may be contributing to your present problem:

	HOW LONG AGO	TYPE OF CARE	PROVIDED BY WHOM
INJURIES			
SURGERIES			
CHILDHOOD DISEASES			
ADULT DISEASES			

FAMILY HISTORY

1. Does anyone in your family suffer with the same condition(s)? No Yes **If yes**, whom?
 grandmother grandfather mother father sister(s) brother(s) son(s) daughter(s)
Have they ever been treated for their condition? No Yes I don't know

2. Any other hereditary conditions the doctor should be aware of? No Yes: _____

SOCIAL HISTORY

- 1. **Smoking:** cigars pipe cigarettes How often? Daily Weekends Occasionally Never
- 2. **Alcoholic Beverage:** consumption occurs Daily Weekends Occasionally Never
- 3. **Recreational Drug use:** Daily Weekends Occasionally Never
- 4. **Hobbies - Recreational Activities - Exercise Regime:** How does your present problem affect? (See Activities of Life form)

I hereby authorize payment to be made directly to Novo Chiropractic, LLC, for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application, or copies thereof, for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to Novo Chiropractic, LLC for any and all services I receive at this office.

Patient or Authorized Person's Signature

____ - ____ - ____
Date Completed

Doctor's Signature

____ - ____ - ____
Date Form Reviewed

ACTIVITIES OF LIFE

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

ACTIVITIES:

EFFECT:

Carry Children/Groceries	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Sit to Stand	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Climb Stairs	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Pet Care	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Extended Computer Use	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Lift Children/Groceries	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Read/Concentrate	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Getting Dressed	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Shaving	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Sexual Activities	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Sleep	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Static Sitting	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Static Standing	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Yard work	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Walking	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Washing/Bathing	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Sweeping/Vacuuuming	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Dishes	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Laundry	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Garbage	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Driving	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Other: _____	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform

List Prescription & Non-Prescription drugs you take: _____

Patient or Authorized Person's Signature

____ - ____ - ____
Date Completed

Doctor's Signature

____ - ____ - ____
Date Form Reviewed

PATIENT'S NAME: _____ Claim #: _____ TODAY'S DATE: _____

REVIEW OF SYSTEMS

Please mark: **P** for in the **Past**

C for **Currently** have

N for **Never**

<input type="checkbox"/> Headache	<input type="checkbox"/> Pregnant (Now)	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Prostate Problems	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Neck Pain	<input type="checkbox"/> Frequent Colds/Flu	<input type="checkbox"/> Loss of Balance	<input type="checkbox"/> Impotence/Sexual Dysfun.	<input type="checkbox"/> Heartburn
<input type="checkbox"/> Jaw Pain, TMJ	<input type="checkbox"/> Convulsions/Epilepsy	<input type="checkbox"/> Fainting	<input type="checkbox"/> Digestive Problems	<input type="checkbox"/> Heart Problem
<input type="checkbox"/> Shoulder Pain	<input type="checkbox"/> Tremors	<input type="checkbox"/> Double Vision	<input type="checkbox"/> Colon Trouble	<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Upper Back Pain	<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Blurred Vision	<input type="checkbox"/> Diarrhea/Constipation	<input type="checkbox"/> Low Blood Pressure
<input type="checkbox"/> Mid Back Pain	<input type="checkbox"/> Pain w/Cough/Sneeze	<input type="checkbox"/> Ringing in Ears	<input type="checkbox"/> Menopausal Problems	<input type="checkbox"/> Asthma
<input type="checkbox"/> Low Back Pain	<input type="checkbox"/> Foot or Knee Problems	<input type="checkbox"/> Hearing Loss	<input type="checkbox"/> Menstrual Problem	<input type="checkbox"/> Difficulty Breathing
<input type="checkbox"/> Hip Pain	<input type="checkbox"/> Sinus/Drainage Problem	<input type="checkbox"/> Depression	<input type="checkbox"/> PMS	<input type="checkbox"/> Lung Problems
<input type="checkbox"/> Back Curvature	<input type="checkbox"/> Swollen/Painful Joints	<input type="checkbox"/> Irritable	<input type="checkbox"/> Bed Wetting	<input type="checkbox"/> Kidney Trouble
<input type="checkbox"/> Scoliosis	<input type="checkbox"/> Skin Problems	<input type="checkbox"/> Mood Changes	<input type="checkbox"/> Learning Disability	<input type="checkbox"/> Gall Bladder Trouble
<input type="checkbox"/> Numb/Tingling arms, hands, fingers		<input type="checkbox"/> ADD/ADHD	<input type="checkbox"/> Eating Disorder	<input type="checkbox"/> Liver Trouble
<input type="checkbox"/> Numb/Tingling legs, feet, toes		<input type="checkbox"/> Allergies	<input type="checkbox"/> Trouble Sleeping	<input type="checkbox"/> Hepatitis (A,B,C)

Patient or Authorized Person's Signature

____ - ____ - ____
Date Completed

Doctor's Signature

____ - ____ - ____
Date Form Reviewed

Novo Chiropractic, LLC

Informed Consent

REGARDING: Chiropractic Adjustments, Modalities, and Therapeutic Procedures:

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risks are most often very minimal, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke-which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments.

Treatment objectives, as well as, the risks associated with chiropractic adjustments and all other procedures provided at Novo Chiropractic, LLC have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

Patient Name (print)

Patient or Authorized Person's Signature

____/____/____
Date



Witness Initials

REGARDING: X-rays/Imaging Studies

FEMALES ONLY: Please read carefully, check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our front desk staff for further explanation.

The first day of my last menstrual cycle was on ____ - ____ - ____ (Date)

I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am not pregnant.

By my signature below, I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration, I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

Patient Name (print)

Patient or Authorized Person's Signature

____/____/____
Date



Witness Initials

PATIENT'S NAME: _____ Claim #: _____ TODAY'S DATE: _____

HIPAA Personal Health Information Release Authorization

I, _____, hereby authorize Novo Chiropractic, LLC to discuss with and/or release information to the following people concerning my appointments, insurance, billing, and health treatment rendered.

- Spouse Name: _____
- Significant Other Name: _____
- Parent/Legal Guardian Name: _____
- Child(ren) Name(s): _____
- Any Specified Person Name: _____
- Information is not to be discussed with or released to anyone.

Restrictions:

- No Restrictions
- Only discuss my appointment time with the above-named individual(s).
- Only discuss issues concerning my account, including insurance and/or billing with the above-named individual(s).
- Only discuss the health treatment rendered to me with the above-named individual(s).

Messages:

Please call my home my work my cell phone

Phone Number: _____ - _____ - _____

If unable to reach me:

- you may leave a detailed message
- please leave a message asking me to return your call
- _____

I understand I may terminate this consent at any time by giving written notice to Novo Chiropractic, LLC. Any changes to this form will require a new consent form to be completed, signed, and dated.

Signature: _____ Date: _____