



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

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date of birth: \_\_\_\_\_ 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: \_\_\_\_\_ Spouse's Name: \_\_\_\_\_

Occupation: \_\_\_\_\_ Spouse's Employer: \_\_\_\_\_

**In case of emergency, notify** \_\_\_\_\_ **Relationship:** \_\_\_\_\_ **Phone** (\_\_\_\_\_) \_\_\_\_\_

**Date of Crash:** \_\_\_\_\_ Hour: \_\_\_\_\_ 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/MOTORCYCLE 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? Name: \_\_\_\_\_ Number: \_\_\_\_\_

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:**

- |  |   |   |  |
|--|---|---|--|
| <input type="checkbox"/> Headache              | <input type="checkbox"/> Middle Back Pain     | <input type="checkbox"/> Lower Back Pain      | <input type="checkbox"/> Ears Ring       |
| <input type="checkbox"/> Neck Pain             | <input type="checkbox"/> Chest Pain           | <input type="checkbox"/> Lower Back Stiffness | <input type="checkbox"/> Buzzing in Ears |
| <input type="checkbox"/> Neck Stiffness        | <input type="checkbox"/> Bruised Chest        | <input type="checkbox"/> Radiating Pain       | <input type="checkbox"/> Dizziness       |
| <input type="checkbox"/> Sleeping Problems     | <input type="checkbox"/> Bruising Anywhere    | <input type="checkbox"/> Tingling in Legs     | <input type="checkbox"/> Loss of Smell   |
| <input type="checkbox"/> Depression            | <input type="checkbox"/> Blurred Vision       | <input type="checkbox"/> Tingling in Arms     | <input type="checkbox"/> Loss of Taste   |
| <input type="checkbox"/> Anxiety               | <input type="checkbox"/> Sensitivity to Light | <input type="checkbox"/> Jaw Pain             | <input type="checkbox"/> Any Burns       |
| <input type="checkbox"/> Fainting              | <input type="checkbox"/> Upper Arm Pain       | <input type="checkbox"/> Upper Leg Pain       | <input type="checkbox"/> Any Stitches    |
| <input type="checkbox"/> Muscle Spasms         | <input type="checkbox"/> Lower Arm Pain       | <input type="checkbox"/> Lower Leg Pain       | <input type="checkbox"/> Any Cuts        |
| <input type="checkbox"/> Other Symptoms: _____ |   |   |  |

**Have you lost time from work?**  Yes  No: If Yes, Dates: \_\_\_\_\_ to \_\_\_\_\_

**Have you done any of the following since the crash:**

- |  |  |                                      |
|--|--|--------------------------------------|
| <input type="checkbox"/> Ice             | <input type="checkbox"/> Medication (name) _____ | <input type="checkbox"/> Rest        |
| <input type="checkbox"/> Heat (any kind) | <input type="checkbox"/> Exercise                | <input type="checkbox"/> Other _____ |

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

- |                |                              |                 |                              |                 |                              |            |                              |
|----------------|------------------------------|-----------------|------------------------------|-----------------|------------------------------|------------|------------------------------|
| Tuberculosis   | <input type="checkbox"/> Yes | Lung Disease    | <input type="checkbox"/> Yes | Gout            | <input type="checkbox"/> Yes | Diabetes   | <input type="checkbox"/> Yes |
| Kidney Disease | <input type="checkbox"/> Yes | Stomach/Ulcer   | <input type="checkbox"/> Yes | Heart Disease   | <input type="checkbox"/> Yes | Hepatitis  | <input type="checkbox"/> Yes |
| Sciatica       | <input type="checkbox"/> Yes | Blood Pressure  | <input type="checkbox"/> Yes | Transfusion     | <input type="checkbox"/> Yes | Polio / Ms | <input type="checkbox"/> Yes |
| Colon Disease  | <input type="checkbox"/> Yes | Stroke          | <input type="checkbox"/> Yes | Cancer          | <input type="checkbox"/> Yes | Bleeding   | <input type="checkbox"/> Yes |
| Paralysis      | <input type="checkbox"/> Yes | Seizures        | <input type="checkbox"/> Yes | Arthritis       | <input type="checkbox"/> Yes | Asthma     | <input type="checkbox"/> Yes |
| Anemia         | <input type="checkbox"/> Yes | Thyroid Disease | <input type="checkbox"/> Yes | Drug Dependence | <input type="checkbox"/> Yes | AIDS       | <input type="checkbox"/> 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)

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date



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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: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Patients Name (print) \_\_\_\_\_

Patient Signature: \_\_\_\_\_ 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, eg. 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 minute 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 definitely 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.

## 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.



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**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.

**Date:** \_\_\_\_\_

**Patient's Signature:** \_\_\_\_\_

If a minor- signature of parent or legal guardian required below:

Signed: \_\_\_\_\_ For: \_\_\_\_\_

**MEDICAL DOCTOR INFORMATION**

Name of Doctor: \_\_\_\_\_

Phone: \_\_\_\_\_

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

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 Personal Health Information. 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 workers 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 - in order 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 apprise 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 manner in which 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 an 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 signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date



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### 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.

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Staff)

For Office Use Only:

\_\_\_\_\_  
(Print Name)

\_\_\_\_\_  
(Date)



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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 that 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 signature

\_\_\_\_\_  
Date



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

Attorneys/ Insurance carrier

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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 in regard to the accident which occurred on

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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.

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Date

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Patient's Signature



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

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 included 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

\_\_\_\_\_  
DOB

\_\_\_\_\_  
[Patient's signature, if patient is a minor have guardian sign and indicate same]

\_\_\_\_\_  
DATE