KATY ELITE CHIROPRACTIC
SPORTS & FAMILY WELLNESS CARE

Weight _____ BP ___/___
Height _____ Pulse _____
*Account #*_____

WRECK/ INJURY QUESTIONNAIRIE

Patient Name:_____ Date:_____

Sex: [ ] M [ ] F Age:_____ Birth Date:_____ Social Security #:_____

Marital Status: [ ] Married [ ] Single [ ] Minor Home Phone:_____ Cell Phone:_____

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

Email:_____ Best way to contact you? Email [ ] Phone [ ]

Employer:_____ Occupation:_____

Emergency Contact: _____ Relationship:_____ Phone:_____

Who may we thank for your first visit? Referred By:_____

Primary care physician? _____ Date of last physical/ exam:_____

COLLISSION INFORMATION

Date of Accident: _____ Time of Accident: _____(am/pm)

City where crash occurred: _____ Street/Intersection: _____

Street was: □ Wet □ Dry □ Icy - Were you the: □ DRIVER □ PASSENGER □ PEDESTRIAN/CYCLIST □ OTHER

Was there any other person in the vehicle with you? _____ Name(s): _____

Estimated damage to your vehicle? $_____ Who made damage estimates on your vehicle? _____

Year, Make, and Model of vehicle you were in: _____

Who owns the vehicle you were involved in? _____ Did the police come to the wreck scene? □ Yes □ No

Did the police make a written report? □ Yes □ No - If yes, report number if known: _____

Were photographs taken of your vehicle? □ Yes □ No If yes, who took them: _____

Check all that apply to you. Indicate which type of automobile accident you were involved in:

□ Single-car crash □ Two-vehicle crash □ Three or more vehicles □ Rear-end crash □ Side crash □ Rollover □ Head-on crash

□ Hit guard rail, tree, or object □ Ran off the road □ Other (Describe):_____

Describe the other vehicle: Make: _____ Model:_____ Year:_____ □ unknown

□ Small car □ Mid-sized car □ Van □ Pick-up truck/sports utility □ Full-sizes car □ Large truck, bus, semi-truck

IN YOUR OWN WORDS, EXPLAIN HOW THE WRECK HAPPENED:

_____

_____

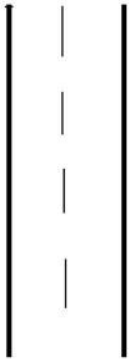
_____

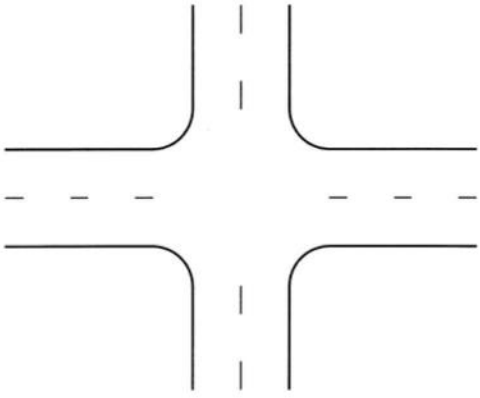
_____

Point of Impact:

□ Front □ Driver Front □ Passenger Front □ Rear □ Driver Side □ Passenger Side □ Passenger Rear □ Driver Rear

I





KATY ELITE CHIROPRACTIC
SPORTS & FAMILY WELLNESS CARE

Patient Name:_____ Date:_____

CURRENT COMPLAINTS

Check all symptoms you had BEFORE and/or AFTER the accident, and/or right NOW:

B	A	N		B	A	N	
O	O	O	Headache	O	O	O	Dizziness
O	O	O	Neck Pain	O	O	O	Head seems too heavy
O	O	O	Neck Stiffness	O	O	O	Pain in Arm(s)
O	O	O	Sleep Disturbance	O	O	O	Pain in Leg(s)
O	O	O	Trouble falling asleep	O	O	O	Numbness in Finger(s)
O	O	O	Back Pain	O	O	O	Numbness in Toe(s)
O	O	O	Nervousness	O	O	O	Shortness of Breath
O	O	O	Pain between Shoulders	O	O	O	Chest Pain/Tightness
O	O	O	Irritability	O	O	O	Fatigue
O	O	O	Sensitivity to Light	O	O	O	Depression/Upset
O	O	O	Sensitivity to Sound	O	O	O	Loss of Memory
O	O	O	Ears Ringing/Buzzing	O	O	O	Cold Hands/Feet
O	O	O	Loss of Hearing	O	O	O	Face Flushed
O	O	O	Fainting	O	O	O	Fever/Cold Sweats
O	O	O	Loss of Balance	O	O	O	Diarrhea/ Constipation
O	O	O	Loss of Taste or Smell	O	O	O	Nausea
O	O	O	Other? _____	O	O	O	Other? _____

ACKNOWLEDGEMENT AND UNDERSTANDING

I hereby acknowledge that I am receiving (or am about to receive) healthcare services at Katy Elite Chiropractic and that I have been advised that the doctor(s) providing the services is (are) willing to wait for payment for these services,provided that there continues to be reasonable certainty that payment will be made either by insurance proceeds or out of the settlement of liability.

I understand that if it is determined either:
1. That there is no insurance company obligated to pay for these services, or if the insurance company involved refuses to acknowledge an assignment to the doctor(s) or make other provisions for the protection of the interest of the doctor(s); or

2. If a liability claim exists, and my attorney refuses to agree to protect the interest of the doctor(s), or I have not engaged in the services of an attorney, then payment for services rendered by the doctor(s) at Katy Elite Chiropractic, will be made by me on a current basis and my bill will be paid in full as soon as my liability claim is settled or the passage of three months from my last treatment, whichever comes first.

In the event that a settlement pays less than 100% of the invoiced amount from the Katy Elite Chiropractic due to a diminished fee being offered by my attorney at any point, I am responsible for the balance owed to the SKaty Elite Chiropractic, and arrangements for payment will be made accordingly in no less than thirty days.

Dated the _____ day of _____, 20_____.

Patient's Name _____

Patient's Signature _____

Witness _____

KATY ELITE CHIROPRACTIC
SPORTS & FAMILY WELLNESS CARE

Patient Name:_____ Date:_____

COLLISION INFORMATION (cont.)

AT THE TIME OF IMPACT YOUR VEHICLE WAS:

□ Slowing down □ Gaining speed □ Stopped, brake engaged □ Stopped, no brake □ Moving at steady speed

What was the position of the top of your headrest? □ Middle of neck □ Middle of head □ Even with with head

If adjustable, did your headrest move due to the crash? □ Yes □ No □ Don't Remember

Seat belt: □ None □ Wearing □ Not Wearing □ Don't Know

Did you find any Bruises? □ Yes □ No - If Yes, where? _____

Did you find any bleeding cut? □ Yes □ No - If Yes, where? _____

Did the airbag deploy? □ Yes □ No - If yes, were you struck by the air bag? □ Yes □ No What body part? _____

Did you strike anything in the vehicle? □ Yes □ No

If yes, what? □ Wheel □ Windshield □ Armrest □ Dashboard □ Side Window □ Airbag □ Side Door

Circle any of your body parts that hit the interior of your car during impact:

Head, Face, Chest, Shoulder (right/left), Arm/Wrist (right/left), Hip (right/left), Leg/Knee (right/left), Other:_____

Direction of your head: □ Turned right □ Turned left □ Straight ahead □ Looking up □ Looking down

Were you aware of impending crash? □ Yes □ No - Did you brace yourself for impact? □ Yes □ No

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

DRIVER ONLY:

Were you holding onto the steering wheel at the time of impact? □ Yes □ No - □ Both hands □ Left hand only □ Right hand only

AFTER THE CRASH

Immediately after the accident, did you experience any of the following: □ Headaches □ Neck Pain □ Mid Back Pain □ Shoulder/Arm Pain

□ Low Back Pain □ Hip/Leg Pain □ Dizziness □ Nausea □ Confusion □ Disorientation □ Other: _____

When did symptoms first appear? _____ (hours) - Where did you go after the crash? □ Work □ Hospital □ Home Other: _____

Emergency Facility/Hospital name: _____ DATE: _____

Mode of transportation:_____

Imaging / testing performed? □ Yes □ No - If yes, please list type (X-ray, MRI, CT, Lab work, EMG, etc.) location and date taken:

1._____ DATE: _____

2._____ DATE: _____

3._____ DATE: _____

Medication prescribed:_____

Other treatments:_____

Have you lost any days of work? □ Yes □ No - If yes, how many: _____

INSURANCE INFORMATION

Have you been in a motor vehicle accident before? □ Yes □ No - If yes, when? _____

YOUR INSURANCE

Your Insurance Company: _____ Claim Number: _____

Adjuster's Name: _____ Phone: _____ Fax: _____

Have you reported this accident to your Insurance Co? □ Yes □ No - Do you have PIP coverage? □ Yes □ No □ Don't know?

Is an attorney representing you? □ Yes □ No - If yes, Name: _____ Phone#: _____

If no, do you need us to provide you with a list of attorneys: _____

OTHER DRIVER'S INSURANCE (Third Party)

Their Insurance Company: _____ Claim Number: _____

Adjuster's Name: _____ Phone: _____ Fax: _____

KATY ELITE CHIROPRACTIC
SPORTS & FAMILY WELLNESS CARE

Patient Name:_____ Date:_____

Duties Performed Under Duress at Work and Home

□ Initial □Update

Please check all that apply to your WORK because of the accident

□ I go to work but work in pain
□ I limit my work activities
□ Bending at work hurts
□ Stooping at work hurts
□ Sitting at work hurts
□ Using the computer at work hurts
□ Pushing at work hurts
□ Kneeling at work hurts
□ I have lost status in my company
□ I have lost job security
□ I didn't get a promotion
□ I don't enjoy work as much as before
□ I doze off at work
□ I take unpaid time off work to go to Dr.
□ I daydream at work more than before
□ I feel tired at work

_____
_____

□ I work in pain because I have bills to pay
□ I can't take time off because I would lose my job
□ I keep working so I don't lose status at company
□ My business would fail if I took time off
□ I believe in working even when I'm in pain
□ I feel obligated to work even though I'm in pain
□ My business would lose money if I took time off
□ My work is not as good as it was before accident
□ My boss reprimanded me for poor performance
□ I got a different job within the same company
□ I got a different job in another company
□ I make less money than before the accident
□ I cannot do the same work/job as before accident
□ I can't concentrate as well at work
□ I take paid time off to go to Dr.
□ I make mistakes at work I didn't use to
□ I hide my poor work performance from my boss

_____
_____

Please check all that apply to your HOME/DOMESTIC because of the accident

□ My house is not as clean now
□ My yard is not as neat now
□ My garden is not as productive now
□ I do yard work, but do it in pain
□ I cannot do my normal yard work
□ I do house work, but do it in pain
□ I cannot do my normal house work
□ Doing laundry hurts me
□ I cannot do laundry now
□ Washing dishes hurts me
□ I cannot vacuum now
□ Cooking hurts me
□ I cannot cook now
□ Washing the car hurts me
□ I cannot wash my car

_____
_____

□ I cannot take time off because I care for children
□ I have _____children ages_____
□ I had to hire a paid housekeeper
□ I asked someone for unpaid housekeeping help
□ I had to hire a paid gardener
□ I asked someone for unpaid yard work help
□ Mowing the lawn hurts me
□ I cannot mow the lawn
□ Taking out the trash hurts me
□ I cannot take out the trash
□ I do not enjoy my gardening/yardwork like I used to
□ I do not enjoy my housework like I used to
□ Gardening hurts me
□ I cannot do my gardening at all since the accident
□ Others living with me do my share of the work now
□ Others living with me do my share of the yard now
□ Others living with me do my share of the gardening

_____

Please check all the DAILY LIVING activities that cause you pain because of the accident

□ Dressing
□ Putting on pants
□ Putting on shoes
□ Tying my shoes
□ Putting on shirt
□ Drying my hair
□ Combing my hair
□ Washing my hair
□ Taking a shower/bath
□ Leaning forward
□ Laying in bed
□ Sleeping
□ Going out with my friends
□ Sitting at a restaurant
□ Shopping
□ Driving to/from work

□ Sitting in Church
□ Playing with my children
□ Caring for my children
□ Sitting in a movie theatre
□ Exercise
□ Eating
□ Squatting down
□ Kneeling
□ Brushing my teeth
□ Riding in a car
□ Opening a jar
□ Lifting a pan when cooking
□ Closing the trunk on my car
□ Opening the garage door
□ Using my home computer
□ Climbing stairs

□ Sexual activity
□ Turning my head to left or right
□ Holding my head up all day
□ Watching TV
□ I have pain sitting & doing nothing
□ Talking on the phone
□ Reading
□ Writing
□ Opening doors
□ Drying with a towel after a bath or shower
□ Life has become a chore just to do normal things
□ It is depressing to live like this

_____
_____
_____

_____ _____
Signature Date

KATY ELITE CHIROPRACTIC
SPORTS & FAMILY WELLNESS CARE

ASSIGNMENT OF BENEFITS – ASSIGNMENT OF CAUSE OF ACTION - CONTRACTUAL LIEN

The undersigned patient and/or responsible party, in consideration of treatment rendered or to be rendered and for deferred payment, irrevocably and exclusively assigns, grants and conveys, to Ammon Zukeran, DC, a lien and assignment of any and all claims, causes of action, and right to any proceeds and/or benefits, including any Personal Injury Protection proceeds and/or benefits that the patient may have against any other person, entity, and/or insurance company for reimbursement and/or payment of the medical charges incurred with all the following rights, power, and authority:

RELEASE OF INFORMATION: You are authorized to release information concerning my condition and treatment to my insurance company, attorney or insurance adjuster for purposes of processing my claim for benefits and payment for services rendered to me.

IRREVOCABLE ASSIGNMENT OF RIGHTS: You are assigned the exclusive, irrevocable right to any cause of action that exists in my favor against any insurance company for the terms of the policy, including the exclusive, irrevocable right to receive payment for such services, make demand in my name for payment, and prosecute and receive penalties, interest, court cost, or other legally compensable amounts owned by an insurance company in accordance with Article 21.55 of the Texas Insurance Code to cooperate, provide information as needed, and appear as needed, wherever to assist in the prosecution of such claims for benefits upon request. A letter of protection issued by an attorney's office will not negate this assignment.

DEMAND FOR PAYMENT: To any insurance company providing benefits of any kind to me/us for treatment rendered by the physician/facility named above within 5 days following your receipt of such bill for services to the extent of such bills are payable under the terms of the policy. This demand specifically conforms to Sec. 542.057 of the Texas Insurance Code, and Article 21.55 of the Texas Insurance Code, providing for attorney fees, 18% penalty, court cost, and interest from judgment, upon violation. I further instruct my carrier to make all checks payable to KATY ELITE CHIROPRACTIC, and send to 416 Park Grove Ln, Katy TX 77450. I instruct my attorney to provide on request to the above-named provider, a settlement breakdown in accordance with the Safekeeping Property Rule, Sec. 1.15.

THIRD PARTY LIABILITY: If my injuries are the result of negligence from a third party, then I instruct the liability carrier to issue a separate draft to pay in full all services rendered, payable directly to KATY ELITE CHIROPRACTIC, and send to 416 Park Grove Ln, Katy TX 77450

STATUTE OF LIMITATIONS: I waive my rights to claim any statute of limitations regarding claims for services rendered or to be rendered by the physician/facility named above, in addition to reasonable cost of collection, including attorney fees and court cost incurred.

LIMITED POWER OF ATTORNEY: I hereby grant to the physician/facility named above power to endorse my name upon any checks, drafts, or other negotiable instrument representing payment from any insurance company representing payment for treatment and healthcare rendered by the physician/facility named above. I agree that any insurance payment representing an amount in excess of the charges for treatment rendered will be credited to my/our account or forwarded to my/our address upon request in writing to the physician/facility named above.

REJECTION IN WRITING: I hereby authorize the physician/clinic named above to establish a PIP or UM/UIM claim on my behalf. I also instruct my insurance carrier to provide upon request to the provider/clinic named above, any rejections in writing as they apply to my lack of PIP or UM/UIM coverage. I allege that electronic signatures are not adequate proof of rejection, and are invalid to establish rejection, and instruct my carrier to provide only copies of my original signature regarding rejection as evidence of rejection of PIP or UM/UIM.

TERMINATION OF CARE: I hereby acknowledge and understand that if I do not keep appointments as recommended to me by my caring doctor at this clinic, he/she has full and complete right to terminate responsibility for my care and relinquish any disability granted me within a reasonable period of time. If during the course of my care, my insurance company requires me to take an examination from any other doctor, I will notify this physician/facility immediately. I understand the failure to do so may jeopardize my case.

Signature of Patient and/or Responsible Parties: I declare under penalty of perjury that the forgoing is true and correct. [CPRC: Sec. 132.001(a)]

Patient Name:_____ Date: _____

Signature:_____

KATY ELITE CHIROPRACTIC
SPORTS & FAMILY WELLNESS CARE

OUR MISSION: offer our patients a drugless, non-surgical approach to health that will allow them to reach their greatest potential... naturally!

OUTLINE PROCEDURE FOR NEW PATIENTS

1. All new patients are requested to fill out paperwork forms
2. Consultation with Dr. Z to discuss your health problems
3. Exam and x-rays if necessary, to determine if chiropractic care is appropriate for your condition
4. If your case requires immediate attention, emergency care will be administered
5. You will be advised as to a time you can return for your "Report of Findings" appointment, during the second appointment Dr. Z will inform you of your examination results and whether or not your case has been accepted.
6. Your recommended program of care will be explained to you along with financial arrangements and insurance coverage as appropriate
7. Care will begin and continue as scheduled until your condition has been fully corrected or until the maximum possible improvement has been obtained

CONSENT FOR TEXT/EMAIL NOTIFICATION

I give Katy Elite Chiropractic permission to send text/email notifications regarding upcoming appointments, news and events.

Printed name_____

Signature_____

KATY ELITE CHIROPRACTIC PHOTO RELEASE

I grant Katy Elite Chiropractic and its employees the right to take photographs of me with connection to the promotion of chiropractic services via their website, social media, and any other avenues. I agree that Katy Elite Chiropractic may use such photographs of me for publicity, illustration, advertising, and web content.

Printed name_____

Signature_____

KATY ELITE CHIROPRACTIC
SPORTS & FAMILY WELLNESS CARE

Patient Acknowledgement and Receipt of Notice of Privacy Practices Pursuant to HIPAA and Consent for Use of Health Information

Name: _____ Date: _____
Print Patient's Name

The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant to HIPAA. The notice is available on our website and also a paper copy is available upon request.

In order for our office to provide ANY information to a partner, spouse, parent, relative or other designates, we must have your permission. (This would include appointment schedules, X-rays, receipts, health records and any other information that pertains to your treatment). You may indicate your permission by listing names here:

My information may be shared with: (list names):

_____
_____
_____
_____
_____

Please indicate the name and contact information of your primary care physician for the purpose of care coordination with the chiropractic physician.

(Primary Care Doctor Name): _____

Address/Phone: _____

The undersigned does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State Law and Federal Law.

PATIENT NAME: _____ DATE: _____

PATIENT/GUARDIAN SIGNATURE: _____ RELATIONSHIP: _____