Automobile Accident Questionnaire

All information is confidential. Please fill all information as accurately as possible.

Name_____ Home Phone _____ Cell Phone _____

Address_____ City_____ State_____ ZIP_____

Age_____ Birth Date _____/_____/_____ Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed How many children?_____

Social Security Number_____ Employer_____

Occupation_____ Work Phone_____

Do you have health insurance? YES or NO Insurance company: _____ Phone # _____

Spouse's name_____ Spouse's Occupation_____

Spouse's Employer_____ Spouse's Work Phone_____

Emergency Contact /Nearest Relative_____ Contact Phone #_____

Your Auto Insurance Company_____ Policy #_____ Phone # _____

Do you have medical payment coverage (med pay)? *YES or NO* Have you opened a claim yet? *YES or NO Claim#*_____

PLEASE CIRCLE THE CORRECT INFORMATION *(THIS INFORMATION IS VERY IMPORTANT!)*

Do you have an attorney? YES or NO If so, what is his name_____

What type of vehicle struck you/did you strike? : CAR TRUCK MOTORCYCLE SUV SEMI-TRUCK

You were heading: NORTH EAST WEST SOUTH on _____

The other vehicle was heading: NORTH EAST WEST SOUTH on_____

Were the police notified? YES or NO Was the other driver cited in the accident? YES or NO

Were you wearing your **seatbelt** at the time of the accident? YES or NO Did your **airbag** deploy? YES or NO

You were **struck** from: BEHIND FRONT PASSENGER SIDE DRIVER'S SIDE

You were **sitting**: DRIVER FRONT PASSENGER REAR LEFT PASSENGER REAR RIGHT PASSENGER

What was the date of the accident? _____ What was the time of the accident? _____ am / pm

Did you feel pain right after the accident? YES or NO Where you evaluated at the scene of the accident? YES or NO

Was a doctor consulted after the accident? YES or NO If so, the doctor's name_____

Where you taken to hospital ? YES or NO Taken to the hospital by: ambulance self family/friend

Did the doctor prescribe: medication brace/support cane off-work x-rays MRI CAT scan

How many times did you see the doctor?_____ How long did you treat with the doctor? _____

Have you lost any time from work since your injury? YES or NO If so, how long?_____

Have your work activities been restricted as a result of this accident/injury? YES or NO

Have your home/family activities been restricted as a result of this accident/injury? YES or NO

Since the injury, are your symptoms getting: WORSE IMPROVING STAYING THE SAME

Please explain any other details that you feel the doctor should know about your condition:_____

_____

_____

_____

_____

Sahara Health Care

1605 S. Maryland Parkway Las Vegas, NV 89104 (702) 382-0211 Fax (702) 382-3994

Doctor's Lien

Patient: _____ Date of Loss: _____

I hereby authorize and direct my attorney/insurance co. to pay directly to Sahara Health Care said sums as may be due and owing for said services rendered to me and to withhold such sums from any settlement, judgment, or verdict as may necessary to adequately protect said medical bills. I hereby further give a lien on my case to my attorneys as the result of the injuries for which I have been treated or injuries in connection therewith. I furthermore authorize Sahara Health Care to provide my attorney/ins co. with a full report of findings, narratives, diagnosis, prognosis, treatment protocol and any other medical records in regards to the motor vehicle accident I was involved in.

Patient hereby instructs that, in the event another attorney is substituted or associated 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/her for the purpose of this contract. "Attorney" shall refer to the attorney named herein, or any attorney who is subsequently substituted or associated in the handling of patient claims.

I hereby direct my attorney/insurance co. to agree to observe all terms of this lien agreement. Further, I will direct my attorney to notify Sahara Health Care if he/she is discharged from representation, if he/she withdraws him/her legal representation, or if he/she closes my file without receiving any payment.

Sahara Health Care will make every effort to settling your medical bills with your attorney/ins co. but if Sahara Health Care is not paid by your attorney/ins co., I fully understand that I am directly and full responsible to said parties for all bills submitted by them, and that this agreement is made solely for said party's protection and in consideration of their awaiting payment. I further understand that such a payment is not contingent on any settlement, claim, judgment or verdict by which may eventually recover said fee.

I agree that if I discharge my attorney from representation all medical bills and expenses are due and payable within 15 days. I agree that if a settlement is made after discharge of my attorney all medical bill and expenses are due within 5 days. I further acknowledge and agree that if such settlement is made all medical bills past 30 days shall bear a compounding interest rate of 1.5% per month. In addition, I agree that in the event I do not pay for medical services rendered by Sahara health Care, my account will be assigned to a collection agency for a 35% collection fee.

Patient signature:_____ Date:_____

The undersigned, being attorney of record for said client, does herby acknowledge receipt of the above lien, and does agree to honor the same to protect adequately said above-named party. The attorney will notify Sahara Health Care promptly upon termination of the attorney-client relationship. Attorney will withhold any funds received on behalf of client to pay Sahara Health Care.

Attorney signature:_____ Date:_____

PLEASE SIGN AND RETURN

Sahara Health Care
1605 S. Maryland Parkway
Las Vegas, NV 89104
(702) 382-0211 Fax (702) 382-3994

ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO DOCTOR PRIVATE AND GROUP, ACCIDENT, AND HEALTH INSURANCE

I hereby instruct and direct the _____ insurance company to pay by check made out and mailed directly to:

Sahara Health Care
Dr. Allan P. Long, D.C.
1605 S. Maryland Parkway
Las Vegas, NV 89104

The professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered. This is a direct assignment of my rights and benefits under this policy. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

A photocopy of this assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company adjuster, or attorney involved in this case.

In Witness whereof the undersigned have hereunto set there hands this____ day of _____, 20__.

_____ _____

Signature of Patient Patient's Full Name Typed

Sahara Health Care

1605 S. Maryland Parkway – Las Vegas, NV 89104
Office: (702) 382-0211 Fax: (702)382-3994

Patient Name:_____

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The nature of the chiropractic adjustment.

The primary treatment I use as a doctor of chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click" much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis / Examination / Treatment

As part of the analysis ,examination and treatment, you are consenting to the following procedures:

_____Spinal Manipulative Therapy	_____Palpation	_____Vital Signs
_____Range of Motion Testing	_____Orthopedic Testing	_____Basic Neurological Testing
_____Muscle Strength Testing	_____Postural Analysis	_____EMS
_____Ultrasound	_____Hot /Cold Therapy	
_____Radiographic Studies	_____Other (please explain)	

(Please initial each procedure you are consenting to)

The material risks inherent in chiropractic adjustment.

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to fractures, disc injuries, dislocations, muscle strain, cervical myclopathy, costovertebral strains, and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

The probability of those risks occurring.

Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the taking of your history and during examination and x-rays. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

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The availability and nature of other treatment options.

Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers
- Hospitalization
- Surgery

If you chose to use one of the above noted " other treatment " options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary care physician.

The risks and dangers attendant to remaining untreated.

Remaining untreated may allow the information of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

Do Not Sign Until You Have Read And Understand The Above.

Please Check The Appropriate Block And Sign Below.

I have read [ ] or have had read to me [ ] the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Dr. Allan P. Long and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Dated:_____ **Dated:**_____

_____ _____

Patient's Name **Doctor's Name**

_____ _____

Signature of Parent or Guardian
(If Patient's a Minor) **Signature**

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 takes effect on APRIL 1, 2018 and remains in effect until we replace it.

1. OUR PLEDGE REGARDING MEDICAL INFORMATION

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our organization. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

2. OUR LEGAL DUTY

Law Requires Us to:

1. Keep your medical information private.
2. Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.
3. Follow the terms of the notice that is now in effect.

We Have the Right to:

1. Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.
2. Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

Notice of Change to Privacy Practices:

1. Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

3. USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION

The following section describes different ways that we use and disclose medical information. Not every use or disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose medical information. We will not use or disclose your medical information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us.

FOR TREATMENT: We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other people who are taking care of you. We may also share medical information about you to your other health care providers to assist them in treating you.

FOR PAYMENT: We may use and disclose your medical information for payment purposes.

FOR HEALTH CARE OPERATIONS: We may use and disclose your medical information for our health care operations. This might include measuring and improving quality, evaluating the performance of employees, conducting training programs, and getting the accreditation, certificates, licenses and credentials we need to serve you.

PATIENT SIGNATURE: _____ **DATE:** _____