ImagineWellness
Chiropractic Centers
822 E. Union Hills Drive Suite 22, Phoenix, AZ 85024
(623) 582- 8951
Dr. Roxane Zamora D. C.
www.ImagineWellnessChiropractic.com

Name: _____ Age: _____ Date of birth: _____ Today's date:_____

Address:_____ Social Security #: _____ ☐ Male ☐ Female

City, State, Zip: _____ Marital Status: ☐ M ☐ S ☐ W ☐ D # of Children _____

Home Phone: (_____)_____ Work Phone: (_____)_____

Cell Phone (_____)_____ Email address: _____

Employer: _____ Occupation: _____

Spouse's Name: _____ Spouse's Employer: _____

In case of emergency, notify_____ R**elationship**: _____ **Phone** (_____) _____

Date of Crash: _____ Time: _____AM _____ PM _____

Current Symptoms: 1. _____ 2. _____ 3. _____ 4. _____

5._____ 6. _____ 7. _____ 8. _____

When did your symptoms begin?_____

In general, what makes your symptoms better? _____

In general, what makes your symptoms worse? _____

In general, how would you describe your pain? (ache, burn, dull, sharp, throbbing): _____

Are your symptoms local or do they travel to another area? (If they travel, to where?) _____

Are symptoms; ☐Constant >76% ☐Frequent 51-75% ☐Occasional 26-50% ☐Intermittent <25% **of your waking hours.**

Were there any symptoms which you had after the crash that have now resolved? (please list) _____

_____

Please list all medications and dosage: **Frequency** **For What Illness?**

_____

_____

List any allergies to medications, foods or other: _____

Are you pregnant? ☐ Yes ☐ No First day of last menstrual cycle: _____

Do you smoke? ☐ Yes ☐ No - how much? _____ Do you drink alcohol? ☐ Yes ☐ No - how much? _____

Please list all serious illness and serious accidents: **Month and Year** **City, State**

_____

_____

Please list any recent x-rays, lab or other tests: **Date** **Facility/Doctor**

_____

Describe in detail, in your own words, how the crash/accident happened and damage to vehicle:

_____

_____

_____

Was EMS on scene? ☐ Yes ☐ No Where did you go after the crash? ☐ Hospital ☐ Urgent Care ☐ Home ☐ Work ☐ Other _____

Hospital ☐ Arranged for ride home ☐ Continued on with activities ☐ Was driven to hospital ☐ Drove home ☐ Transported to hospital

Were you taken by ambulance? ☐ Yes ☐ No To which hospital? _____

Date of Hospitalization: _____Attending E.R. Doctor: _____Treatment Given? _____

AUTOMOBILE/MOTORCYLCE ONLY

Were police on scene ☐ Yes ☐ No

Were traffic citations issued to? ☐ You ☐ Driver of Your Vehicle ☐ Driver of the Other Vehicle ☐ No Citations Given

In the crash: Were you the ☐ Driver ☐ Passenger ☐ Pedestrian ☐ Other? _____

Who was in vehicle with you? Names:_____

How fast were you traveling and which direction?_____

Did your vehicle strike the other vehicle? ☐Yes ☐No Did the other vehicle strike your car? ☐Yes ☐No

Were you struck from? ☐ Behind ☐ Front ☐ Driver Side ☐ Passenger Side

Did airbags deploy? ☐Yes ☐No Was the vehicle towed? ☐Yes ☐No

Did any body part hit inside of vehicle?_____ If yes, what part? _____

Did you brace for the accident? With: ☐ Feet ☐ Hands ☐ Both **Motorcycle Only: ☐ Left Side ☐ Right Side**

CHECK ANY OF THE FOLLOWING SYMPTOMS YOU HAVE NOTICED SINCE THE CRASH/ACCIDENT:

☐ Headache	☐ Middle Back Pain	☐ Lower Back Pain	☐ *Ears Ring*
☐ Neck Pain	☐ Chest Pain	☐ Lower Back Stiffness	☐ *Buzzing in Ears*
☐ Neck Stiffness	☐ Bruised Chest	☐ Radiating Pain	☐ *Dizziness*
☐ Sleeping Problems	☐ Bruising Anywhere	☐ Tingling in Legs	☐ Loss of Smell
☐ *Depression*	☐ *Blurred Vision*	☐ Tingling in Arms	☐ Loss of Taste
☐ *Anxiety*	☐ Sensitivity to Light	☐ Jaw Pain	☐ *Any Burns*
☐ *Fainting*	☐ Upper Arm Pain	☐ Upper Leg Pain	☐ *Any Stitches*
☐ Muscle Spasms	☐ Lower Arm Pain	☐ Lower Leg Pain	☐ *Any Cuts*

☐ Other Symptoms: _____

Have you lost time from work? ☐ Yes ☐ No: If Yes, Dates: _____ to _____

Have you done any of the following since the crash:

☐ Ice ☐ Rest ☐ Medication (name)_____

☐ Heat (any kind) ☐ Exercise ☐ Other _____

DO YOU HAVE A HISTORY OF ANY OF THE FOLLOWING DISEASES?:

Tuberculosis	☐ Yes	Lung Disease	☐ Yes	Gout	☐ Yes	Diabetes	☐ Yes
Kidney Disease	☐ Yes	Stomach/Ulcer	☐ Yes	Heart Disease	☐ Yes	Hepatitis	☐ Yes
Sciatica	☐ Yes	Blood Pressure	☐ Yes	Transfusion	☐ Yes	Polio / Ms	☐ Yes
Colon Disease	☐ Yes	Stroke	☐ Yes	Cancer	☐ Yes	Bleeding	☐ Yes
Paralysis	☐ Yes	Seizures	☐ Yes	Arthritis	☐ Yes	Asthma	☐ Yes
Anemia	☐ Yes	Thyroid Disease	☐ Yes	Drug Dependence	☐ Yes	AIDS	☐ Yes

Please provide us with the appropriate insurance information:

Your Automobile Insurance Carrier

Automobile Insurance Company: _____

Address: _____ Insured: _____

Claim #: _____ Policy #: _____ Claim Representative: _____

Telephone: (_____) _____ Fax: (_____) _____

Med-Pay Benefits: _____ Uninsured (UM) Benefits: _____ Underinsured (UIM) Benefits: _____

Have you signed a selection waiver of benefits? ☐ Yes ☐ No ☐ Unsure

Health Insurance Company

Insurance Company: _____ Insured ID: _____

Telephone: (_____) _____ Fax: (_____) _____

Adverse Third-Party Insurance

Automobile Insurance Company _____ Insured: _____

Claim #: _____ Policy #: _____ Claim Representative: _____

Telephone: (_____) _____ Fax: (_____) _____

Attorney

Law Firm: _____ Legal Assistant: _____

Telephone: (_____) _____ Fax: (_____) _____

HIPAA Compliance

Our office is required by law to maintain the HIPAA Notice of Privacy Practices. This notice explains our legal duties and privacy practices with respect to your protected health information. Signature below acknowledges that I have read this Notice of our Privacy Practices. A copy will be provided to me upon request.

_____

Patient's Name (print) If a minor – signature of parent or legal guardian required

_____

Patient's Signature If a minor – signature of parent or legal guardian required Date _____

PERSONAL AFFECTS QUESTIONNAIRE

We want to make sure and understand any of the personal consequences that this collision has caused you. Please complete and return to us at your convenience.

Patient Name: _____ Date: _____Date of Injury: _____

The collision has affected me physically as follows: _____

_____

_____

The collision has affected me emotionally as follows: _____

_____

_____

The collision has affected me financially as follows: _____

_____

_____

The collision has affected my relationship with my family as follows: _____

_____

_____

The collision has affected me at work as follows: _____

_____

_____

The collision has affected my home activities as follows: _____

_____

_____

The collision has affected my hobbies as follow: _____

_____

_____

_____

Patient's Name (print) If a minor – signature of parent or legal guardian required

_____

Patient's Signature If a minor – signature of parent or legal guardian required Date _____

Revised Oswestry Low Back Pain Disability Questionnaire

PLEASE READ: This questionnaire is designed to enable us to understand how much your low back pain has affected your ability to manage your everyday activities. Please answer each section by circling the ONE CHOICE that most applies to you. We realize that you may feel that more than one statement may relate to you, but PLEASE JUST CIRCLE ONE CHOICE WHICH MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.

SECTION 1 – Pain Intensity

A. The pain comes and goes and is very mild.
B. The pain is mild and does not vary much.
C. The pain comes and goes and is moderate.
D. The pain is moderate and does not vary much.
E. The pain comes and goes and is severe.
F. The pain is severe and does not vary much.

SECTION 2 – Personal Care

A. I would not have to change my way of washing or dressing in order to avoid pain.
B. I do not normally change my way of washing or dressing even though it causes some pain.
C. Washing and dressing increases the pain, but I manage not to change my way of doing it.
D. Washing and dressing increases the pain and I find it necessary to change my way of doing it.
E. Because of the pain, I am unable to do some washing and dressing without help.
F. Because of the pain, I am unable to do any washing or dressing without help
.

SECTION 3 – Lifting

A. I can lift heavy weights without extra pain.
B. I can lift heavy weights, but it causes extra pain.
C. Pain prevents me from lifting heavy weight off the floor.
D. Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned - i.e. on a table.
E. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
F. I can only lift very light weights, at the most.

SECTION 4 – Walking

A. Pain does not prevent me from walking any distance.
B. Pain prevents me from walking more than one mile.
C. Pain prevents me from walking more than ½ mile.
D. Pain prevents me from walking more than ¼ mile.
E. I can only walk while using a cane or on crutches.
F. I am in bed most of the time and have to crawl to the toilet.

SECTION 5 – Sitting

A. I can sit in any chair as long as I like without pain.
B. I can only sit in my favorite chair as long as I like.
C. Pain prevents me from sitting more than one hour.
D. Pain prevents me from sitting more than ½ hour.
E. Pain prevents me from sitting more than ten minutes.
F. Pain prevents me from sitting at all.

SECTION 6 – Standing

A. I can stand as long as I want without pain.
B. I have some pain while standing, but it does not increase with time.
C. I cannot stand for longer than one hour without increasing pain.
D. I cannot stand for longer than ½ hour without increasing pain.
E. I cannot stand for longer than ten minutes without increasing pain.
F. I avoid standing, because it increases the pain straight away.

SECTION 7 – Sleeping

A. I get no pain in bed.
B. I get pain in bed, but it does not prevent me from sleeping well.
C. Because of pain, my normal night's sleep is reduced by less than one quarter.
D. Because of pain, my normal night's sleep is reduced by less than one-half.
E. Because of pain, my normal night's sleep is reduced by less than three-quarters.
F. Pain prevents me from sleeping at all.

SECTION 8 – Social Life

A. My social life is normal and give me no pain.
B. My social life is normal but increases the degree of my pain.
C. Pain has no significant effect on my social life apart from limiting my more energetic interests, My dancing, etc.
D. Pain has restricted my social life and I do not go out very often.
E. Pain has restricted my social life to my home.
F. I have hardly any social life because of the pain.

SECTION 9 – Traveling

A. I get no pain while traveling.
B. I get some pain while traveling, but none of my usual forms of travel make it any worse.
C. I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
D. I get extra pain while traveling which compels me to seek alternative forms of travel.
E. Pain restricts all forms of travel.
F. Pain prevents all forms of travel except that done lying down.

SECTION 10 – Changing Degree of Pain

A. My pain is rapidly getting better.
B. My pain fluctuates, but overall is getting better.
C. My pain seems to be getting better, but improvement is slow at present.
D. My pain is neither getting better nor worse.
E. My pain is gradually worsening.
F. My pain is rapidly worsening.

Patient's Name (print): _____ Patient's Signature: _____

Date: _____

For Internal Use only - Score _____

Revised Oswestry Neck Back Pain Disability Questionnaire

PLEASE READ: This questionnaire is designed to enable us to understand how much your low back pain has affected your ability to manage your everyday activities. Please answer each section by circling the ONE CHOICE that most applies to you. We realize that you may feel that more than one statement may relate to you, but PLEASE JUST CIRCLE ONE CHOICE WHICH MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.

Section 1– Pain Intensity

___ I have no pain at the moment.
___ The pain is very mild at the moment.
___ The pain is moderate at the moment.
___ The pain is fairly severe at the moment.
___ The pain is very severe at the moment.
___ The pain is the worst imaginable at the moment.

Section 2– Personal Care (washing, dressing, etc.)

___ I can look after myself normally without causing extra pain.
___ I can look after myself normally, but it causes extra pain.
___ I am slow and careful because it is painful for me to look after myself.
___ I need some help but manage most of my personal care.
___ I need help every day in most aspects of care.
___ I do not get dressed, I wash with difficulty and stay in bed.

Section 3– Lifting

___ I can lift heavy weight without extra pain.
___ I can lift heavy weight, but it causes extra pain.
___ I cannot lift heavy weight off the floor, but I can manage if they are conveniently positioned like on a table.
___ I cannot lift heavy weight, but I can manage light to medium weights if they are conveniently positioned.
___ I cannot lift any weight due to neck pain.

Section 4– Reading

___ I can read as much as I want to with no pain in my neck.
___ I can read as much as I want to with slight neck pain.
___ I can read as much as I want to with moderate neck pain.
___ I cannot read as much as I want to due to moderate neck pain.
___ I can hardly read at all because of severe neck pain.

Section 5– Headaches

___ I have no headaches at all.
___ I have slight headaches that occur infrequently.
___ I have moderate headaches that occur infrequently.
___ I have frequent moderate headaches.
___ I have frequent severe headaches.
___ I have severe headaches all the time.

Section 6- Concentration

___ I can concentrate fully when I want to with no difficulty.
___ I can concentrate fully when I want to with slight difficulty.
___ I have a fair degree of difficulty in concentrating when I want to.
___ I have a great deal of difficulty in concentrating when I want to.
___ I cannot concentrate at all.

Section 7- Work

___ I can do as much work as I want to.
___ I can only do my usual work, but no more.
___ I can do most of my usual work, but no more.
___ I cannot do my usual work.
___ I can barely do any work at all.
___ I cannot do any work at all.

Section 8- Driving

___ I can drive my car without any neck pain.
___ I can drive my car as long as I want with slight neck pain.
___ I can drive my car as long as I want with moderate neck pain.
___ I cannot drive my car as long as I want.
___ I can hardly drive at all because of severe neck pain.
___ I cannot drive my car at all.

Section 9- Sleeping

___ I have no trouble sleeping.
___ My sleep is slightly disturbed (less than 1 hour sleepless)
___ My sleep is mildly disturbed (1 hour sleepless)
___ My sleep is moderately disturbed (2 to 3 hours sleepless)
___ My sleep is greatly disturbed (4 to 5 hours sleepless)
___ My sleep is completely disturbed (6 to 7 hours sleepless)

Section 10- Recreation

___ I am able to engage in all my recreation activities with no neck pain.
___ I am able to engage in all my recreation activities with some neck pain.
___ I am able to engage in most, but not all of my usual recreation activities.
___ I am able to engage in a few of my usual recreation activities.
___ I can hardly do any recreation activities.
___ I cannot do any recreation activities due to neck pain.

Patient's Name (print):_____ Patient's Signature:_____Date:_____

For Internal Use only - Score_____

Patient/Paciente: (Print) _____ **Date/Fecha:** _____ **DOA** _____

Please list your crash related symptoms below and the relative Intensity 0-10 <u>for each</u> symptom using the pain scale.

Por favor enumerar los síntomas relacionados con el choque y por debajo de la intensidad relativa 0-10 <u>para cada</u> síntoma mediante la escala de dolor.

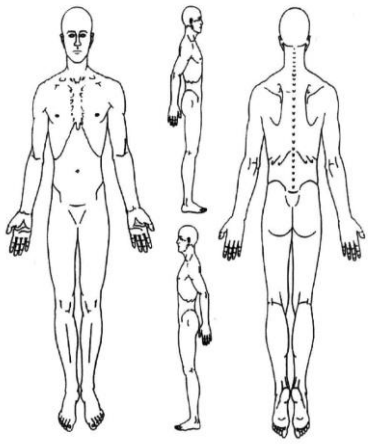
Area:

1) _____		0	1	2	3	4	5	6	7	8	9	10
2) _____		0	1	2	3	4	5	6	7	8	9	10
3) _____		0	1	2	3	4	5	6	7	8	9	10
4) _____		0	1	2	3	4	5	6	7	8	9	10
5) _____		0	1	2	3	4	5	6	7	8	9	10
6) _____		0	1	2	3	4	5	6	7	8	9	10
7) _____		0	1	2	3	4	5	6	7	8	9	10
8) _____		0	1	2	3	4	5	6	7	8	9	10

Mark how often each symptom occurs using the following:

C = Constant/ Constante (76-100%)
F = Frequent/Frecuente (51-75%),
I = Intermittent/ Intermitente (26-50%),
O = Occasional/ Ocasional (0-25%),

How it effects my daily life:



Please mark on the diagram above the following symbols as they relate to your symptoms
Por favor marquee en el diagrama anterior los siguintes que se relacionan con los sintomas

SS = Spasms/ Espasmos
SH = Shooting Pain/ Disparos Dolor
ST = Stiffness / Rigidez
TI = Tingling/ Hormiqueo
DP = Dull Pain/ Dolor Sordo
NU = Numbness/ Entumecimiento
SP = Sharp Pain/ Dolor Agudo
A = Achy/ Adolorido

By signing below I am indicating that the above information is correct. I give Imagine Wellness Chiropractic Center permission to treat my condition as deemed necessary**.**
Al firmar abajo estoy indicando que la informacion anterior es correcta. Doy permiso a Imagine Wellness Chiropractic Center para tartar **mi condicion** NECESARIO atribuido

Patient Signature/Firma: _____ **Date/Fecha:** _____**Staff:** _____

Patients Please Do Not Write Below this Line

<u>Stretches</u> <u>Area:</u> C T L SI FS Extremity:	**<u>MASSAGE</u>** <u>Area:</u> C T L SI FS Extremity:	**<u>I-S TRACTION</u>** <u>Area:</u> C T L SI FS	**<u>THERAPEUTIC TRACTION:</u>** <u>Area:</u> C T L SI FS	**<u>VIBRATORY PLATFORM:</u>** <u>Area:</u> C T L SI FS Extremity:	**<u>ADDITIONAL THERAPIES:</u>** <u>Area:</u> C T L SI FS Extremity:
☐ Trigger Point ☐ Deep Tissue ☐ Soft Tissue ☐ Reflexology	☐ Trigger Point ☐ Deep Tissue ☐ Soft Tissue ☐ Vibratory				☐ SOT BLOCKS ☐ HOMECARE / ADL ☐ ISOMETRIC EXERCISES

Doctor's Signature _____Date _____

Rivermead Post Concussion Symptoms Questionnaire

Name: Date:

After a head injury or accident some people experience symptoms that can cause worry or nuisance. We would like to know if you now suffer any of the symptoms given below. Because many of these symptoms occur normally, we would like you to compare yourself now with before the accident. For each symptom listed below please circle the number that most closely represents your answer.

0 = Not Experienced at All
1 = No More of a Problem
2 = A Mild Problem
3 = A Moderate Problem
4 = A Severe Problem

Compared with **before** the accident, do you **now** (i.e., over the last 24 hours) suffer from:

	not experienced	no more of a problem	mild problem	moderate problem	severe problem
Headaches	0	1	2	3	4
Feelings of dizziness	0	1	2	3	4
Nausea and/or vomiting	0	1	2	3	4
Noise sensitivity (easily upset by loud noise)	0	1	2	3	4
Sleep disturbance	0	1	2	3	4
Fatigue, tiring more easily	0	1	2	3	4
Being irritable, easily angered	0	1	2	3	4
Feeling depressed or tearful	0	1	2	3	4
Feeling frustrated or impatient	0	1	2	3	4
Forgetfulness, poor memory	0	1	2	3	4
Poor concentration	0	1	2	3	4
Taking longer to think	0	1	2	3	4
Blurred vision	0	1	2	3	4
Light sensitivity (easily upset by bright light)	0	1	2	3	4
Double vision	0	1	2	3	4
Restlessness	0	1	2	3	4
Are you experiencing any other difficulties? Please specify, and rate as above.					
1.	0	1	2	3	4
2.	0	1	2	3	4

_____

Patient's Name (print) If a minor – signature of parent or legal guardian required

_____

Patient's Signature If a minor – signature of parent or legal guardian required Date _____

Administration only:

RPQ-3 (total for first three items) _____ **RPQ-13 (total for next 13 items) _____**

Brain Injury Management

Your history and clinical findings indicate that you have sustained a traumatic brain injury. Here are some helpful tips and useful strategies to facilitate your recovery.

1. Stop the glutamate cascade process:
    a. No dietary glutamates (i.e. monosodium glutamate, monopotassium glutamate, yeast extract, hydrolyzed protein, glutamic acid, calcium caseinate, yeast food, hydrolyzed corn gluten, gelatin, textured protein, yeast nutrient, autolyzed yeast).
    b. No aspartame, sucralose (i.e. fake sugars – Stevia is okay).
    c. NO TRANS FATS (hydrogenated oils) period.
    d. Reduce omega-6 fats (i.e. corn, sunflower, safflower, cottonseed, peanut, soy oils).
    e. Minimize refined carbohydrates (sugary foods and drinks, bread, pasta, potatoes, white rice). When eating carbohydrates, try to maintain at least a 4:1 ratio of carbohydrates to fiber.
    f. Eat lean protein sources with higher omega-3 content (i.e. grass-fed beef, free-range turkey, chicken, omega-3 eggs).
2. Protect against free radical oxidation and cellular oxidative stress:
    a. Eat 7-12 servings of fruits and vegetables per day; incorporate all the different colors – red, orange, green, purple, blue, etc. in the fruit & veggie families!
    b. Take antioxidants – NeuroPlex PMG, calcium lactate, LigaPlex.
    c. Eat frequent, small meals to stabilize blood sugar levels.
3. Add nutrients to rebuild and support neural synapses:
    a. Take omega-3 oils – as much as 10 *grams*/day for 4 months and then start to reduce to 2500 *mg*/day and keep it at that level. DO NOT take this much oil without consulting with your chiropractor or medical doctor first.
    b. Take antioxidants and eat fresh fruits and vegetables to protect the oils from going rancid in your body.
    c. DO NOT take cheap over-the-counter oils as they may contain mercury and carcinogens – only take pharmaceutical grade oils.
    d. DO NOT eat farmed salmon – EVER (i.e. Atlantic, “organic”, etc.) – wild salmon is OK 6-nights a week!
    e. Avoid tuna, swordfish, shark and other big fish.
    f. Buy omega-3 eggs.
4. Eat lean protein sources with higher omega-3 content:
    a. Grass fed beef.
    b. Free-range turkey and chicken.
    c. Omega-3 eggs.
5. Stimulate the nervous system.

Patient name (print): _____

Patient signature: _____ Date: _____

Imagine Wellness Chiropractic Center NOTICE OF PRIVACY PRACTICE

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your **P**ersonal **H**ealth **I**nformation. In addition, we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as **dictated by our office policy,** we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. In addition, you will find we have placed several copies in report folders labeled **'HIPAA'** on tables in the reception. Once you have read this notice, please sign the last page, and return only the signature page (page 2) to our front desk receptionist. Keep this page for your records.

PERMITTED DISCLOSURES:

1. Treatment purposes- discussion with other health care providers involved in your care
2. Inadvertent disclosures- open treating area mean open discussion. If you need to speak privately to the doctor, please let our staff know so we can place you in a private consultation room.
3. For payment purposes - to obtain payment from your insurance company or any other collateral source.
4. For worker's compensation purposes- to process a claim or aid in investigation
5. Emergency- in the event of a medical emergency we may notify a family member
6. For Public health and safety - to prevent or lessen a serious or eminent threat to the health or safety of a person or general public.
7. To Government agencies or Law enforcement – to identify or locate a suspect, fugitive, material witness or missing person.
8. For military, national security, prisoner and government benefits purposes.
9. Deceased persons –discussion with coroners and medical examiners in the event of a patient's death.
10. Telephone calls or emails and appointment reminders -**we may call your home and leave messages** regarding a missed appointment or apprize you of changes in practice hours or up coming events.
11. Change of ownership- in the event this practice is sold, the new owners would have access to your PHI.

YOUR RIGHTS:

1. To receive an accounting of disclosures
2. To receive a paper copy of the comprehensive "Detail" Privacy Notice
3. To request mailings to an address different than residence
4. To request Restrictions on certain uses and disclosures and with whom we release information to, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction.
5. To inspect your records and receive one copy of your records at no charge, with notice in advance
6. To request amendments to information. However, like restrictions, we are not required to agree to them.
7. To obtain **one copy** of your records at no charge, when timely notice is provided (72 hours). **X-rays** are original records and you are therefore not entitled to them. If you would like us to outsource them to an imaging center, to have copies made, we will be happy to accommodate you. However, you will be responsible for this cost.

COMPLAINTS:

If you wish to make a formal complaint about how we handle your health information, please call Nallely at 623-582-8951 If she is unavailable, you may make an appointment with our receptionist to see her within 72 hours or 3 working days. If you are still not satisfied with the way this office handles your complaint, you can submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Ave. SW
Room 509F HHH Building
Washington DC 20201

I have received a copy of _____ Chiropractic's Patient Privacy Notice. I understand my rights as well as the practices duty to protect my health information and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this 'Notice of Privacy Practice" at a time in the future and will make the new provisions effective for all information that it maintains past and present.

I am aware that a more comprehensive version of this "Notice" is available to me and several copies kept in the reception area. At this time, I do not have any questions regarding my rights or any of the information I have received.

_____

Patient's Name (print) If a minor – signature of parent or legal guardian required

_____

Patient's Signature If a minor – signature of parent or legal guardian required Date _____

_____ _____

Witness Date

Imagine Wellness Chiropractic
822 E. Union Hills Drive Suite 22
Phoenix, AZ 85024
(623) 582- 8951

AUTHORIZATION TO RELEASE OR OBTAIN MEDICAL RECORDS

Re: _____

D.O.B.: _____

SS#: _____

I hereby grant permission to *Imagine Wellness Chiropractic* to release or obtain medical records needed to evaluate my condition or treatment.

I also authorize Imagine Wellness Chiropractic to release medical records and/or medical bills for services rendered, to any insurance company, whether pursuant to medical payments coverage, health insurance, or liability coverage, as long as I have an outstanding balance with them. I further authorize any insurance company to provide insurance and status information to Imagine Wellness Chiropractic. Medical records obtained may be re-disclosed to other sources with proper authorization.

I understand that I may revoke this authorization at any time, providing I notify Imagine Wellness Chiropractic in writing. This authorization is valid for three years from the date it is signed by me.

_____

Patient's Name (print) If a minor – signature of parent or legal guardian required

_____

Patient's Signature If a minor – signature of parent or legal guardian required Date _____

MEDICAL DOCTOR INFORMATION

Name of Doctor: _____

Phone: _____

A photocopy of this original is to be treated as an original

Imagine Wellness Chiropractic
822 E. Union Hills Drive Suite 22
Phoenix, AZ 85024
(623) 582- 8951

Insurance Subscriber Acknowledgement Form

Medical insurance procedures vary regarding reimbursement for services covered. They may pay us, the provider, directly or they may pay you, the subscriber. In order to make your situation with the insurance company more convenient, we have offered to bill for the services you receive in our office and not collect payment for these services at the time they are provided, except for your co-pays. All insurance correspondence and claim information will be sent to **you, the patient/subscriber**. Our clinic WILL receive notification of claim status, amount covered from your insurance and whether the reimbursement (payment for services rendered) was sent **to you, the patient**.

Initial the following statements in acknowledgement of your understanding of each statement:

_____ If you receive a payment from _____, please bring the payment and any insurance correspondence to our office **immediately** for the reconciliation of your account. Your insurance correspondence may include an Explanation of Benefits (EOB), a check, a letter of information, etc.

_____ If the checks for your insurance claims are not provided, the patient/subscriber is responsible for the entire balance of each claim (**no discounts would apply**.)

If you have any questions, please contact our office at 623-582-8951.

_____
Patient's Name (print) If a minor – signature of parent or legal guardian required

_____
Patient's Signature If a minor – signature of parent or legal guardian required Date _____

Imagine Wellness Chiropractic
822 E. Union Hills Drive Suite 22
Phoenix, AZ 85024
(623) 582- 8951

As a potential new patient, we feel it is important that you understand our office policies regarding, how patients of this practice are cared for, and the various methods we offer to facilitate payment for that care. Please read each policy carefully so there is no misunderstanding as to what you can expect as a patient of this practice, and what we expect in return. Once you have read "Our Office Policies", if you have any questions or any of these policies are unclear to you, and you would like further explanation before submitting your ***Application for Care,*** please let our front desk know and a member of our staff will be happy to discuss them with you further. We believe it is in everyone's best interests to provide potential new patients as much information as possible about how the doctors at this office practice chiropractic so that an informed decision can be made as to whether they wish to become a patient.

Over time, individuals who are accepted, as patients at this office, gain a greater understanding as to the purpose of chiropractic. Since the majority of patient care occurs in an open bay area, patients have a unique opportunity to observe firsthand the positive results that are achieved, and the benefits derived from being under chiropractic care. This knowledge and awareness reaps a positive environment that promotes healing and encourages families to maintain good health. We want your experience with us to be an exceptional one, so help us to help you and together we can make affirmative changes in your life and the lives of those you care about.

☐ **PATIENT PRIVACY –** Since the majority of patient care takes place in an open bay area it is important to understand that any conversations you have with the doctor can be overheard by other patients. In order to maintain patient privacy, it is the policy of this practice to refrain from discussing any confidential matters with patients during treating hours while patients are being adjusted. If you have a confidential matter you wish to discuss, please let us know and we will schedule time for you to speak to the doctor in a private consultation room. These consultations must be scheduled in advance.

☐ **YOUR CARE** - When a patient seeks chiropractic health care and we agree to provide that care, it is essential for the patient and the doctor to be working toward the same objective. Chiropractic care at **Imagine Wellness Chiropractic Center** is rendered primarily to minimize and reduce subluxations, which are a major interference to the expression of the body's innate wisdom. The doctors utilize Palmer, Activator, and Thompson Drop and a myriad of techniques to accomplish this goal. It is important that you understand both the objective and the method(s) so there is no confusion or disappointment. Tremendous progress has been made in the rehabilitating and correction of spinal problems. Where in the past, chronic spinal structural problems could not be reversed or corrected, today they can. Your doctor will outline a course of treatment that will take you beyond simple pain relief, through three distinct phases of care to make a structural correction to your spine that will enable your central nervous system to function optimally, thereby improving you overall health.

☐ **FIRST THINGS FIRST**- Prior to receiving chiropractic care at this office, a health history and examination will be completed. Imaging studies as well as any other necessary diagnostics may also be ordered, to confirm the true nature of your condition and exact location of subluxations. The results of these procedures will aid in assessing your presenting problem, your overall health and, in particular, the condition of your spine. They will also assist the doctor in determining the type and amount of care you will need. All relevant findings will be reported to you along with care plan recommendations so t**h**at you can make the best possible decision regarding your health care needs. Our gold standard for care is to ensure the reduction of subluxation while teaching patients what they need to do in addition to being adjusted to maintain their health for a lifetime.

☐ **PATIENT'S REPORT OF FINDINGS** – To enhance your understanding of the chiropractic approach that will be used to manage your health, immediately following your first adjustment, you will be scheduled for a 'Doctors Report of Findings'. The information you receive at this appointment will be both informative and clinically relevant to your case, therefore attendance is required for individuals who wish to become new patients of this practice. Because the results of your x-rays and all examinations as well as the doctors' recommendations for care, will be discussed at that time, we strongly urge new patients to invite their spouse or significant other to attend. We know from experience that when a patient's family understands the goals and objectives of chiropractic care and how restoring and maintaining good health can affect their lives as well, they become infinitely supportive and helpful in making important decisions concerning treatment options.

I hereby acknowledge receiving a copy of the practices 'Office Policies' a two-page document, the first page of which I have read and retained. This second page is recognized by me as the signature page and will be retained by the practice as evidence of my receiving and understanding this 'Notice'. I further acknowledge that any concerns regarding these 'Policies 'as well as all my questions have been answered by a qualified member of the staff to my complete satisfaction.

_____

Patient's Name (print) If a minor – signature of parent or legal guardian required

_____

Patient's Signature If a minor – signature of parent or legal guardian required Date _____

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822 E. Union Hills Drive Suite 22
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Attorney/ Insurance carrier

_____

_____

_____

I do hereby authorize Imagine Wellness Chiropractic Center to furnish you, my attorney/ insurance carriers, with a full report of his examination, diagnosis, treatment, prognosis, of myself regarding the accident which occurred on _____

I hereby authorize and direct you, my attorney, to pay directly to said doctor such sums as may be due the owing him for medical service rendered me both by reason of this accident and by reason of any other bills that are due his office and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect and fully compensate said doctor. And I hereby further give a lien on my case to said doctor against any and all proceeds of my settlement, judgment or verdict which may be paid to you, my attorney, or myself, as the result of the injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by him for service rendered me and that this agreement is made solely for said doctor's additional protection and in consideration of his awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

I agree to promptly notify said doctor of any change or addition of attorney(s) used by me in connection with this accident, and I instruct my attorney to do the same and promptly deliver a copy of this lien to any substituted or added attorney(s).

Please acknowledge this letter by signing below and returning to the doctor's office. 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 may declare the entire balance due and payable. I further direct my attorney to pay said doctor one hundred percent of all chiropractic costs associated with my treatment. I understand all costs associated with my care and believe them to be necessary, reasonable and customary.

_____

Patient's Name (print) If a minor – signature of parent or legal guardian required

_____

Patient's Signature If a minor – signature of parent or legal guardian required Date _____

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PATIENT FINANCIAL AGREEMENT

(Equitable Lien/Benefit Assignment Contract and Indemnification Agreement)

Please read the following very carefully as it concerns your financial responsibility to the Health Care or Service Provider from whom you are about to receive services.

I the undersigned Patient hereby agree to establish a lien/assignment of benefits or claim in favor of **Imagine Wellness Chiropractic Center** by this contract and pursuant to any state statutes that apply in the state where I reside. I give my permission for **Imagine Wellness Chiropractic Center** and/or their agent, to file, record and serve notice of this agreement (lien/assignment) upon myself and all other parties who may be liable to me for damages arising from the accident which occurred on _____ **[*d a t e*]** and any subsequent claims arising from this accident for which I am about to receive health care. I understand that by doing so ***I have entered into a* CONTRACT *with the above-named health care or service provider***.

THIS AGREEMENT AUTHORIZES DIRECT PAYMENT TO SAID PROVIDER FROM ANY AND ALL PROCEEDS FROM ANY INSURANCE POLICY, SETTLEMENT, COMPROMISE, JUDGMENT VERDICT for damages to which I may be entitled and paid in connection with the settlement of claims or litigation arising from this accident, in such sums necessary to fully compensate the health care or service provider from whom I have received care. I also fully authorize that **Imagine Wellness Chiropractic Center** be named on any settlement checks issued regardless of whose policy pays the claim. This will include but not limited to, First Parties Med Pay, UIM/UM and PIP. Any hold harmless agreement that I or my attorney may sign does not indemnify the responsible party(ies) and/or insurance company(ies) from their legal and financial obligations to honor the Recorded HealthCare Provider Lien/Assignment. The lien/assignment is created by this Equitable Lien Contract and Indemnification Agreement and shall have priority from the date the patient first receives treatment, over any subsequent liens or assignments of my interests in claims arising from this accident.

In exchange for providing necessary medical care without requiring payment in full at the time service is received, I agree to be responsible for all charges associated with my care, regardless of the insurance companies' reimbursement, settlement or compromise. Charges for which I agree to be responsible include any administrative expenses associated with processing my claim such as charges incurred by the provider for recording and/or serving notice of this lien/assignment upon any liable parties and their insurance companies. Also included are any collection charges or legal costs and fees incurred by the provider while attempting to collect the medical bills related to this claim should such actions becomes necessary.

I further understand that as part of the process of recording a lien/assignment, I will receive a copy of the lien/assignment for my own records.

_____

Patient's Name (print) If a minor – signature of parent or legal guardian required

_____

Patient's Signature If a minor – signature of parent or legal guardian required Date _____