

**Abel Chiropractic**  
8827 E. Reno Suite 201  
Midwest City, OK 73110

Date: \_\_\_\_\_  
Drivers License # \_\_\_\_\_  
Email: \_\_\_\_\_

**AUTO ACCIDENT HISTORY FORM**

**PERSONAL INJURY HISTORY INFORMATION**

Name: \_\_\_\_\_ SSN: \_\_\_\_\_  
Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ Gender: M F Marital Status: S M W D  
Home Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_  
Employer: \_\_\_\_\_ Occupation/Title: \_\_\_\_\_  
Spouse: \_\_\_\_\_ Spouse's Occupation: \_\_\_\_\_  
Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

**LIABILITY INFORMATION:**

Has the accident been reported to the liability insurance company?  Yes  No  
Have you been contacted by any insurance company?  Yes  No  
Insurance Carrier: \_\_\_\_\_ Phone: \_\_\_\_\_  
Name of Insured: \_\_\_\_\_ Claim #: \_\_\_\_\_  
Name of Adjuster: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax#: \_\_\_\_\_  
Address for claim(s): \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Do you have a copy of the police report?  Yes  No \*\*If yes, please provide us with a copy\*\*

**MEDPAY INFORMATION:**

Have you contacted your Auto Insurance Company about the accident?  Yes  No  
Do you have (MedPay) medical payments coverage through your Auto Insurance Company?  Yes  No  
Insurance Carrier: \_\_\_\_\_ Phone: \_\_\_\_\_  
Name of Adjuster: \_\_\_\_\_ Claim #: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**AUTO ACCIDENT INFORMATION:**

Date of Accident: \_\_\_\_\_ Time: \_\_\_\_\_ AM/PM Location of Accident: \_\_\_\_\_  
City/State: \_\_\_\_\_ Closest bisecting street/town: \_\_\_\_\_  
Driver of car: \_\_\_\_\_ Who owns vehicle? \_\_\_\_\_  
Year/Make/Model of YOUR car: \_\_\_\_\_ Year/Make/Model of OTHER car: \_\_\_\_\_  
Where were you seated?  Driver  Front center passenger  Front right passenger  
 Rear left passenger  Rear center passenger  Rear right passenger  Pedestrian  
Number of people in your vehicle: \_\_\_\_\_ Other vehicle: \_\_\_\_\_ Number of cars involved: \_\_\_\_\_  
Road conditions at time of accident:  Wet  Dry  Icy  Clear  Other \_\_\_\_\_  
Visibility at time of accident:  Good  Fair  Poor  Other \_\_\_\_\_  
Where was the vehicle struck  Right  Left  Rear  Front  Side  Other \_\_\_\_\_  
Type of accident:  Head-on collision  Rear-end collision  Broad-side collision  Front impact  
Non-collision (describe) \_\_\_\_\_  
Did you see the accident coming?  Yes  No; Did you brace for the impact?  Yes  No;  
Did car have a headrest?  Yes  No; Did your head hit the head rest?  Yes  No;  
Airbags deployed  Yes  No  Driver  Front  Side  
At the time of the impact, was your vehicle:  Stopped  Moving; If moving how fast were you going? \_\_\_\_ mph  
Estimate how fast other car was going? \_\_\_\_\_ mph; Which vehicle is responsible for accident? \_\_\_\_\_  
Did the vehicle flip over?  Yes  No; Were you thrown out of your seat?  Yes  No  
In your own words describe the accident: \_\_\_\_\_

Did you receive any cuts or lacerations?  Yes  No; If yes, where? \_\_\_\_\_  
Did you sustain any bruising because of accident?  Yes  No; If yes, where: \_\_\_\_\_  
Head or body position at the time of impact:  Head straight ahead  Head turned to left/right  
 Head looking back  Body straight in sitting position  Body rotated left/right  Other \_\_\_\_\_  
Did you feel immediate pain?  Yes  No; If yes, where? \_\_\_\_\_

Did you strike anything in the vehicle at time of impact?  Yes  No; If yes, what body part of your body struck what? ie: Head, Chest, Chin, Right / Left Shoulder, Right / Left Knee, Right / Left ankle, Right / Left wrist

Steering Wheel \_\_\_\_\_  Dashboard \_\_\_\_\_  Windshield \_\_\_\_\_

Roof \_\_\_\_\_  Driver Side Door \_\_\_\_\_  Passenger Door \_\_\_\_\_

Driver Side Window \_\_\_\_\_  Passenger Window \_\_\_\_\_  Other \_\_\_\_\_

As a result of the accident you were:  Unconscious  Dazed/Dizzy  In Shock  Unphased  Disoriented

Nervous  Nauseous  Upset  Weak  Other: \_\_\_\_\_

Were you able to walk unaided after the accident  Yes  No

If no, why not? \_\_\_\_\_

Did you go to the emergency room/hospital after the accident?  Yes  No

If yes were you taken by:  Ambulance  Driven by another person  Able to take yourself

Hospital / Clinic Name: \_\_\_\_\_ Dr. Name(s) \_\_\_\_\_

What treatment was given?  none  x-rayed  given stitches  given pain medication  placed in cervical collar  given instructions regarding sprains and strains  Other \_\_\_\_\_

If x-rays what area(s) \_\_\_\_\_

Please describe how you felt immediately after the accident: \_\_\_\_\_

The next day: \_\_\_\_\_

List all medications/reasons you are currently taking because of the accident: \_\_\_\_\_

Have you seen any other doctor for this accident?  Yes  No; Are you still treating with him/her?  Yes  No

If yes, what treatment was given: \_\_\_\_\_

**Check symptoms since the accident:**  Headache  Blurred vision  Memory loss  Neck pain  Dizziness

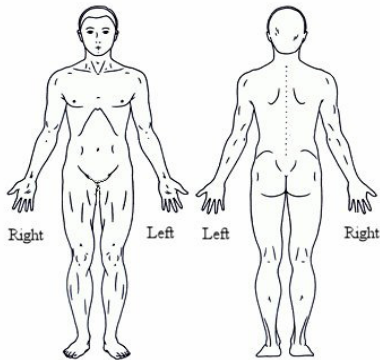
Jaw/TMJ pain  Loss of Sleep  Muscle spasms  Loss of balance  Finger/Toe Numbness  Mid back pain

Low back pain  Ringing in the ears  Confusion  Fainting  Extremity pain  Loss of smell  Loss of taste

Indicate your ability to perform the following activities because of this injury using codes:

**N – Normal, L – Limited, D – Difficult, P – Painful, U – Unable**

____ Walking short distance	____ Lying flat on stomach	____ Sex Activity	____ Gripping	____ Stooping
____ Lying on side with knees bent	____ Lying on back	____ Dressing Self	____ Reaching	____ Pushing
____ Standing for more than 1 hour	____ Coughing/Sneezing	____ Kneeling	____ Sitting at table	____ Pulling
____ Bending over forward	____ Turning over in bed	____ Bending forward to brush teeth		
____ Getting into/out of car				



**CIRCLE AREA(S) OF PAIN**

Severity of Pain: List region of pain and circle severity  
1 low pain, 4 moderate pain, 7 intense pain, 10 emergency

EX	NECK									
	1	2	3	4	5	6	7	8	9	10
1.	1	2	3	4	5	6	7	8	9	10
2.	1	2	3	4	5	6	7	8	9	10
3.	1	2	3	4	5	6	7	8	9	10
4.	1	2	3	4	5	6	7	8	9	10
5.	1	2	3	4	5	6	7	8	9	10

### MEDICAL HISTORY

What medications/drugs are you taking (not related to this injury)? \_\_\_\_\_

Date of last physical examination? \_\_\_\_\_

What operations have you had? Please include dates: \_\_\_\_\_

By signing below, I certify that the information I have written in all these pages is correct to the best of my knowledge.

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Patient Signature (or parent / guardian)

\_\_\_\_\_  
Date

**ABEL CHIROPRACTIC  
8827 E. Reno Suite 201  
MIDWEST CITY, OK 73110  
(405)732-7700**

**AUTHORIZATION AND ASSIGNMENT**

**To: ABEL CHIROPRACTIC, 8827 E. Reno Suite 201, Midwest City, Oklahoma 73110**

In consideration of your undertaking to render care and treatment to me, I agree as follows:

1. I authorize you to release any information to deem appropriate concerning my condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred for services rendered by you to me.
2. I further authorize and direct any insurance company and/or my attorney, to pay directly to you such sums as may be due and owing for services rendered to me, and to withhold such sums from disability benefits, including, but not limited to, governmental agency benefits, medical payments benefits, health and accident benefits, workers compensation benefits, or any other insurance benefits or from any settlement, judgment or verdict on my behalf as may be necessary to adequately pay for any financial obligation owed to you by me.
3. I further agree that, in the event an insurance company may be obligated to make payments to me for the charges made by you for services, and it refuses to make such payments, this agreement will serve as an assignment by me to you of all my rights and benefits to the extent of the charges for services provided. Further, I hereby assign and transfer to you any and all causes of action that I might have or that might exist in my favor against such insurance company and authorize you to prosecute said cause of action either in my name or in your name and further I authorize you as my assignee to compromise, settle, or otherwise resolve said claim or cause of action and I further understand and agree that I shall remain obligated and bound to pay you for your services in the event no sums are realized and received by you from my attorney or any insurance company.
4. I hereby further grant to you a lien against, and an assignment of any and all insurance benefits that I may have and any and all proceeds of any settlement, judgment or verdict which may be due to me as result of the injuries or illness for which I may be treated by you.
5. I authorize you to file my health insurance as it relates to this accident. I further understand that payment from my health insurance company will help defray costs of my medical bills not pay them in full.
6. I attest that I have come to this clinic for purposes of acquiring medical care. I am here for help for my medical problems and have no intent to mislead or defraud my treating practitioners in any way that might result in inappropriate charges to third party payers, federal, state, or local governments, or insurance carriers. Further I attest that my injuries are real and that I am in pain and in need of medical treatment as a result of the medical condition for which I am consulting your clinic. I also attest that I understand the context of this statement with complete comprehension of this content.

**DATE:** \_\_\_\_\_ **SIGNED:** \_\_\_\_\_

**PATIENTS NAME** \_\_\_\_\_

**WITNESS:** \_\_\_\_\_

Date of injury: \_\_\_\_\_ Policy or Claim #: \_\_\_\_\_

Name of Insurance Company: \_\_\_\_\_

Patients Ins. Co.: \_\_\_\_\_ Policy #: \_\_\_\_\_

**ABEL CHIROPRACTIC**



Dr. Abel Harrington, B.S., D.C.  
8827 E. Reno Suite 201  
Midwest City, OK 73110  
(405) 732-7700

**CONSENT TO X-RAY**

I HEREBY AUTHORIZE ABEL CHIROPRACTIC AND WHOM-EVER THE CLINICIAN MAY DESIGNATE AS HIS/HER ASSISTANT(S) TO TAKE X-RAYS OF MYSELF AND SAID MINOR.

DATED THE \_\_\_\_\_ DAY OF \_\_\_\_\_, 20\_\_\_\_\_

WITNESS

PATIENT

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
SIGNATURE

**CONSENT TO X-RAY - PREGNANCY RELEASE**

DATE OF ONSET OF PATIENT'S LAST MENSTRUAL PERIOD (LMP) \_\_\_\_\_

I HEREBY RELEASE ABEL CHIROPRACTIC FROM ANY AND ALL LIABILITY.

DATED THE \_\_\_\_\_ DAY OF \_\_\_\_\_, 20\_\_\_\_\_

WITNESS

PATIENT

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
SIGNATURE

# NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

**ABEL CHIROPRACTIC  
8827 E. Reno Suite 201  
Midwest City, OK 73110  
405-732-7700**

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

PATIENT NAME:

\_\_\_\_\_

RELATIONSHIP TO PATIENT:

\_\_\_\_\_

SIGNATURE:

\_\_\_\_\_

DATE:

\_\_\_\_\_

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## OFFICE USE ONLY

\*Signed form received by: \_\_\_\_\_

\*I attempted to obtain the patient's signature in acknowledgement on the Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

DATE:	INITIAL S	REASON:
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# NOTICE OF PRIVACY PRACTICES

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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.

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## **OUR LEGAL DUTY**

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 04-14-2003, 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 the 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.

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## **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 qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

**Your Authorization:** In addition to our use of 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 not affect any use or disclosures permitted by your authorization while it was 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 Rights 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 filled prescriptions, 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 official 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).

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## **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 practicably 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 \$0. 25 for each page, \$ 0.00 per hour for staff time to copy your health information, 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, we will prepare 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.

**Electronic Notice:** If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

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## **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 this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. 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 U.S. Department of Health and Human Services.

### **Abel Chiropractic**

8827 E. Reno Suite 201

Midwest City, OK 73110

ph: (405) 732-7700 fax: (405) 732-7774