MOTOR VEHICLE COLLISION/PERSONAL INJURY QUESTIONNAIRE

Please answer all questions completely:

1. Your name and address:

   ____

   ____

   ____

2. Phone Number: ______________________________

3. Please describe the collision in your own words:

   ____

   ____

   ____

4. Where did the collision occur? City/Town: ____________________ State: ______
5. Date of collision: ____________________ Time: ________________ AM PM
6. Were you the: ☐ driver ☐ passenger ☐ pedestrian
7. If passenger, were you in the ☐ front seat ☐ right rear seat ☐ left rear seat
8. What type of vehicle were you in? ______________________________
9. What type was the other vehicle? ______________________________
10. Did your vehicle strike the other vehicle? ☐ yes ☐ no
11. Was your car struck by the other vehicle? ☐ yes ☐ no
12. What direction was your vehicle going? ______________________________
13. What direction was the other vehicle going? ______________________________
14. Was the impact from: ☐ the front ☐ the rear ☐ the left side ☐ the right side
15. What was the approximate speed at the time of the impact?

    Your vehicle _________ mph Other vehicle _________ mph
16. What was the weather at the time of the collision? ☐ dry ☐ wet ☐ icy
17. Was your vehicle in: ☐ park ☐ neutral ☐ in gear ☐moving ☐stopped
18. Were your brakes being applied? ☐ yes ☐ no
19. Was your vehicle shoved: ☐ forward ☐ backward ☐ sideways
20. Were you shoved: ☐ forward ☐ whipped backward
21. Did your seat have a head restraint (headrest?) ☐ yes ☐ no

©Breakthrough Coaching, LLC 2000 UNAUTHORIZED DUPLICATION IS ILLEGAL FORM 135

22. If yes, what was the position ☐ low ☐ midposition ☐ high
23. Did your head ride over the headrest? ☐ yes ☐no
24. Did your hat/glasses end up in the back seat or rear window? ☐ yes ☐ no
25. Did any other part of your body hit the interior of the vehicle? ☐ yes ☐ no
26. If yes, please specify: ☐ seatbelt restraints ☐ steering wheel ☐ dashboard
    ☐ windshield ☐ side door ☐ side window ☐ other ______________
27. Which part of your body? ☐ chest ☐ head ☐ chin ☐ face ☐ R L knee
    ☐ R L shoulder ☐ R L hand ☐ other ______________
28. Were you holding on to the steering wheel? ☐ yes ☐ no
29. Did you brace your arms against the dash? ☐ yes ☐ no
30. Did you brace your legs against the floorboard? ☐ yes ☐ no
31. Was your ankle turned? ☐ yes ☐ no
32. Did the vehicle go into a spin or roll as a result of the impact? ☐ yes ☐ no
33. If yes, explain: ______________
34. How much damage was there to the outside of the vehicle? ☐ none ☐ some ☐ a lot
35. How much damage was there to the inside of the vehicle? ☐ none ☐ some ☐ a lot
36. At the point of impact, where did you experience pain? Be specific:

____

____

37. Immediately after the accident were you: ☐ conscious ☐ dazed ☐ unconscious
38. If you lost consciousness, how long? ______________
39. Were you wearing a seat belt? ☐ yes ☐ no
40. Did the belt have a shoulder harness? ☐ yes ☐ no
41. If yes, did it contribute to the pain you are experiencing? ☐ yes ☐ no
42. At the time of impact were you: ☐ looking straight ahead ☐ looking to the right
    ☐ looking to the left ☐ looking down ☐looking up
43. Did the seat break as a result of the impact? ☐ yes ☐ no
44. Were you braced for the impact? ☐ yes ☐ no
45. Were you surprised by the impact? ☐ yes ☐ no
46. Did you go to the hospital? ☐ yes ☐ no
47. If yes, when? ☐ right after the accident ☐ next day ☐ other ______________

©Breakthrough Coaching, LLC 2000 UNAUTHORIZED DUPLICATION IS ILLEGAL FORM 135

48. If yes, how did you get there? ☐ ambulance other: ______________________

49. If by ambulance, did the ambulance attendants place you in a: ☐ neck brace ☐ back brace ☐ other ______________________

50. Any medication or medical supplies given? ______________________

51. Did you have x-rays taken at the hospital? ☐ yes ☐ no

If you went to the hospital, please answer the following:

Name of hospital ______________________

Name of doctor ______________________

Diagnosis ______________________

Treatment Received ______________________

____

52. Have you had any similar problems before? ☐ yes ☐ no

53. If yes, explain: ______________________

54. Are you diabetic? ☐ yes ☐ no

55. Do you have high blood pressure? ☐ yes ☐ no

56. Do you have low blood pressure? ☐ yes ☐ no

57. Do you have arthritis or degenerative joint disease? ☐ yes ☐ no

58. What type of work do you do? ______________________

59. What are your job requirements? ______________________

60. Have you lost any days of work from this injury? ☐ yes ☐ no

61. If yes, give dates: ______________________

Patient Signature ______________________ Date ____________

Witness ______________________ Date ____________

Print Name ______________________

©Breakthrough Coaching, LLC 2000 UNAUTHORIZED DUPLICATION IS ILLEGAL

PAIN LOCATION, INTENSITY & FREQUENCY QUESTIONNAIRE

PATIENT NAME ______________________________ DATE ________________

KEY

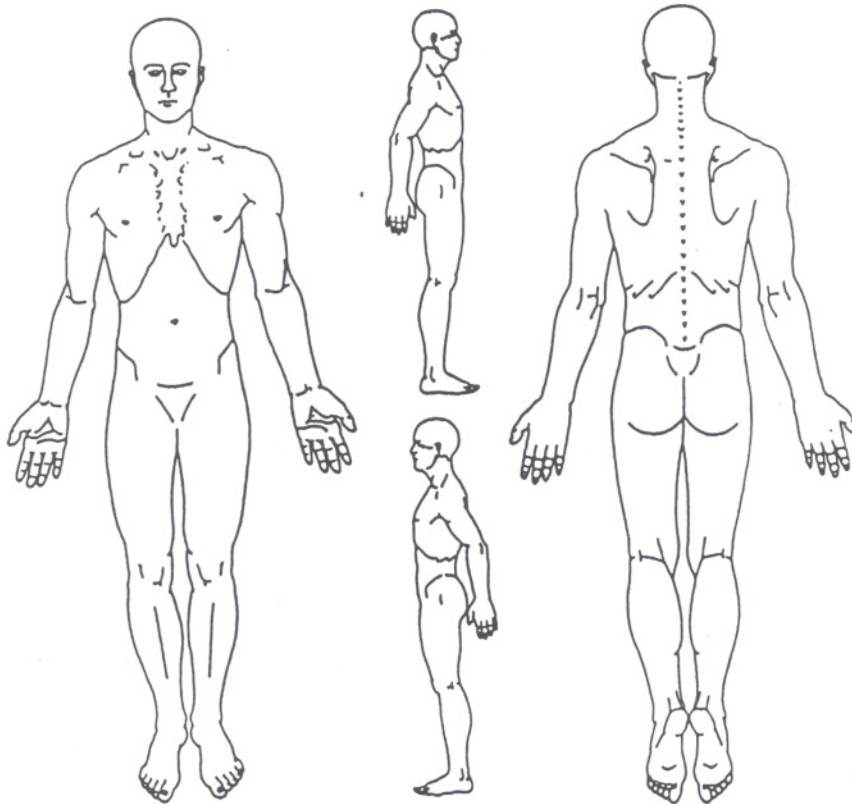
USE LETTERS BELOW TO INDICATE TYPE AND LOCATION OF DISCOMFORT		
A = ACHE	B = BURNING	C = STABBING
N = NUMBING	P = PINS & NEEDLES	O = OTHER

WHAT IS YOUR CURRENT PRIMARY COMPLAINT: ______________________________

SECONDARY COMPLAINT: ______________________________

COMMENTS: ______________________________

PLEASE USE THE ABOVE CODES TO EXPLAIN AND LOCATE THE AREAS THAT ARE BOTHERING YOU.



PLEASE RATE THE INTENSITY & FREQUENCY OF YOUR PAIN USING 0 – 10 PAIN SCALE (0=NO PAIN, 10=MOST SEVERE IMAGINABLE)

PRESENT PAIN LEVEL ____; AVERAGE PAIN LEVEL ____, PRESENT ____% OF THE TIME;

WORST PAIN LEVEL ____, PRESENT ____% OF THE TIME; LOWEST PAIN LEVEL ____, PRESENT ____% OF TIME.

WHAT WILL INCREASE YOUR PAIN? ______________________________

WHAT GIVES YOU THE GREATEST RELIEF/CONTOL OF PAIN? ______________________________

WHAT ARE YOU UNABLE TO DO BECAUSE OF YOUR PAIN? ______________________________

____

FRONT RANGE DIAGNOSTIC RADIOLOGY

2504 E Pikes Peak Ave., Ste. 105 Colorado Springs, CO 80909 (719) 471-3070

PATIENT INFORMATION

Last Name ____________ First Name ____________ Date of Birth ____________

Address ____________ City ____________ State & Zip ____________

Telephone # ____________ Male ______ Female ______ SS # ____________

Marital Status: Married / Single / Widowed / Divorced / Separated Relation to Insured: Self / Spouse / Child / Other

INSURANCE INFORMATION: *Please complete in its entirety.*

Primary Insurance

Insurance Company: ____________
Address: ____________
City, State, Zip: ____________
Telephone # ____________
Claim # ____________
Policy # ____________

Secondary Insurance

Insurance Company: ____________
Address: ____________
City, State & Zip: ____________
Telephone # ____________
Claim # ____________
Policy # ____________

Insured's Name: ____________
Address: ____________

Date of Birth: ____________ SS # ____________
Telephone # ____________

Type of Case: Group Health _____ Auto _____ Work Comp _____ Patient _____ Other _____

Attorney's Information:
Name: ____________
Address: ____________
Telephone # ____________

Employer's Information:
Name: ____________
Address: ____________
Telephone # ____________

CLINICAL INFORMATION

Chief Complaint: ____________

Trauma: ____________ Date of Injury: ____________

Surgery: ____________ Malignancy: ____________

Referring Clinic / Doctor: ____________

I understand that there will be a separate fee for radiology services. I authorize the release of any medical information necessary to process this claim. I also authorize all claims to be sent directly to my insurance company and I authorize payment to be made directly to Front Range Diagnostic Radiology. I also agree to pay for any co-pay or deductible, and in the event that I should receive payment for these services, I agree to promptly remit payment to Front Range Diagnostic Radiology. I also accept personal responsibility for any balance due.

Patient Signature: ____________ *Date:* ____________

Office Use Only
Date Submitted: Date Billed: Date Paid:

PATIENT OBSERVER PROTOCOLS

In order to promote a good patient-doctor relationship and to foster an environment in which the patient and doctor feel comfortable, Dr. Vincent Loparco, D.C. will utilize an observer during the examination and treatment of all patients. This observer shall be present at all times while Dr. Loparco is performing an examination of a patient and shall also be present at all times when Dr. Loparco is treating a patient. If physical therapy modalities are to be utilized and applied by a chiropractic assistant, an observer need not be present.

The observer shall be aware of the usual and customary components of the chiropractic examinations performed by Dr. Loparco and shall also be aware of the usual and customary chiropractic treatments utilized by Dr. Loparco. Although it is not Dr. Loparco's policy, if during a patient's examination it becomes necessary to expose a portion of a patient's breast tissue, genital or gluteal area, Dr. Loparco shall inform the patient of the reasons for that portion of the examination and the patient's understanding and consent shall be confirmed by the observer. In addition, if treatment requires exposure of a portion of the patient's breast area, genital or gluteal area, Dr. Loparco shall advise the patient of the treatment that he proposes to utilize and obtain the patient's consent to proceed. The observer shall confirm the patient's consent.

In the event the patient wishes to confer privately with Dr. Loparco, the observer shall ascertain that the patient is appropriately clothed. The observer shall remain in the immediate area so as to be available to the patient, as needed.

NOTICE OF PATIENT OBSERVER PROTOCOLS AND CONSENT

I,______________________________________, acknowledge that I have been provided a copy of Dr. Vincent Loparco's Patient Observer Protocols and consent to having the observer present during my examinations and treatment.

______________________________ ______________________________

PRINT PATIENT NAME PATIENT SIGNATURE

____

DATE

Witness:______________________________ Date:______________________________

3/05

DOCTOR'S LIEN

To: Attorney

____
____
____

Doctor:

Rocky Mountain Chiropractic
1880 Dublin Blvd. Suite E
Colorado Springs, CO 80909

RE: Authorization for Release of Records and Doctor's Lien, Assignment, and Direction to my Attorney

I hereby authorize Rocky Mountain Chiropractic to furnish you, my Attorney, with a full report and records regarding my case history, examination, diagnosis, treatment and prognosis with regards to treatment related to my accident which occurred on __________________________________.

I hereby give a lien and assignment to Rocky Mountain Chiropractic on the proceeds or any settlement, claim, judgement or verdict which results from said accident and hereby authorize, direct and instruct you, my Attorney, to pay directly to Rocky Mountain Chiropractic such sums as may be due and owing for service rendered me, and to withhold such sums from such settlement, claim, judgement or verdict as may be necessary to protect Rocky Mountain Chiropractic any outstanding balance owed at the time of distribution of funds from any settlement, claim, judgement or verdict.

I fully understand that I am directed and fully responsible to Rocky Mountain Chiropractic for all bills submitted by Rocky Mountain Chiropractic for services rendered to me, and that this agreement is solely for Rocky Mountain Chiropractic's additional protection and in consideration of said Doctors awaiting payment. I further understand that such payment is not contingent on any settlement, claim, judgement, or verdict which I may eventually recover.

I fully understand that the Lien given to Rocky Mountain Chiropractic herein is irrevocable.

TO MY ATTORNEY: I DIRECT THAT YOU BE BOUND BY THIS LIEN AND TREAT IT, IRREVOCABLY, AS AN ASSIGNMENT TO ROCKY MOUNTAIN CHIROPRACTIC OF ANY SUM THAT MAY BE DUE TO ME, TO THE EXTENT AND ACCORDING TO THE TERM SUM SET FORTH ABOVE. BE ADVISED THAT ROCKY MOUNTAIN CHIROPRACTIC IS RELYING UPON THIS LIEN, ASSIGNMENT, AND DIRECTIVE TO YOU, AND AS A RESULT OF SUCH RELIANCE, AT MY REQUEST, IS PROVIDING CHIROPRACTIC CARE AND TREATMENT FOR WHICH THIS LIEN , ASSIGNMENT, AND DIRECTIVE TO YOU PROVIDES SECURITY FOR PAYMENT. MOREOVER, IT IS MY INTENTION THAT ROCKY MOUNTAIN CHIROPRACTIC BE VIEWED AS A 3RD PARTY BENEFICIARY OF THIS DIRECTION TO YOU, AND I INTEND THEREBY TO IMPOSE UPON YOU AN OBLIGATION TO ROCKY MOUNTAIN CHIROPRACTIC TO COMPLY WITH THE TERMS OF THIS DIRECTION TO YOU.

____________________	____________________
DATE	PATIENT'S SIGNATURE
WITNESS	PRINT PATIENT'S NAME

ROCKY MOUNTAIN CHIROPRACTIC
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 14 April, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualification of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will affect any use or disclosures permitted by your authorization while it is in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Right section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement officials having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicable do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $1.00 for each printed page, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of the Notice. You also may submit a written complaint to the US Department of Health and Human Services. We will provide you with the address to file your complaint with the US Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the US department of Health and Human Services.

Contact Officer:
Dr. Vincent P Loparco DC
1880 Dublin Blvd. Suite E
Colorado Springs, CO 80917
Phone: (719) 535-9900
Fax: (719) 535-9901

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, (print)______________________ have received a copy of this office's Notice of Privacy Practices.

______________________ ____________
Signature Date