



Patient Legal Name: _____ Date of Accident: _____

Chief Complaint: _____

Who is at fault? (You, Other Driver, Employer Name): _____

Employer Contact Person: _____ Phone# _____

Do you have an Attorney: Yes No Name: _____ Phone# _____

Personal AUTO Insurance Company: _____

Adjuster Name: _____ Phone# _____

ClaimID#: _____ Med Pay Limit: \$ _____ Billing Fax# _____

HEALTH Insurance Provider: _____ ID# _____ Group# _____

Other Driver AUTO Ins Company: _____ Claim# _____

Adjuster Name: _____ Phone# _____

WELCOME

The staff of Harris Chiropractic welcome you and want to provide the best care possible. We will conduct a thorough history and physical examination to decide if we can assist you. If we do not believe that your condition will respond to chiropractic care, we will not accept you as a patient but refer you to another healthcare provider, if appropriate.

INSURANCE

This office will do the utmost to provide sufficient information to your carrier to obtain payment for your treatment. We have found that in some instances, however, insurance companies will deny or reduce payment despite our best efforts to demonstrate the necessity for care. In the event that full payment is not made for any reason, you must understand that you are responsible to make payment in full.

ACCEPTANCE ASA PATIENT

I understand and agree that Harris Chiropractic has the right of refusal to accept me as a patient at any time before treatment begins. The taking of a history and the conducting of a physical examination are not considered treatment, but are part of the information gathering process.

CANCELLATION / RESCHEDULE / NO-SHOW POLICY

Failure to show up for your appointment OR give 24-hr notice for a cancellation/reschedule/no-show will result in a **\$35 fee**.

Credit Card # _____ Exp: _____ Zip Code: _____

Patient Signature (or Legal Guardian)

Date

last edit: 7/25/24



CONSENT TO TREATMENT

Healthcare providers are required to advise patients of the nature of treatment to be provided, the risks and benefits of the treatment, and any alternatives to the treatment.

There are some risks that may be associated with treatment, in particular you should note:

- a. While rare, some patients have experienced rib fractures or muscle and ligament sprains or strains following treatment.
- b. There have been rare reported cases of disc injuries following cervical and lumbar spinal adjustments although no scientific study has ever demonstrated such injuries are caused, or may be caused, by spinal or soft tissue manipulation or treatment.
- c. There have been reported cases of injury to a vertebral artery following osseous spinal manipulation. Vertebral artery injuries have been known to cause a stroke, sometimes with serious neurological impairment, and may, on rare occasion, result in paralysis or death. The possibility of such injuries resulting from cervical spine manipulation is extremely remote.

* Osseous and soft tissue manipulation have been the subject of government reports and multi-disciplinary studies conducted over many years and have been demonstrated to be highly effective treatments for spinal conditions including general pain, loss of mobility, headaches and other related symptoms. Musculoskeletal care contributes to your overall well-being. The risk of injury or complication from treatment is substantially lower than that with many medical treatments, medications, and procedures provided for the same symptoms.

I acknowledge I have discussed the following with my healthcare provider:

- 1. The condition that the treatment is to address
- 2. The nature of the treatment
- 3. The risks and benefits of the treatment
- 4. Any alternatives to that treatment

I have had the opportunity to ask questions and receive answers regarding the treatment.

I consent to the treatments offered or recommended to me by my healthcare provider, including osseous and soft tissue manipulation. I intend this consent to apply to all my present and future care with **Dr. Jeffrey Harris DC, CCSP.**

Patient Signature (or Legal Guardian)	Printed Name	Date
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Witness Signature	Printed Name	Date
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Patient Name: _____ Date: _____

Address _____ City _____ State ____ Zip _____

H. Phone _____ W. Phone _____ Cell Phone _____

Email Address: _____

Sex M F Marital Status M S D W Date of Birth _____ Age _____

Occupation _____

Employer _____

Emergency Contact / Phone Number: _____

Height _____ Weight _____ B/P (if known) _____ HR _____ O2 _____

Have you ever received Chiropractic Care? Yes / No If yes, when? _____

Name of most recent Chiropractor: _____

1 | SINCE THE MOTOR VEHICLE COLLISION, HAVE YOU EXPERIENCED ANY OF THE FOLLOWING:

- A. Loss of Range of Motion: Yes / No
 - a. What body parts: _____
- B. Visual Disturbance: Yes / No
 - Blurring L / R Floaters L / R Vision Loss L / R Hypersensitivity L / R
 - % of time: _____ % of time: _____ % of time: _____ % of time: _____
- C. Dizziness: Yes / No % of time: _____
- D. Anxiety/Depression: Yes / No % of time: _____
- E. Difficulty Sleeping: Yes / No

2 | PAST HEALTH HISTORY

A. SURGICAL HISTORY

Date	Type of Surgery
_____	_____
_____	_____
_____	_____
_____	_____

B. PREVIOUS INJURY OR TRAUMA? _____

Have you ever broken any bones? Which? _____

C. ALLERGIES: _____

PREGNANCY (past or current)? _____

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Patient Name: _____ Date: _____

3 | FAMILY HEALTH HISTORY

Do you have a family history of? (Please indicate all that apply)

- Cancer Strokes/TIA's Headaches Heart disease Neurological diseases
- Adopted/Unknown Cardiac disease below age 40 Psychiatric disease Diabetes
- Other _____ None of the above

A. DEATHS IN IMMEDIATE FAMILY:

Cause of parents' or siblings' death	Age at death
_____	_____
_____	_____
_____	_____
_____	_____

4 | SOCIAL & OCCUPATIONAL HISTORY

- A. Job description: _____
- B. Work schedule: _____
- C. Recreational activities: _____
- D. Lifestyle:
 - Hobbies: _____
 - Level of Exercise: _____
 - Alcohol Use: _____
 - Tobacco Use: _____
 - Drug Use: _____
 - Diet: _____

5 | MEDICATIONS

Medication	Reason for taking
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____



Patient Name: _____ Date: _____

REVIEW OF SYMPTOMS

Have you had any of the following pulmonary (lung-related) issues?

- Asthma/difficulty breathing COPD Emphysema Other _____ None of the above

Have you had any of the following cardiovascular (heart-related) issues or procedures?

- Heart surgeries Congestive heart failure Murmurs or valvular disease Heart attacks/MIs Heart disease/problems Hypertension Pacemaker Angina/chest pain Irregular heartbeat Other _____ None of the above

Have you had any of the following neurological (nerve-related) issues?

- Visual changes/loss of vision One-sided weakness of face or body History of seizures One-sided decreased feeling in the face or body Headaches Memory loss Tremors Vertigo Loss of smell Strokes/TIAs Other _____ None of the above

Have you had the following endocrine (glandular/hormonal) related issues or procedures?

- Thyroid disease Hormone replacement therapy Injectable steroid replacements Diabetes Other _____ None of the above

Have you had any of the following renal (kidney-related) issues or procedures?

- Renal calculi/stones Hematuria (blood in the urine) Incontinence (can't control) Bladder Infections Difficulty urinating Kidney disease Dialysis Other _____ None of the above

Have you had any of the following gastroenterological (stomach-related) issues?

- Nausea Difficulty swallowing Ulcerative disease Frequent abdominal pain Hiatal hernia Pancreatic disease Irritable bowel/colitis Hepatitis or liver disease Bloody or black tarry stools Vomiting blood Bowel incontinence Constipation Gastroesophageal reflux/heartburn Other _____ None of the above

Have you had any of the following hematological (blood-related) issues?

- Anemia Regular anti-inflammatory use (Motrin/Ibuprofen/Naproxen/Naprosyn/Alieve) HIV positive Abnormal bleeding/bruising Sickle-cell anemia Enlarged lymph nodes Hemophilia Hypercoagulation or deep venous thrombosis/history of blood clots Anticoagulant therapy Regular aspirin use Other _____ None of the above

Have you had any of the following dermatological (skin-related) issues?

- Significant burns Significant rashes Skin grafts Psoriatic disorders Other _____ None of the above

Have you had any of the following musculoskeletal (bone/muscle-related) issues?

- Rheumatoid arthritis Gout Osteoarthritis Broken bones Spinal fracture Spinal surgery Joint surgery Arthritis (unknown type) Scoliosis Metal implants Other _____ None of the above

Have you had any of the following psychological issues?

- Psychiatric diagnosis Depression Suicidal ideations Bipolar disorder Homicidal ideations Schizophrenia Psychiatric hospitalizations Other _____ None of the above

Any past medical history that you feel is important to your care here? _____

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of chiropractic to provide me with chiropractic care, in accordance with this state's statutes. If my insurance will be billed, I authorize payment of medical benefits to Harris Chiropractic for services performed.

Patient or Guardian Signature _____ Date _____

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Patient Name: _____ Date: _____

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy describes how we may use and disclose your protected health information (PHI) to carry our treatment, payment or health care operations (TPO) for other purposes that are permitted or required by law. "Protected Health Information" is information about you, including demographic information that may identify you and that related to your past, present, or future physical or mental health or condition and related care services.

Use and Disclosures of Protected Health Information:

Your protected health information may be used and disclosed by your physician, our staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, pay your health care bills, to support the operations of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your health care information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing, and fund raising activities, and conduction or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations included as required by law, public health issues, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, and organ donation. Required uses and disclosures under the law, we must make disclosures to you when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES WILL BE MADE ONLY WITH YOUR CONSENT, AUTHORIZATION OR OPPORTUNITY TO OBJECT UNLESS REQUIRED BY LAW.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Signature of Patient or Representative

Date

Printed Name

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Patient Name: _____ Date: _____

AUTO COLLISION / WORK INJURY QUESTIONNAIRE

Symptom # _____ Please describe: _____

On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time (circle one): 1 2 3 4 5 6 7 8 9 10

What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

Did the symptom begin (circle one) Suddenly or Gradually
When did the symptom begin? _____
How did the symptom begin? _____

What makes the symptom worse? (circle all or state all that apply):
nothing, any movement, bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, driving, standing, walking, running, lifting, sitting, getting up from seated position, chewing, changing positions, lying down, reading, working, exercising, laying on side in bed,
other (please describe): _____

What makes the symptom better? (circle or state all that apply):
nothing, resting, ice, heat, stretching, exercise, walking, pain medication, muscle relaxers, chiropractic adjustments, massage, other (please describe): _____

Describe the quality of the symptom (circle or state all that apply):
Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging
Other (please describe): _____

Does the symptom radiate to another part of your body (circle one): yes no
If yes, where does the symptom radiate? _____

Is the symptom worse at certain times of the day or night? (please circle)
No difference Morning Afternoon Evening Night Other _____

Have you received treatment for this condition and episode prior to today's visit?
 No Anti-inflammatory meds Pain meds Muscle relaxers Cortisone injections
 Trigger point injections Surgery Massage Physical Therapy Chiropractic
 Other _____

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 Trigger point injections Surgery Massage Physical Therapy Chiropractic
 Other _____

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Medical Lien Form

314 W Main St, Middleton, ID 83644
phone 208.424.5100 | fax 208.424.3225
www.Harris-Clinic.com

To: Attorney(s) _____

For: Doctor Jeffrey Harris, DC (Harris Chiropractic)

Patient's Name _____ Date of accident _____

I do hereby authorize the above doctor to furnish to you, my attorney, or any substitute attorney, a full report of his/her examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I was involved.

I hereby authorize and direct you, my insurance company, and/or my attorney to pay directly to said doctor such sums as may be due and owing him for medical service rendered to me both by reason of settlement, judgment, or verdict as may be necessary to adequately protect said doctor. 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 agree never to rescind this document and that a rescission will not be honored by my attorney. I hereby instruct that in the event another attorney is substituted in this matter, the new attorney honor this lien as inherent to the settlement and enforceable upon the case as if it were executed by him.

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. I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

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.

Patient Signature _____ Date _____

Address _____ City _____ St _____ Zip _____

ATTORNEY(S): Please sign, date and return one copy to doctor's office and keep one copy for your records.

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

Attorney Signature: _____ Date: _____