# Atlas Rehabilitation

## Vehicle Accident Questionnaire

Please print clearly and accurate

Name: Last_____First_____Middle_____ Phone#_____

Address_____City_____State_____Zip_____

SS#_____Age_____Date of Birth_____ Sex M/F ___ Marital status_____

#Children____ Employer_____Address_____Phone#_____

Job title/duties_____ Spouse Name_____

## Insurance Information

**Must complete all Blanks**

Your auto insurance company_____Policy No._____

Claim No._____Phone #_____Address_____

Other vehicle's insurance company_____Policy No._____

Claim No._____Phone#_____Address_____

Driver of your car_____Driver of other car_____

Name of adjuster_____

## Accident Information

**Date of Accident_____ Time_____AM/PM** Conditions: wet/dry: sunny/dark No. of passengers____

Police? WPD___DPS___ Seat Belt? Yes___No__ Shoulder Strap? Yes__No___ Head rest? Yes___No____

You were: passenger___driver___ Air Bag? Yes____No____ Did not deploy_____

Front seat___ back seat____ RT/LT/Mid You were struck from: front___ rear___right side____ left side____

Make/Model of your vehicle_____Make/Model of other vehicle_____

Were you unconscious? Yes____NO____ Were you taken Home? Yes____NO____

Were you taken to the Hospital? Yes____NO___ Hillcrest ER____ Providence ER____SW__ By Amb.____Car_____

You were taken to the Hospital? Immediately_____ Hours later #_____ Days later #_____ Drove self? Yes__No___

Did you see a Doctor? Yes____No___ if yes, who_____MD. DO.

Did you receive ? Exam____ Xrays_____ Cat scan____ MRI_____ other_____

Did you receive any Medicine? Yes____No___ if yes, what? _____

Estimated damage amount to your vehicle $_____/unknown Witnesses? Y/N if yes,who_____

## Work Information

How long have you been employed at your Job? ____days____wks____months_____years

Have you missed work due to your accident/injury? Yes____No____ if yes, _____days_____wks____months

Have you returned to work? Yes____No___ if yes, Light duty_____Regular duty_____ same job? Yes___No___

Have you ever been injured on the Job? Yes____No____ if yes, when?_____ receive treatment? Yes___No___

Are you disabled? Yes___No___ VA____SSI____ I am: Retired_____Student____Unemployed____Part time_____

Any prior treatment for this injury? Yes____No____

Are you receiving current care for this condition? Yes____No____ if yes, where?_____

Please describe the accident:

_____

_____

_____

_____

_____

Please describe the injuries and symptoms and the location:

_____

_____

_____

_____

Please circle the amount of pain you are in today:

No pain 0 1 2 3 4 5 6 7 8 9 10 severe pain The pain is: worse____improved____same_____

While I am awake, my pain is:
Constant___ (76-100%) Frequent____ (61-75%) Intermittent____ (26-50%) Occasional____ (1-25%) of the time.

My pain is: deep/sharp/dull/burning/tingling/stabbing/pulling/drawing/throbbing/piercing/numbness

It is worse when: sitting/standing/bending/sleeping/turning or_____

I currently have pain in: neck/mid back /low back/pelvic Arm rt/lt Leg rt/lt Head/ headache Foot/hand

I have: Blurred vision___ Ringing in ears____ Dizzy____ Groin pain_____ Bladder___Bowel_____

My condition is better when: _____ /nothing

Are you pregnant? Yes____No____if yes, How many weeks_____ Do you have Allergies? Yes___No____

List Surgeries_____

List Fractures_____

Smoker? Yes____NO____ ½ pk ____PKS Alcohol? frequent____occasional____social____ beer____hard____

Education: High school/ GED/College/ grade complete____ other_____Have you missed school?____days____wks

Sign:_____ Date:_____ DR._____init.

# PARTIAL ASSIGNMENT OF THE CAUSES OF ACTION, ASSIGNMENT OF PROCEEDS, CONTRACTUAL LIEN AND TREATMENT AGREEMENT

(Herein, "Agreement")

**Consideration.** In order to improve the ability of the Office to collect my Charges directly from various Payers and also to set forth the terms of my financial responsibility to the Office, I, the undersigned, as consideration for the Office's services, agree to the following and direct all Payers as follows:

**Definitions.** In this Agreement, the following terms shall have the following meaning: "Office" and "Clinic" shall refer to the provider referenced below; "Payer" shall refer to, without limit, any insurance carrier, health benefit plan administrator and fiduciary, health maintenance organization, preferred and independent provider organization, attorney, at-fault party, individual, and any other entity, which may elect or be obligated to pay or disburse Proceeds to me, either now or in the future, for any reason; "Proceeds" shall include, without limit, the proceeds from any settlement, judgment, or verdict, the proceeds from any promise to pay or reimburse, and the proceeds relating to the following benefits, plans, or coverages: individual and group health benefits, Medicare, Medicaid, workers' compensation, disability, liability, uninsured and underinsured motorist, no-fault, medical payments benefits, personal injury protection, lost wages, lost services, property damage, and malpractice; "Charges" shall include, without limit, the full fees for the Office's services (including, without limit, treatment, medical equipment, supplies, supplements, narrative reports, photocopies, depositions, and testimony), any Collection Costs incurred by the Office, 18% interest on outstanding Charges, and any other charges incurred by me at the Office; "Collection Costs" shall include, without limit, any pre- and post judgment court costs, filing fees, service of process charges, attorneys fees, and any other costs of collection incurred by the Office in any effort or action to collect my Charges either from me or from any Payer.

**Partial Assignment of the Causes of Action, Assignment of Proceeds, and Contractual Lien.** I hereby assign to the Office, insofar as permitted by law, but only to the extent of my Charges, all of my rights, remedies, and benefits relating to any Payer, including without limit my right to receive Proceeds from any Payer now or in the future, and any and all causes of action that I might have against any Payer now or in the future, the right to prosecute such causes of action either in my name or in the Office's name, and the right to settle or otherwise resolve such causes of action as the Office sees fit. I further grant a contractual lien to the Office with respect to my Charges. I further intend for this Agreement to create a secured interest under the applicable Uniform Commercial Code and hereby direct the Office to file the form(s) normally filed with the secretary of state or other governmental agency in order to perfect such lien. Consistent with these provisions, I hereby direct any and all Payers, to pay the Proceeds directly to, immediately to, and exclusively in the name of, the Office to the extent of my Charges.

**Specific Direction to Any Attorney I Retain, Such as in Accident Cases.** In the event that I retain one or more attorneys to assist me in collecting any Proceeds, I hereby direct (and the Office hereby requests) each attorney to provide immediate notice to the Office regarding any Proceeds received by the attorney, to promptly pay the Office in-full out of such Proceeds, and to provide a full accounting of such Proceeds to the Office. I agree that the purpose of any Proceeds received by the attorney is to pay my Charges.

**Collection of Higher of Allowed Amounts When Two or More Payers Are Involved.** Unless otherwise agreed to in writing, I authorize and direct the Office to submit my Charges, as well as a copy of this Agreement, to any and all Payers including, without limit, my primary health benefit plan. I understand that some or all of these Payers may utilize fee schedules to which the Office has agreed ("allowed fees"). I further understand that the fees allowed or utilized by one Payer may exceed the fees allowed by another Payer. In the event that the fees allowed or utilized by one Payer exceed the fees allowed by another Payer, I hereby authorize and direct the Office to collect its Charges up to, but not in excess of, the higher of the two amounts. In the event that a particular Payer does not utilize any fee schedule at all, I direct the Office to collect up to its full Charges.

**Personal Responsibility for My Charges.** I understand that I remain personally responsible for my Charges and that at any time; I can request a copy of my total Charges from the Office. Except where provided otherwise by law or by contract, I agree to pay the full amount of my Charges to the Office upon its demand. I agree that any partial payments received by the Office towards my Charges shall not constitute a waiver of the Office's right to receive payment-in-full upon demand and shall not constitute an accord and satisfaction of my Charges, irrespective of any restrictions indicated on any payments. I hereby waive any statute of limitations, which may apply to the collection of my Charges.

**Personal Responsibility for Verifying the Terms of My Coverage.** I understand that in any given situation, a Payer may refuse to pay for a particular Charge incurred at the Office, or may actually request a refund from the Office after making payment. I understand, for instance, that a Payer may deny payment for a Charge, stating that the Charge is "not covered" by the policy. I also understand that a Payer may claim, based on internal criteria, that a particular Charge is or was not medically necessary. Unless otherwise agreed to in writing, I agree that I am solely and exclusively responsible for verifying all exclusions and limitations in the policy of any Payer. I also agree that I am solely and exclusively responsible for verifying criteria used by any Payer to assess the medical necessity of my Charges. Should any Payer deny payment, or request a refund, based on an exclusion or limitation in the policy, or should any Payer deny payment or request a refund based on the rationale that a Charge was not medically necessary, consistent with the previous provision, I agree that I am personally and fully responsible for my Charges.

**Miscellaneous Provisions.** I authorize the Office to endorse or sign my name on any and all checks listing me as a payee, which are received by the Office for payment of Charges incurred by me, my spouse or my dependents. I further authorize the Office to apply any credit balances on my Charges to any other outstanding Charges still owed by me, my spouse, or my dependents, regardless of whether these other Charges are related to my condition. Except as provided in this paragraph, this Agreement shall not be modified or revoked without the expressed, written consent of the Office. I hereby revoke with the Office's consent the terms of any previously signed documents to the extent those terms conflict with the terms of this Agreement. This Agreement shall be governed under the laws of the state where the Office is located, and is performable in the county where the Office is located. I hereby consent to personal jurisdiction and venue of any court in said county and waive all objections based on improper jurisdiction, venue, or forum non-conveniens. I agree that each and every provision of this Agreement is reasonably necessary for the protection of the rights and interests of the Office and myself. However, should any provision of this Agreement be found to be invalid, illegal or unenforceable, or for any reason cease to be binding on any party hereto, all other portions and provisions of this Agreement shall, nevertheless, remain in full force and effect.

I hereby direct all payers to release to the Office any pertinent information regarding any coverage I may have including, but not limited to, the amount of the coverage, the amount paid thus far, and the amount of any outstanding claims. I authorize this Office to release any information regarding my treatment or pertinent to my case(s) to all payers as defined above to facilitate collection under this Agreement. I hereby direct this Office to file a copy of this Agreement, together with any applicable charges, with any or all payers, regardless of whether a claim has been established with said payers.

I have read, understood, and agree to the terms of this Agreement.

Patient Name (print): _____

Patient Signature: _____ Date: ____/____/____

Name of Custodial Parent or Legal Guardian, on Behalf of the Patient (please print): _____

Parent/Guardian Signature: _____ Date: ____/____/____

Clinic Name: Atlas Rehabilitation

Name of Authorized Employee: _____ Title: _____

By: _____ Date: ____/____/____
(Signature of Authorized Employee)

PATIENT NAME:

# ARBITRATION AGREEMENT

**Article 1: Agreement to Arbitrate:** It is understood that any dispute as to medical malpractice, including whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by state and federal law, and not by a lawsuit or resort to court process, except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration. Further, the parties will not have the right to participate as a member of any class of claimants, and there shall be no authority for any dispute to be decided on a class action basis. An arbitration can only decide a dispute between the parties and may not consolidate or join the claims of other persons who have similar claims.

**Article 2: All Claims Must be Arbitrated**: It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, as to whether this agreement is unconscionable, and any procedural disputes, will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the health care provider, including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and the health care provider and/or other licensed health care providers, preceptors, or interns who now or in the future treat the patient while employed by, working or associated with or serving as a back-up for the health care provider, including those working at the health care provider's clinic or office or any other clinic or office whether signatories to this form or not.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the health care provider, and/or the health care provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages. This agreement is intended to create an open book account unless and until revoked.

**Article 3: Procedures and Applicable Law:** A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days, and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees, or other expenses incurred by a party for such party's own benefit. Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder, any existing court action against such additional person or entity shall be stayed pending arbitration. The parties agree that provisions of state and federal law, where applicable, establishing the right to introduce evidence of any amount payable as a benefit to the patient to the maximum extent permitted by law, limiting the right to recover non-economic losses, and the right to have a judgment for future damages conformed to periodic payments, shall apply to disputes within this Arbitration Agreement. The parties further agree that the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this Arbitration Agreement.

**Article 4: General Provision:** All claims based upon the same incident, transaction, or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

**Article 5: Revocation:** This agreement may be revoked by written notice delivered to the health care provider within 30 days of signature and, if not revoked, will govern all professional services received by the patient and all other disputes between the parties.

**Article 6: Retroactive Effect**: If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment), patient should initial here. _____. Effective as of the date of first professional services.

If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this Arbitration Agreement. By my signature below, I acknowledge that I have received a copy.

**NOTICE: BY SIGNING THIS CONTRACT, YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION, AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.**

(Date)

PATIENT SIGNATURE X

(Or Patient Representative) (Indicate relationship if signing for patient)

(Date)

OFFICE SIGNATURE X

ALSO **SIGN** THE **INFORMED CONSENT** ON **REVERSE** SIDE

# CHIROPRACTIC INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of chiropractic procedures, including various modes of physical therapy/physiotherapy, diagnostic x-rays, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic indicated below and/or other licensed doctors of chiropractic and support staff who now or in the future treat me while employed by, working or associated with, or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and procedures.

I understand that chiropractic adjustments and supportive treatment are designed to reduce and/or correct subluxations, allowing the body to return to improved health. It can also alleviate certain symptoms through a conservative approach with hopes to avoid more invasive procedures. However, I understand and am informed that, as is with all healthcare treatments, results are not guaranteed, and there is no promise to cure. In addition, I understand and am informed that, as is with all healthcare treatments, in the practice of chiropractic there are some risks to treatment, including, but not limited to, muscle spasms for short periods of time, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns from heat lamps, ice or heating devices, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I further understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include, but are not limited to, self-administered, over-the-counter analgesics and rest; medical care with prescription drugs, such as anti-inflammatories, muscle relaxants and painkillers; physical therapy; steroid injections; bracing; and surgery. I understand and have been informed that I have the right to a second opinion and to secure other opinions if I have concerns as to the nature of my symptoms and treatment options.

I understand that all payment(s) for treatment(s) are final and no refunds will be issued. However, prorated fees for unused, prepaid treatments will be refunded if I wish to cancel the treatment.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below, I agree to the above-named procedures. I intend this consent to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

CHIROPRACTOR NAME: David Kast D.C. / Michael Mattlage D.C.

(Date)

PATIENT SIGNATURE X

(Or Patient Guardian/Parent/Representative) (Provide name and relationship if signing for patient)

ALSO **SIGN** THE **ARBITRATION AGREEMENT** ON **REVERSE** SIDE