SPINE AND WELLNESS CINCINNATI
ACCIDENT QUESTIONNAIRE

Dear Patient: This information is considered confidential. We need this information because we care enough to want to know, and your answers will help us determine if we can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. In order for us to understand your condition properly, please be as neat and accurate as possible while completing this form. **THANK YOU**.

Name_____ Sex_____ Marital Status_____ DOB_____ Home Phone _____

Address _____ City_____ State_____ Zip_____ Cell #_____

Email _____ Height ____' _____" Weight _____ lbs

Occupation _____ Who referred you to our office?_____

SSN _____ Business Phone_____ Company Name _____ Location _____

Spouse_____ Spouse SSN _____ Spouse Employer_____ Location _____

Please explain in detail how your accident happened _____
_____
_____
_____

What were the time and date of present injury? _____

Where did you feel pain immediately after the accident? _____

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

Did you require post accident hospitalization? ☐ Yes ☐ No

Check the symptoms you have noticed since the accident:

☐ Headache	☐ Dizziness	☐ Depression	☐ Fatigue
☐ Stomach Upset	☐ Sensitivity to Light	☐ Buzzing in Ears	☐ Diarrhea
☐ Neck Pain	☐ Head Seems too Heavy	☐ Loss of Memory	☐ Feet Cold
☐ Neck Stiff	☐ Pins and Needles in Arms	☐ Ears Ring	☐ Hands Cold
☐ Fainting	☐ Pins and Needles in Legs	☐ Loss of Balance	☐ Back Pain
☐ Flushed	☐ Numbness in Fingers	☐ Constipation	☐ Tension
☐ Nervousness	☐ Numbness in Toes	☐ Loss of Smell	☐ Fever
☐ Irritability	☐ Shortness of Breath	☐ Loss of Taste	☐ Chest Pain
☐ Cold Sweats	☐ Sleeping Problems	☐ _____	☐ _____

Symptoms other than above:_____
_____

Where were you taken after the accident? _____

Hospitalized? ☐ Yes ☐ No If yes, admitted?_____ How Long?_____
Name of Hospital _____
Name of Doctors _____
What treatment was given? _____

Was there any other doctor consulted after your accident? ☐ Yes ☐ No

If so, what was the doctor's name? _____ ☐ D.C. ☐ M.D. ☐ D.O. ☐ D.D.S.
What was the diagnosis? _____
What treatment was given? _____
How often did you see the doctor? _____
How long did you see the doctor? _____

Have you ever had any complaints in the involved area before? ☐ Yes ☐ No
If so, what were the complaints? _____

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

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

Since the accident are your symptoms ☐ Improving? ☐ Getting Worse? ☐ Same?

Driver of other vehicle (if any)

Name_____ Insurance Company_____ Policy #_____

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

Name_____ Insurance Company_____ Policy #_____

Name of your insurance adjustor: _____

Have you retained an attorney? ☐ Yes ☐ No

If so his/her name and address: _____

You were heading ☐ North ☐ East ☐ South ☐ West on _____(Street or highway)

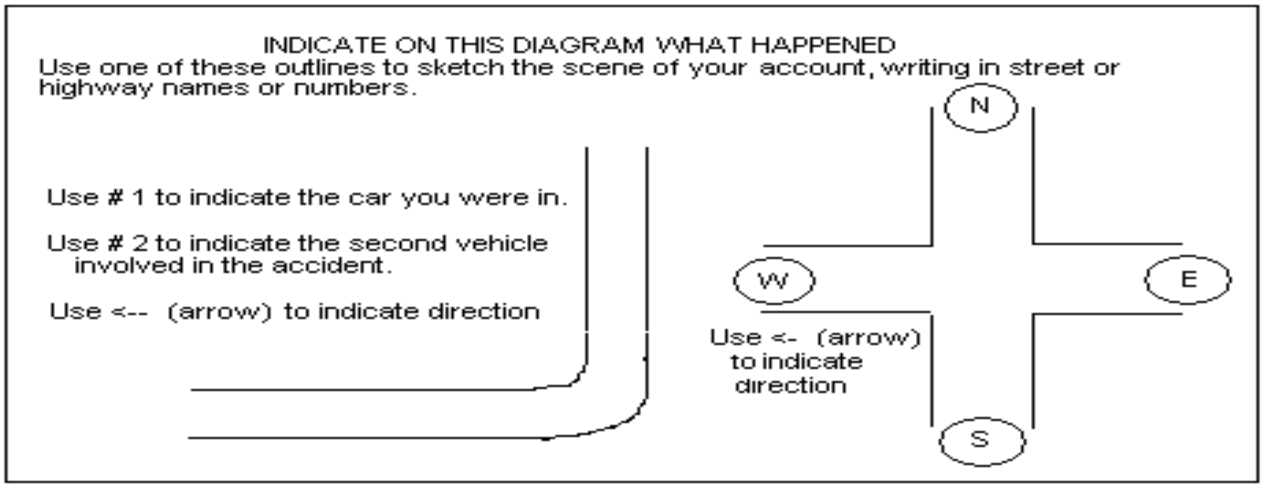
Other vehicle was headed ☐ North ☐ East ☐ South ☐ West on _____(Street or highway)

Were police notified? ☐ Yes ☐ No

Were you knocked unconscious? ☐ Yes ☐ No If so, how long? _____

Were you struck from ☐ Behind ☐ Front ☐ Left Side ☐ Right Side

You were ☐ Driver ☐ Passenger ☐ Front Seat ☐ Back Seat ☐ Using Seat Belts ☐ Other Protective Devices



I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this Chiropractic Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this Chiropractic Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES of:
Spine and Wellness Cincinnati, LLC
7809 Laurel Ave. Suite 11, Cincinnati, OH 45243

I hereby acknowledge that I have received and had an opportunity to ask questions concerning the above named practice's Notice of Privacy Practices.

In addition, I have read and agree to all the above Financial Policies and Notices.

_____ _____ **X** _____

Date Print Patient's Name or Representative Signature of Patient or Representative

_____ _____

Date Witness Spine Wellness Cincinnati

SPINE AND WELLNESS CINCINNATI
PERSONAL INJURY ASSIGNMENT OF BENEFITS

I, the undersigned insured or beneficiary of an insurance policy, irrevocably assign to **(Spine and Wellness Cincinnati, LLC)** whatever rights I have under any policy of insurance and under Ohio law, including, without limitation, any and all claims for attorney's fees, costs, interest and /or damages pursuant to Ohio Statute. This Assignment of Benefits (AOB) includes an assignment of any potential claim for common law or statutory bad faith. If the Insurer disputes the validity of this AOB, then the insurer is instructed to notify the provider in writing within 10 days of receipt of this document. Failure to do so shall result in the provider relying on this AOB for direct payment and could constitute a waiver by the insurer to contest the validity of this document. I do hereby confirm that this AOB is irrevocable and instruct any insurance company or other collateral source for which I am entitled to benefits to pay for monies owed as a result of medical services rendered by **Spine and Wellness Cincinnati** to promptly make payment in the name of and directly to **Spine and Wellness Cincinnati.**

Pursuant to this AOB, **Spine and Wellness Cincinnati** is authorized to file suit on my behalf against any insurance company that reduces or denies benefits for medical services rendered to me and to collect any damages awarded or settlement monies for services rendered, plus interest, costs, reasonable attorney's fees and a contingency fee multiplier. I understand that in any such lawsuit, my name or other identifying information will need to be included in and/or portions of my medical file attached to pleadings and/or formal discovery. I waive any confidentiality of my records and /or information but only to the extent necessary to prosecute a claim for unpaid or owed medical expenses against the insurance company or any other responsible party.

I acknowledge that **Spine and Wellness Cincinnati** objects to any reductions or partial payments by the Insurer. Any partial or reduced payment, regardless of the accompanying language, issued by the Insurer and deposited by **Spine and Wellness Cincinnati** shall be done under protest, at the risk of the insurer and the deposit shall not be deemed a waiver, accord, satisfaction, discharge, settlement or agreement by the provider to accept a reduced amount as payment in full. **Spine and Wellness Cincinnati** reserves the right to seek the full amount of the bill submitted from the insurance company (ies) or me. Accordingly, the insurer is hereby instructed to set aside (escrow) any and all reduced or denied benefit payments for medical services rendered by this provider and not pay the disputed amount to anyone until the dispute is resolved.

I further instruct my insurance company to cooperate with the above-captioned **Spine and Wellness Cincinnati** in resolving all medical billing disputes. Cooperation includes, but is not limited to, providing any and all declaration pages, Med Pay logs, payout ledgers, explanations of benefits, copies of checks, and any and all other documents or information to **Spine and Wellness Cincinnati** or its attorneys, employees or other representatives acting on behalf of **Spine and Wellness Cincinnati**. If the insurer schedules a defense examination, examination under oath (EUO) or Independent Medical Examination (IME) of the patient, the insurer is hereby instructed to send a copy of said notification to this provider and the provider's attorneys. The provider and/or the provider's attorneys are authorized to appear at any patient EUO or IME set by the insurer. **THIS ASSIGNMENT OF BENEFITS DOES NOT ASSIGN ANY RIGHTS OR OBLIGATIONS UNDER THE POLICY OF INSURANCE, TO SUBMIT TO AN EUO OR RECORDED STATEMENT.** I further direct and authorize you to speak to an attorney, employee or any other representative of **Spine and Wellness Cincinnati** or anyone acting on their behalf over the phone and provide them with any and all information you may have or documentation not previously listed above that they may request.

I, as the patient, agree to remain personally liable for the amounts billed by **Spine and Wellness Cincinnati** regardless of the amount paid by the insurance company, unless ordered by a court of law. I fully understand that said health care services were provided to me in consideration for an unconditional promise to pay and for me providing these instructions to my insurance company. I, as the patient, further agree to be liable for reasonable attorney's fees and costs incurred in collecting any delinquent accounts or unpaid balances. By executing this document, I am placing my insurance company (ies) on notice that the claims for medical treatment rendered by **Spine and Wellness Cincinnati** are related to my accident (or my covered conditions) and should be paid directly to **Spine and Wellness Cincinnati** pursuant to this assignment of benefits and Ohio law. Any delay in paying benefits owed under the insurance policy could adversely affect me.

BY EXECUTING THIS DOCUMENT, I AM PLACING MY INSURANCE COMPANY ON NOTICE THAT THIS IS A DIRECT ASSIGNMENT OF BENEFITS PURSUANT TO OHIO LAW. AS THE INSURED OR BENEFICIARY OF SAID INSURANCE POLICY, I AM IRREVOCABLY ASSIGNING WHATEVER RIGHTS I HAVE UNDER MY POLICY OF INSURANCE (LESS THE DUTY TO ATTEND AN EUO) AND UNDER OHIO LAW TO THIS HEALTH CARE PROVIDER. A photocopy of this assignment shall be considered as effective and valid as the original.

Patient's Name/DOB	Signature of Policy holder or Claimant/Date
Name of Policy holder or Claimant	Acceptance of **Spine and Wellness Cincinnati**/Date

SPINE AND WELLNESS CINCINNATI

Patient Name _____ Date _____

PATIENT INFORMED CONSENT

Before you receive care as a patient of Laser Pain Center, it is important that you read this Consent and understand the nature of treatment. Laser Pain Center utilizes a multidisciplinary approach to health and wellness. Treatment usually involves a blend of laser therapy, acupuncture, herbal medicine, and manual medicine. To understand the risk associated with care, you need to understand these unique modalities.

Laser Therapy is a non-surgical application of laser light. Unlike most other forms of therapy, laser therapy is classified "actinotherapy" as it results in a chemical/metabolic change of the involved tissues. Thus, laser therapy can relieve pain, decrease inflammation, accelerate tissue healing (biostimulation), increase blood flow and decrease tissue swelling.

Like all forms of medical treatment, there are associate risks as well as benefits. Laser exposure to the eyes during the procedure may result in damage of the retina. Under certain situations a superficial burn of the skin could occur. This is based upon skin pigmentation, skin discolorations (i.e. tattoos), or the use of topical creams, lotions or analgesic balms. To prevent adverse reactions to laser therapy, all patients must adhere to the guidelines for care supplied separately.

"Acupuncture" means a form of health care performed by the insertion and removal of specialized needles, with or without the use of supplemental techniques, to specific areas of the human body. *See* Ohio Statute 4762.

Manual medicine (or chiropractic care) involves the adjustment, manipulation and treatment of your body in which vertebral subluxations and other malpositioned articulations may be interfering with the normal generation, transmission and expression of nerve impulse between the brain, organs and tissue cells, thereby causing disease. Chiropractic adjustments, manipulations, and treatments are intended to restore the normal flow of nerve impulse which produces normal function and consequent health.

"Chiropractic physicians" examine, analyze, and diagnose the human living body and its disease by use of (a) any physical, chemical, electrical or thermal methods, (b) x-ray for diagnosing, (c) blood tests and (d) other chiropractic methods. *See* Ohio Statute 4734.01.

The undersigned Patient understands and acknowledges that there are risks associated with the application of laser chiropractic medicine, chiropractic care, acupuncture, therapy including, but not limited to ataxia, bruising, thermal injuries, dislocations/subluxations, dizziness, fracture(s), mobility disruption, paralysis, pneumothorax, spinal injury, stroke, vision disturbances and others. The most common side effect following any treatment is an ache or stiffness at the site of the treatment.

I, hereby give authorization for **consent of treatment** to **Laser Pain Center** and whomever they may designate as their assistants to perform and administer therapy and treatment as they deem necessary.

I, the undersigned Patient, understand the risks and limitations associated with treatment at Laser Pain Center and application of therapeutic modalities such as Laser, heat, ice, ultrasound, traction, muscle stimulation, acupuncture, herbal medicine, chiropractic and others treatments by **Laser Pain Center**. **All my questions have been answered in detail and I fully understand and certify that no guarantee or assurances have been made to the results or outcome from treatment that may or will be rendered.**

Patient or Authorized Signature X **Date**

SPINE AND WELLNESS CINCINNATI
LETTER OF PROTECTION

I, the undersigned, hereby agree that this agreement constitutes a lien against any recovery of proceeds paid by any insurance carrier or from whatever source, settlement, judgment or verdict which may be paid to my attorney or myself as a result of the injuries by reason of this accident.

I hereby authorize my attorney to discuss my case or provide **Spine and Wellness Cincinnati** with any information necessary to have payment paid directly to them for such sums as may be due and owing for medical services rendered to me. I, furthermore, authorize my attorney to withhold such sums from any insurance payments or from whatever source, settlement, judgment or verdict and pay **Spine and Wellness Cincinnati** as soon as possible for said debt.

I authorize the release of any information pertinent to my case to my insurance company, adjustor and attorney to facilitate collection. I also authorize the release of medical records to any other doctor involved in my case. Further, I hereby authorize the **RELEASE OF MEDICAL RECORDS.**

I, _____, fully understand that I am directly responsible to **Spine and Wellness Cincinnati** for all medical bills for services rendered to me and this agreement does not relieve me of any personal responsibility for said charges. I further understand that this agreement is made solely for the protection of said provider and such payment is not contingent on any settlement, judgment or verdict by which I may recover said fee.

I understand that this Letter of Protection is irrevocable and shall apply to any cause of action whether or not I should engage legal counsel or substitute attorney at any future time. I further understand and agree to notify **Spine and Wellness Cincinnati** in writing if I change or terminate attorney/client relationship.

_____	_____	_____	_____
Patient Signature	Date	Claim #	Date of Accident

ATTORNEY

I, the undersigned, being the attorney of record for the above patient, do hereby agree to observe all the terms of the above agreement and agree to withhold such sums from any insurance payments or from whatever source, settlement, judgment or verdict and pay **Spine and Wellness Cincinnati** as soon as possible for said debt.

I, furthermore, understand and agree to immediately notify **Spine and Wellness Cincinnati** in writing should there occur a substitution of counsel, referral to another attorney or law firm, retention of co-counsel or should the attorney/client relationship be terminated or modified in any manner.

NOTICE TO MY ATTORNEY OF THIS DOCTOR'S LIEN:

I, THE UNDERSIGNED, HEREBY NOTIFY MY ATTORNEY OF RECORD THAT I HAVE SIGNED AND AGREED TO THIS DOCTOR'S LIEN, and it **CANNOT BE RESCINDED, REVOKED OR ALTERED** BY ME OR ANY LEGAL REPRESENTATIVE THAT I HAVE PRESENTLY OR MAY HAVE IN THE FUTURE.

(A photocopy of this agreement shall be considered as effective and valid as the original)

_____
Attorney Name

_____	_____
Attorney Signature	Date

REVIEW OF SYSTEMS - SPINE AND WELLNESS CINCINNATI

Do you have: (please check all that apply):

Constitutional:
□Fevers □Weight loss □Difficulty sleeping □Tiredness or fatigue □Chills □Night sweats □**None**

Eyes:
□Flashing lights or "stars" □Blind spots □Double vision □**None**

Ears, Nose, Throat, Mouth:
□Earache or discharge □Ringing in ears □Difficulty hearing □Nose bleeds □Sinusitis □Hoarseness □Sores in mouth □Sore throats □**None**

Cardiovascular:
□Chest pain □Squeezing or tightness in chest □ Angina □Need to sleep with head of the bed elevated
□Cramps in buttocks, thighs or calves when walking □Shortness of breath at rest or walking/climbing
□Palpitations or fluttering heart □Poor circulation □Gangrene □Swelling of hands, face, legs or feet □High cholesterol □**None**

Respiratory:
□Cough □Sputum production □Coughing up blood □Pleurisy □Wheezing □Asthma □**None**

Gastrointestinal:
□Nausea or vomiting □Diarrhea □Constipation □Abdominal pain □Vomiting of blood □Very dark or light stool □Jaundice □Liver or gall bladder problems □Colitis or other bowel problems □Bleeding from rectum □Ulcer □**None**

Genitourinary:
□Blood in urine or very dark urine □Get up at night to urinate □Burning with urination □Unusual urgency to urinate □Difficulty in getting urine stream started □Kidney stones □Prostate problems □Bladder problems □Albumin or protein in urine □Pus in urine □Infection in urine □Large amounts of urine or very frequent urination □**None**

Musculoskeletal:
□Low back pain □Neck pain □Muscle ache □Joint pain □Mid back pain □Shoulder/arm pain □Hip/leg pain □Arthritis □**None**

Neurological:
□Headaches □Drooping of face □Loss of strength in hands, arms, legs, feet □Numbness/tingling □Seizures □Loss of consciousness □Dizziness □Fainting spells □**None**

Skin:
□Rashes □Skin ulcers □Nodules on skin □**None**

Emotional/Psychiatric:
□Depression □Anxiety □Psychiatric problems □**None**

Endocrine:
□Enlarged thyroid □Sweating □Diabetes □Excess thirst □Change in appetite □Feeling unusually hot or cold □Flushing □Abnormal menses □Post-menopausal □**None**

Hematologic/Lymphatic/Oncologic:
□Anemia □Iron deficiency □Enlarged lymph glands □Easy bruising □Cancer □**None**

Allergic/Immunologic:
□Hay fever □Seasonal allergies □Other_____ □**None**

Patient Signature	**Date**	**Physician Signature**

SPINE AND WELLNESS CINCINNATI
ASSESSMENT OF ACTIVITIES OF DAILY LIVING

Patient Name_____ **Date**_____

Standing

- □ Able to stand as long as desired without pain
- □ Able to stand for 60 minutes without pain
- □ Able to stand for 45 minutes without pain
- □ Able to stand for 30 minutes without pain
- □ Able to stand for 25 minutes without pain
- □ Able to stand for 15 minutes without pain
- □ Able to stand for 10 minutes without pain
- □ Able to stand for 5 minutes without pain
- □ Unable to stand at all due to pain

Bending

- □ Able to bend as far as would like without pain
- □ Able to bend 80 degrees without pain
- □ Able to bend 70 degrees without pain
- □ Able to bend 60 degrees without pain
- □ Able to bend 50 degrees without pain
- □ Able to bend 40 degrees without pain
- □ Able to bend 30 degrees without pain
- □ Able to bend 20 degrees without pain
- □ Able to bend 10 degrees without pain
- □ Unable to bend at all due to pain

Driving

- □ Able to drive when necessary without pain
- □ Able to drive for 120 minutes without pain
- □ Able to drive for 90 minutes without pain
- □ Able to drive for 60 minutes without pain
- □ Able to drive for 45 minutes without pain
- □ Able to drive for 30 minutes without pain
- □ Able to drive for 20 minutes without pain
- □ Able to drive for 10 minutes without pain
- □ Unable to drive at all due to pain

Walking

- □ Able to walk as far as desired without pain
- □ Able to walk 2-3 miles without pain
- □ Able to walk 1 mile without pain
- □ Able to walk ½ mile without pain
- □ Able to walk ¼ mile without pain
- □ Able to walk 1 block without pain
- □ Able to walk 100 feet without pain
- □ Able to walk 50 feet without pain
- □ Unable to walk at all due to pain

Picking up Objects

- □ Able to pick up heavy objects without pain
- □ Able to pick up 45 pounds without pain
- □ Able to pick up 35 pounds without pain
- □ Able to pick up 25 pounds without pain
- □ Able to pick up 20 pounds without pain
- □ Able to pick up 15 pounds without pain
- □ Able to pick up 10 pounds without pain
- □ Able to pick up 5 pounds without pain
- □ Unable to lift anything due to pain

Sitting

- □ Able to sit without pain
- □ Able to sit 8 hours without pain
- □ Able to sit 7 hours without pain
- □ Able to sit 6 hours without pain
- □ Able to sit 5 hours without pain
- □ Able to sit 4 hours without pain
- □ Able to sit 3 hours without pain
- □ Able to sit 2 hours without pain
- □ Able to sit 1 hour without pain
- □ Able to sit 30 minutes without pain
- □ Unable to sit at all due to pain

Housework

- □ Able to do housework 90 minutes without pain
- □ Able to do housework 80 minutes without pain
- □ Able to do housework 70 minutes without pain
- □ Able to do housework 60 minutes without pain
- □ Able to do housework 50 minutes without pain
- □ Able to do housework 40 minutes without pain
- □ Able to do housework 30 minutes without pain
- □ Able to do housework 20 minutes without pain
- □ Able to do housework 10 minutes without pain
- □ Unable to do housework at all due to pain

Headaches

- □ Having no headaches
- □ Having 2 headaches per month
- □ Having 1 headache per month
- □ Having 1 headache per day
- □ Having 5 headaches per week
- □ Having 3-4 headaches per week
- □ Having 1-2 headaches per week
- □ Having constant headaches

Opening Jars

- □ Able to open any jar without pain
- □ Able to open very tight jars without pain
- □ Able to open medium tight jars without pain
- □ Able to open lightly closed jars without pain
- □ Unable to open any jar due to pain

Lying Down

- □ Able to lay as long as would like without pain
- □ Able to lay for 120 minutes without pain
- □ Able to lay for 90 minutes without pain
- □ Able to lay for 60 minutes without pain
- □ Able to lay for 30 minutes without pain
- □ Able to lay for 20 minutes without pain
- □ Able to lay for 10 minutes without pain
- □ Unable to lay at all without pain

Patient Signature_____

Physician Signature_____

Spine and Wellness Cincinnati

7809 Laurel Avenue, Suite 11, Madeira, OH 45243

Telephone: 513-428-9355 Facsimile: 513-271-9355

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Full Name: _____ Date of Birth: _____

This is an authorization under the Privacy Rules of the Health Insurance Portability and Accountability Act of 1996 [45 CFR 164.508]. I authorize [PRACTICE], my physician and/or administrative and clinical staff to (check all that apply):

__ use the following protected health information, and/or

__ disclose the following protected health information to [*Name of entity or class of persons to receive information*]:

_____

_____

Description of information to be used or disclosed:

_____

_____

This protected health information is being used or disclosed for the following purposes: [*List specific purposes here. "At the request of the individual" is acceptable if the request is made by the patient, and the patient does not want to state a specific purpose.*]

_____

_____

This authorization shall be in force and effect until: (1) _____ [*expiration date*] date or (2) _____ [*event that relates to the patient or the purpose of the use or disclosure*] at which time this authorization to use or disclose this protected health information expires.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the practice's Privacy Officer at the above practice address. I understand that a revocation is not effective to the extent that [PRACTICE] has relied on the use or disclosure of the protected health information or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

My physician will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure except: (1) if my treatment is related to research, or (2) health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party. I understand that I may refuse to sign the Authorization.

If the use/disclosure is for marketing, I understand that the use or disclosure requested under this authorization will result in direct or indirect remuneration to my physician from a third party. _____ [*Patient Initials if applicable*]

_____ _____

Signature of Patient Dated

_____ _____

Print Name of Patient or Personal Representative Description of Personal Representative's Authority

[**Provide a copy of this form to the patient.**]