Dimensions Chiropractic

Last Name: ______________________ First Name: ____________________ M/F: _____

Street Address: ____

City: ____________________ State: ______________ Zip Code: ________________

Home Phone: ____________ Work Phone: ____________ Cell Phone: ____________

Social Security #: ______________ Date of Birth: ______________________

Emergency Contact: ______________ Relationship: __________ Phone: __________

Employer: ____________________ Employer Address: ______________________

Name of Insurance/Third Party: ______________________________________

Insurance Address: ____

Insurance Phone Number: ______________________ Fax: ____________________

Claim Number: ______________________ Adjuster Name: ____________________

1. What was the date of the accident?______________________________________
2. What time did the accident occur? ______________________________________
3. How many vehicles were involved in the accident? _________________________
4. What was the estimated damage to the vehicle you were in? __________________
5. What state did the accident occur in? ___________________________________
6. What city did the accident occur in? ____________________________________
7. What street or intersection were you on when the accident occurred? ___________
8. What direction were you traveling in? ___________________________________
9. What type of impact was the auto accident? ______________________________
10. Did your vehicle hit anything after the accident? if yes, please describe

    ____
11. Where were you sitting in the vehicle during the accident? ___________________
12. Did you know the accident was coming? __________________________________

13. What type of vehicle were you in? ______________________________

14. What type of vehicle impacted yours? ______________________________

15. At the time of the impact, how fast was your vehicle moving? ____________________

16. At the time of impact, how fast was the other vehicle moving? ____________________

17. During and after the crash what happened to your vehicle? (circle all that apply)

- kept going straight
- kept going straight hitting a car in front
- was hit by another vehicle
- spun around
- spun around and hit a stationary object
- hit a stationary object

18. Did you lose consciousness during the accident? -yes - no

19. How was your head positioned during the accident? ______________________________

20. How was your torso positioned during the accident? ______________________________

21. How were your hands positioned during the accident? ______________________________

22. Did your head hit anything during the accident? -no - yes, please describe ____________

23. Did your face hit anything during the accident? -no - yes, please describe____________

24. Did your shoulders hit anything during the accident? -no - yes, please describe____________

25. Did your neck hit anything during the accident? -no - yes, please describe____________

26. Did your chest hit anything during the accident? -no - yes, please describe____________

27. Did your hips hit anything during the accident? -no - yes, please describe____________

28. Did your knees hit anything during the accident? -no - yes, please describe____________

29. Did your feet hit anything during the accident? -no - yes, please describe____________

30. What kind of headrest was in your vehicle?
- movable fixed headrest - non-movable fixed headrest - no headrest

31. Where was the headrest positioned on your head? ______________________________

32. Did you have your seatbelt on during the accident? - yes -no

33. Did you slide out of your seatbelt during the accident? ______________________________

34. What was damaged in your vehicle? (Circle all that apply)

- windshield
- steering wheel
- dashboard
- seat frame
- side window
- rear window
- rear bumper
- front bumper
- trunk
- front left door
- front right door
- back left door
- mirror
- knee bolster
- back right door
- completely totaled

35. Choose the items that dented inward
- floorboards - side door - dashboard

36. Choose the doors that would not open as a result of the accident
- front left - front right
- rear left - rear right

37. Did you go to the hospital? -yes -no (if no, why? and do not answer 38-43)

____

38. How did get to the hospital? ______________________________________

39. What was the name of the hospital? ________________________________

40. Were you hospitalized overnight? __________________________________

41. Circle what you were prescribed at the hospital
- pain medication - muscle relaxers - neck brace

42. Did you receive any stitches for any cuts at the hospital? _______________

43. Were x rays taken at the hospital? If yes, which area was taken?

____

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the doctor to release any information including the diagnosis and the records of any treatment or examination rendered to me or my dependent during the period of such chiropractic care to a third party and/or health practitioners. I authorize and request my insurance company to pay directly to Dimensions Chiropractic insurance benefits that are otherwise payable to me. I understand that my chiropractic insurance carrier may cover only a portion of or not cover all of services rendered.

I agree to be ultimately responsible for all fees for services rendered and that fees are payable when services are rendered.

Patient Signature______________________________ **Date:**______________

Guardian Signature (if patient is a minor) ____________________ **Date:**______________

Dimensions Chiropractic

PATIENT INTAKE FORM

Patient Name: ______________________________ Date: _______________

Address: __________________________________ Date of Birth: ___________

City: __________________ State: _______ Zip: ________ Gender: Male Female

Phone (H): _____________ Phone (W): _____________ Phone (C): _____________

Social Security Number: ____________________ Email: ______________________

Emergency Contact: _______________ Relation: ____________ Phone: __________

Referral (Who may we thank for referring you to our office?): ______________________

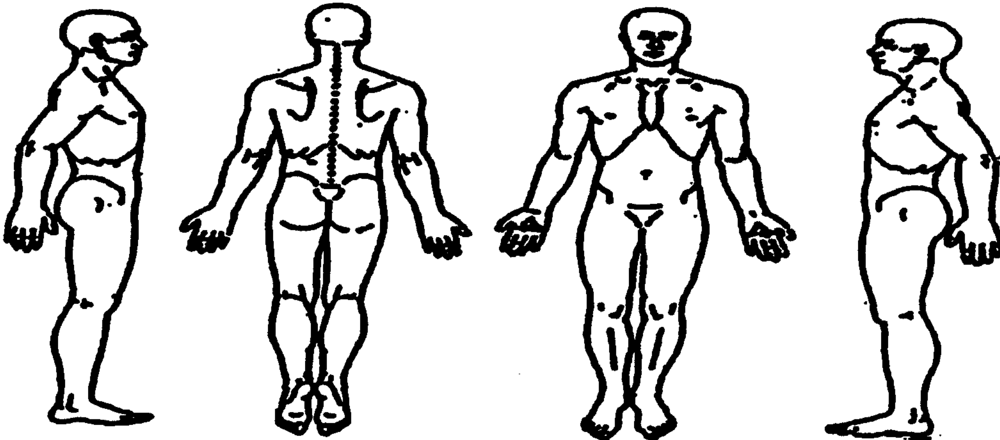
Financial and Insurance Information Do you have health insurance: YES NO

Name of Subscriber of Party Responsible for Payment: ___________________________

Subscribers Date of Birth: _____________ Relationship: _______________________

1. Is today's problem caused by: □ Auto Accident □ Worker's Compensation □ N/A

2. Indicate on the drawings below where you have pain/symptoms



3. How often do you experience your symptoms?

□ Constantly (76-100% of the time)
□ Frequently (51-75% of the time)
□ Occasionally (26-50% of the time)
□ Intermittently (1-25% of the time)

4. How would you describe the type of pain?

□ Sharp
□ Dull
□ Diffuse
□ Achy
□ Burning
□ Shooting
□ Stiff
□ Numb
□ Tingly
□ Sharp with motion
□ Shooting with motion
□ Stabbing with motion
□ Electric like with motion
□ Other:_______________

5. How are your symptoms changing with time?

□ Getting Worse □ Staying the Same □ Getting Better

6. Using a scale from 0-10 (10 being the worst), how would you rate your problem?

0 1 2 3 4 5 6 7 8 9 10 (*Please circle*)

7. How much has the problem interfered with your work?

□ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely

8. How much has the problem interfered with your social activities?

□ Not at all □ A little bit □ Moderately Quite a bit □ Extremely

9. Have you seen a chiropractor in the past?

Chiropractor Name: ______________________ Dates: ______________

Results: GREAT GOOD FAIR MIXED POOR Other:______________

Why did you discontinue care? ______________________________

Who else have you seen for your problem?

□ Primary Care Physician Name: ______________
□ Neurologist Name: ______________
□ ER physician Name: ______________
□ Orthopedist Name: ______________
□ Massage Therapist Name: ______________
□ Physical Therapist Name: ______________
□ Other: ______________________________

10. How long have you had this problem? ________

11. How do you think your problem began?

____

12. Do you consider this problem to be severe?

□ Yes □ Yes, at times □ No

13. What aggravates your problem?

____

14. What concerns you the most about your problem; what does it prevent you from doing?

____

What alleviates your pain? ______________________________

15. What is your: Height________ **Weight** __________ **Date of Birth** __________

Occupation ______________________**# of hours worked/week:** ________

Describe a typical work day: ______________________________

____

16. How would you rate your overall Health?

□ Excellent □ Very Good □ Good □ Fair □ Poor

17. What type of exercise do you do?

□ Stenuous □ Moderate □ Light □ None

18. Indicate if you have any immediate family members with any of the following:

□ Rheumatoid Arthritis □ Diabetes □ ALS □ Epilepsy
□ Heart Problems □ Cancer □ Auto-Immune Diseases (Lupus, MS, etc)

19. For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

Past	Present	Past	Present	Past	Present
□	□ Headaches	□	□ High Blood Pressure	□	□ Diabetes
□	□ Neck Pain	□	□ Heart Attack	□	□ Excessive Thirst
□	□ Upper Back Pain	□	□ Chest Pains	□	□ Frequent Urination
□	□ Mid Back Pain	□	□ Stroke	□	□ Smoking/Tobacco Use
□	□ Low Back Pain	□	□ Angina	□	□ Drug/Alcohol Dependance
□	□ Shoulder Pain	□	□ Kidney Stones	□	□ Allergies
□	□ Elbow/Upper Arm Pain	□	□ Kidney Disorder	□	□ Depression
□	□ Wrist Pain	□	□ Bladder Infection	□	□ Systemic Lupus
□	□ Hand Pain	□	□ Painful Urination	□	□ Epilepsy
□	□ Hip Pain	□	□ Loss of Bladder Control	□	□ Dermatitis/Eczema/Rash
□	□ Upper Leg Pain	□	□ Prostate Problems	□	□ HIV/AIDS
□	□ Knee Pain	□	□ Abnormal Weight Gain/Loss		
□	□ Ankle/Foot Pain	□	□ Loss of Appetite	**For Females Only**	
□	□ Jaw Pain	□	□ Abdominal Pain	□	□ Birth Control Pills
□	□ Joint Pain/Stiffness	□	□ Ulcer	□	□ Hormonal Replacement
□	□ Arthritis	□	□ Hepatitis	□	□ Pregnancy
□	□ Rheumatoid Arthritis	□	□ Liver/Gallbladder Disorder		No. of Pregnancies: ______
□	□ Cancer	□	□ General Fatigue		No. of Vaginal Births: ___
□	□ Tumor	□	□ Muscular Incoordination		No. of Cesareans: ________
□	□ Asthma	□	□ Visual Disturbances		Date of last menstrual
□	□ Chronic Sinusitis	□	□ Dizziness		period: ________________
□	□ Other:____________________________				Date of last Pap Exam: ___

20. List all prescription medications you are currently taking:

____

21. List all of the over-the-counter medications you are currently taking:

____

22. List all surgical procedures you have had:

____

23. What activities do you do daily:

□ **Sit:** □ Most of the day □ Half the day □ A little of the day
□ **Stand:** □ Most of the day □ Half the day □ A little of the day
□ **Computer work:** □ Most of the day □ Half the day □ A little of the day
□ **On the phone:** □ Most of the day □ Half of the day □ A little of the day

24. What activities do you do outside of work (leisure, hobbies, sports, etc.)?

____

25. Have you ever been hospitalized? □ No □ Yes

If yes, explain: ____

26. Have you had significant past trauma? □ No □ Yes

If yes, explain: ____

Lifestyle

Hours of computer/tablet use daily? ______ Right/left handed? _______

Number of hours driving/day: ___________ Hours on your feet daily: ______

Hours of sleep each night (circle one): 0-2 3-5 6-8 9+

Is sleep (circle all that apply): restful restless hard to fall asleep wake up often

Do you smoke: yes no How much per day: _________________

How much alcohol do you consume weekly? _______________________

How much coffee/tea/caffeine do you consume daily? _______________

Daily water intake (circle one):

When I'm thirsty 2-4 glasses 5-8 glasses 9-12 glasses Constantly, I'm always thirsty

27. Are there any specific questions about your condition or chiropractic that you want Dr. Tammy or Dr. Kristen to address at today's visit?

____

____

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the doctor to release any information including the diagnosis and the records of any treatment or examination rendered to me or my dependent during the period of such chiropractic care to a third party and/or health practitioners. I authorize and request my insurance company to pay directly to Dimensions Chiropractic insurance benefits that are otherwise payable to me. I understand that my chiropractic insurance carrier may cover only a portion of or not cover all of services rendered.

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Patient Signature___________________________________ **Date:**_________________

Guardian Signature (if patient is a minor) _____________________ **Date:**_________________

Dimensions Chiropractic

LOW BACK DISABILITY INDEX

Name:____ **Date:**____________

This questionnaire helps us to understand how much your low back has affected your ability to perform everyday activities. Please check the one box in each section that most clearly describes your problem now.

SECTION 1 - Pain Intensity

- ☐ The pain comes and goes and is very mild.
- ☐ The pain is mild and does not vary much.
- ☐ The pain is moderate and does not vary much.
- ☐ The pain comes and goes and is moderately increasing
- ☐ The pain comes and goes and is severe.

SECTION 2 - Personal Care (Washing, Dressing, etc.)

- ☐ I would not have to change my way of washing or dressing in order to avoid pain.
- ☐ I do not normally change my way of washing or dressing even though it causes some pain.
- ☐ Washing and dressing increase the pain, but I manage not to change my way of doing it.
- ☐ Washing and dressing increase the pain and I find it necessary to change my way of doing it.
- ☐ Because of the pain, I am unable to do some washing and dressing without help.
- ☐ Because of the pain, I am unable to do any washing and dressing without help.

SECTION 3 - Lifting

- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights but it gives extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g. on a table).
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can only lift very light weights at the most.

SECTION 4 - Walking

- ☐ I have no pain on walking.
- ☐ I have some pain on walking but it does not increase with distance.
- ☐ I cannot walk more than one mile without increasing pain.
- ☐ I cannot walk more than ½ mile without increasing pain.
- ☐ I cannot walk more than ¼ mile without increasing pain.
- ☐ I cannot walk at all without increasing pain.

SECTION 5 - Sitting

- ☐ I can sit in any chair as long as I like without pain.
- ☐ I can sit only in my favorite chair as long as I like.
- ☐ Pain prevents me from sitting more than 1 hour.
- ☐ Pain prevents me from sitting more than ½ hour.
- ☐ Pain prevents me from sitting more than 10 minutes.
- ☐ I avoid sitting because it increases pain immediately.

SECTION 6 – Standing

- ☐ I can stand as long as I want without pain.
- ☐ I have some pain standing, but it does not increase with time.
- ☐ I cannot stand for longer than 1 hour without increasing pain.
- ☐ I cannot stand for longer than ½ hour without increasing
- ☐ The pain is severe and does not vary much.
- ☐ I cannot stand for longer than 10 minutes without increasing pain.
- ☐ I avoid standing because it increases the pain immediately.

SECTION 7 – Sleeping

- ☐ I get no pain in bed.
- ☐ I get pain in bed but it does not prevent me from sleeping well.
- ☐ Because of pain, my normal sleep is reduced by less than ¼.
- ☐ Because of pain, my normal sleep is reduced by less than ½.
- ☐ Because of pain, my normal sleep is reduced by less than ¾.
- ☐ Pain prevents me from sleeping at all.

SECTION 8 - Social Life

- ☐ My social life is normal and gives me no pain.
- ☐ My social life is normal but increases the degree of pain.
- ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. dancing . . .
- ☐ Pain has restricted my social life and I do not go much.
- ☐ Pain has restricted my social life to my home
- ☐ I have hardly any social life because of my pain.

SECTION 9 - Traveling

- ☐ I get no pain while traveling.
- ☐ I get some pain while traveling, but none of my usual forms of travel make it worse.
- ☐ I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
- ☐ I get extra pain while traveling which compels me to seek alternative forms of travel.
- ☐ Pain prevents all forms of travel except done lying down.
- ☐ Pain restricts all forms of travel.

SECTION 10 - Changing Degrees of Pain

- ☐ My pain is rapidly getting better.
- ☐ My pain fluctuates, but overall is definitely getting better.
- ☐ My pain seems to be getting better, but slowly improves.
- ☐ My pain is neither getting better nor worse.
- ☐ My pain is gradually worsening.
- ☐ My pain is rapidly worsening.

From Vernon H, Minor S. JMPT 1991; 14(7):409-415):409-415 ☐

Dimensions Chiropractic

NECK DISABILITY INDEX

Name:____ **Date:**____________

This questionnaire helps us to understand how much your neck pain has affected your ability to perform everyday activities. Please check the one box in each section that most clearly 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.
- ☐ It is painful to look after myself and I am slow and careful.
- ☐ I need some help but manage most of my personal care.
- ☐ I need help every day in most aspects of self-care.
- ☐ I do not get dressed, I wash with difficulty and stay in bed.

SECTION 3 - Lifting

- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights but it gives extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned.
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned
- ☐ I can lift very light weights.
- ☐ I cannot lift or carry anything at all.

SECTION 4 - Reading

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

SECTION 5 - Headaches

- ☐ I have no headaches at all.
- ☐ I have slight headaches that come infrequently.
- ☐ I have moderate headaches that come infrequently.
- ☐ I have moderate headaches that come frequently.
- ☐ I have severe headaches that come frequently.
- ☐ I have headaches almost 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 lot 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 hardly 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 pain in my neck.
- ☐ I can't drive my car as long as I want because of moderate pain in my neck.
- ☐ I can hardly drive at all because of severe pain in my neck
- ☐ I can't drive my car at all.

SECTION 9 – Sleeping

- ☐ I have no trouble sleeping
- ☐ My sleep is slightly disturbed (less than 1 hr sleepless).
- ☐ My sleep is mildly disturbed (1-2 hrs sleepless).
- ☐ My sleep is moderately disturbed (2-3 hrs sleepless).
- ☐ My sleep is greatly disturbed (3-5 hrs sleepless).
- ☐ My sleep is completely disturbed (5-7 hrs sleepless).

SECTION 10 - Recreation

- ☐ I am able to engage in all my recreation activities with no neck pain at all.
- ☐ I am able to engage in all my recreation activities, with some pain in my neck.
- ☐ I am able to engage in most, but not all of my usual recreation activities because of neck pain.
- ☐ I am able to engage in a few of my usual recreation activities because of pain in my neck.
- ☐ I can hardly do any recreation activities because of pain in my neck.
- ☐ I can't do any recreation activities at all.

From Vernon H, Minor S. JMPT 1991; 14(7):409-415):409-415 ☐

Dimensions Chiropractic

PATIENT HEALTH INFORMATION CONSENT FORM &

HIPPA PRIVACY PRACTICES ACKNOWLEDGEMENT

We want you to know how your patient health information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form of our policies and procedures concerning the privacy of your PHI we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their patient health information for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. This chiropractic office has the right to obtain any past records that the chiropractic physician finds necessary for the purpose of treatment, payment, healthcare operations and coordination of care.
3. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosure has been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
4. A patient's written consent need only be obtained one time for all subsequent care given to the patient in this office.
5. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
6. For your security and right to privacy, all staff has been trained in the area of patient record privacy and privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
7. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
8. If the patient refused to sign this consent for the purpose of treatment, payment, and healthcare operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Name of Patient (Print) Signature of Patient (Guardian) Date

Dr. Tammy Wilke, D.C & Dr. Kristen Wills D.C, 109 South Douty Street, Hanford, CA 93230

Phone: (559) 584-5211 Fax: (559)582-5211 www.dimensionschiro.com

PC ☐

Dimensions Chiropractic

DOCTOR-PATIENT RELATIONSHIP IN CHIROPRACTIC CARE & INFORMED CONSENT

CHIROPRACTIC

It is important to acknowledge the difference between the health care specialties of chiropractic, osteopathy, medicine, and for the patient to understand what to expect from chiropractic care. It is the chiropractic premise that proper spinal alignment allows normal nerve transmission throughout the body and gives the body an opportunity to use its inherent recuperative powers. In this way, chiropractic health care seeks to restore health through natural means without the use of drugs or surgery. This gives the body maximum opportunity to utilize its inherent recuperative powers. The success of chiropractic procedures often depends on environment, underlying causes, and the physical and spinal conditions of each individual patient. It is important that the patient understands what to expect from your chiropractic care. Due to the complexities of nature, and the many variables (both known and unknown) that can affect a patient's response, no doctor can promise specific results. The doctor of chiropractic provides a specialized, unique, non-duplicating health service. The Doctor of Chiropractic is licensed in a special area of practice and is available to work with other types of providers in your health care regime.

ANALYSIS

Your doctor will conduct a clinical analysis for the express purpose of determining whether there is evidence that your situation may be the result of a vertebral subluxation and that you might respond satisfactorily to chiropractic care. If such is found, chiropractic care will be recommended in an attempt to restore spinal integrity.

RESULTS

The purpose of chiropractic care is to promote natural health through the reduction of the vertebral subluxation. Since there are so many variables, it is difficult to predict the time schedule or the efficacy of the chiropractic adjustment on any given patient. Sometimes the response is phenomenal, however, I most cases there is a more gradual, but quite satisfactory response. Occasionally, the results are less than expected. Two or more similar conditions may respond differently to the same type of care and actual response is not predictable. Many medical failures have found significant benefit through chiropractic care. In turn, many conditions, which do not respond to chiropractic care, may be helped through medical treatment. Chiropractic and medicine may be never be so exact as to provide definite answers to all problems; however, both have made great strides in patient care.

DIAGNOSIS

Although doctors of chiropractic are experts in the analysis of structural alignment of the human spine, and its effects on the nervous system, they are not internal medical specialists. Every patient should be mindful of his/her own symptoms and should secure other opinions should he/she have any concerns as to the nature of his/her total condition. Your doctor of chiropractic may express an opinion as to whether or not you should take this step, but you are responsible for the final decision.

INFORMED CONSENT FOR CHIROPRACTIC CARE

By signing below, the patient gives the doctor permission and authority to care for him/her in accordance with recognized and acceptable chiropractic analytical and corrective procedures. The chiropractic adjustment is usually beneficial and seldom causes any adverse reactions. In rare cases, undetected physical defects, deformities, or pathologies may render the patient susceptible to injury. The doctor, of course will not give an adjustment if he is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known or to learn through other health care procedures whether he/she is suffering from pathological conditions (latent of otherwise), illnesses, injuries, or deformities which would otherwise not come to the attention of the doctor.

TO THE PATIENT

Please discuss any questions or problems with the doctor before signing this statement of understanding and consent for care.

I have read and understand the foregoing explanation of chiropractic care given to me. I hereby give my consent for the doctor to render chiropractic care to me.

Patient's Signature: ______________________________ Date______________

Dr. Tammy Wilke, D.C & Dr. Kristen Wills D.C, 109 South Douty Street, Hanford, CA 93230

Phone: (559) 584-5211 Fax: (559)582-5211 www.dimensionschiro.com

Dimensions Chiropractic

OFFICE POLICY

Patients will be expected to (please mark one):

- ☐ **Cash patient** - pay in full at time of service (I have insurance but do not want to bill)
- ☐ **Insurance** - show current and eligible medical insurance
- ☐ **Hardship Patient** - establish specific payment terms, including payment amounts and dates.

If terms or plans become necessary for you, our staff will be pleased to work out arrangements that we trust will be mutually agreeable.

______ Initial **If a scheduled appointment is missed, the patient will be charged a fee of $25.00.**
**If 24 hour notice is provided, the patient will NOT be charged.*

______ Initial **An after-hours call requires cash payment at the time of service.** An additional fee of $100 - $150 is added to normal office visit fees for an afterhours call.

______ Initial **In the event that payment is not made when due**, I the patient, understand that 1.5% interest charge will be added monthly to my account and I will be responsible for all costs involved in collection.

INSURANCE

If patient has insurance it is their responsibility to provide Dimensions Chiropractic with the following information:

1. Whether or not chiropractic care is covered by the patient's insurance.
2. The amount of the deductible and whether or not it has been met.
3. Whether the deductible is for calendar year or per injury.
4. The percent of care covered and any applicable exclusions (i.e.: back supports, vitamins, etc.)
5. **This information is available through your insurance.**

______ Initial **If insurance benefits have become exhausted, it is the patient's responsibility to pay for treatment.**

______ Initial **Co-pays are due at the time of service.**

I have read and understand the above policy and agree to the above terms.

______________________________ Patient's Signature

______________________________ Date

Witnessed by: ______________________________

Date: ______________________________

PC ☐

Dimensions Chiropractic

Dr. Tammy Wilke and Dr. Kristen Wills
109 S. Douty St.
Hanford, CA 93230
Office: (559)584-5211; Fax: (559)584-5212

PLEASE RELEASE THE MEDICAL RECORDS REGARDING:

Name: ______________________ Date of Birth: ______________

Address: ____

Regarding:

Surgery/Operative Reports
X-Rays (Copies of films & reports)
Pathology Reports
Office Notes
Lab Reports
Discharge Summary
Other: ______________________________________

Dates of Service: ______________________________________

Condition/Diagnosis: ___________________________________

Requested from:

Name: ____

Address: ____

Phone: ______________________ Fax: ______________________

Signed: ______________________ Date: __________ Relation: __________

Witnessed: ____________________ Date: ______________________

Dimensions Chiropractic

Third Party Lien and Direct Payment to Provider

I hereby authorize and direct_______________________________________Insurance Company, to pay to Dr.__________________________ such sums as may be due and owing him/her for medical/chiropractic services rendered me by reason of the accident 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 request that payment be made directly to said doctor which would otherwise be paid to myself, as the result of the treatment charges injured for injuries in connection therewith. This is a direct assignment of my rights and benefits under this claim.

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

Please acknowledge your agreement to this request by signing below and returning to the doctor's office below. I have been advised that if you do 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 by me.

Date______________________ Patient Signature________________________________

The undersigned Insurance company does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment or verdict, as may be necessary to adequately protect and fully compensate said doctor above and below named and make payment payable directly to said doctor.

Date______________________ ____

Insurance Company Representative

____

Print First and Last Name

Please date, sign and return one copy to the doctor's office below.

DIMENSIONS CHIROPRACTIC
109 SOUTH DOUTY STREET
HANFORD, CA 93230
559-584-5211

Dimensions Chiropractic

Dr. Tammy Wilke and Dr. Kristen Wills
109 S. Douty St., Hanford, CA 93230
Office: (559)584-5211; Fax: (559)584-5212

NOTICE OF DOCTOR'S LIEN

Patient: ______________________________ Date of Accident/Injury: ________________

I do hereby authorize Tammy K Wilke, DC and Kristen Wills, DC of Dimensions Chiropractic to furnish you, my attorney, with a full report of their examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I was recently involved.

I hereby authorize and direct you, my attorney, to pay directly to said doctors any suns as may be due and owing them for medical services rendered me both by reason of this accident and any other bills that are due their office and to withhold such sums from any settlement, judgment, or verdict as may be necessary to adequately protect and fully compensate said doctors. And I hereby further give a Lien on my case to said doctors 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 doctors for all medical bills submitted by them for services rendered me and that this agreement is made solely for said doctor's additional protection and in consideration of their 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 doctors 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 to promptly deliver a copy of the lien to any such substituted 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 and may declare the entire balance due and payable.

________________ ______________________________________

Dated Patient Signature

The undersigned being attorney of record for the above patient does hereby agree to observe all terms of the above and agrees to withhold such sums from any settlement, judgment, or verdict, as may be necessary to adequately protect and fully compensate said doctors above-named. Attorney further agrees that in the event this lien is litigated, that the prevailing part will be awarded attorney fees and costs.

________________ ______________________________________

Dated Attorney Signature