Anthem Chiropractic
Family Practice • Injuries • Wellness
Dr. Derek Day, D.C.
10170 S. Eastern Ave. #110 Henderson, NV 89052 (702) 614.6777 fax (702) 614.6778
Website: www.drderekday.com Email: drday1@lvcoxmail.com

PATIENT INFORMATION

Name: _____ Date _____

Date of Birth: _____ Height _____ Weight _____ Dominant Hand: R / L

Address:_____City/State:_____Zip: _____

Phone: (cell) _____ Other:_____

Email: _____ Driver's License # _____

Your Car Ins. Company _____ Policy#:_____

Address:_____ City/State: _____ Zip:_____

Adjuster: _____ Phone: _____

Policy#: _____ Claim # _____

Other Party Car Ins. Company: _____

Address:_____City/State:_____Zip:_____

Adjuster: _____ Phone: _____ Ext _____

Agent: _____ Phone: _____ Ext _____

Policy#: _____ Claim # _____

Medical Payment Coverage?_____ Uninsured Motorist Coverage? _____

What Law Firm Represents you? _____

Address: _____City/State: _____ Zip:_____

Your Lawyers Name: _____ Phone: _____

Name of Insured on your car policy: _____

Date of Loss/Accident: _____ Date you first saw any Dr. after accident_____

Cost of all medical treatments since the accident? $ _____

How much income have you lost since the accident? $ _____

What is the property damage repair amount of your car? _____

Name of your Personal M.D. _____ Phone: _____

Address: _____ City/State: _____ Zip:_____

Any prior auto injuries? _____ Work related injuries?_____

Write any ambulance, Hospitals, M.D., Chiropractor, Dentist, Acupuncturist, PT, etc. since accident.

Name	**Type**	**Phone#**	**Amount of Bill**
_____	_____	_____	$_____
_____	_____	_____	$_____
_____	_____	_____	$_____

Symptoms

Patient _____ Date _____ Date of Injury _____

Please fill in all symptoms you currently have that you did not have before the accident.

Orthopedic & Musculoskeletal Symptoms

- ☐ "Clunk" sound with neck movements
- ☐ Neck pain
- ☐ Upper back pain
- ☐ Low back pain
- ☐ Shoulder pain ☐ Left ☐ Right
- ☐ Upper arm pain ☐ Left ☐ Right
- ☐ Elbow pain ☐ Left ☐ Right
- ☐ Forearm pain ☐ Left ☐ Right
- ☐ Wrist pain ☐ Left ☐ Right
- ☐ Hand pain ☐ Left ☐ Right
- ☐ Hip pain ☐ Left ☐ Right
- ☐ Upper leg pain ☐ Left ☐ Right
- ☐ Knee pain ☐ Left ☐ Right
- ☐ Lower leg pain ☐ Left ☐ Right
- ☐ Ankle pain ☐ Left ☐ Right
- ☐ Foot pain ☐ Left ☐ Right
- ☐ Jaw pain
- ☐ Clicking in Jaw
- ☐ Pain when chewing
- ☐ Face pain
- ☐ Chest pain
- ☐ Stomach pain
- ☐ Bruise to _____
- ☐ Scrape/Cut to _____
- ☐ Other Symptom _____
- ☐ Other Symptom _____

Neurological Symptoms

- ☐ Numb/Tingling Arm / Hand L R
- ☐ Numb/Tingling Leg / Foot L R
- ☐ Weakness Arm / Hand L R
- ☐ Weakness Leg / Foot L R

Symptoms Associated with Injuries

- ☐ Stiffness or limited movement in joint(s)
- ☐ Headaches
- ☐ Muscle spasms/sore muscles
- ☐ Dizziness, lightheaded, woozy feeling
- ☐ Visual disturbances or vision change
- ☐ Sleep changes/disruption of patterns
- ☐ Pain radiates from one place to another
- ☐ Anxiety or nervous when driving
- ☐ Irregular Heartbeat or uneven pulse
- ☐ Feeling depressed about things
- ☐ I am taking the following medications ____ _____

Brain/Neuropsych/MTBI/PTSD Symptoms

- ☐ I prefer being alone now (not socializing)
- ☐ I am sleepy, tired during day or doze off easily
- ☐ Upset stomach, nausea, heartburn or vomiting
- ☐ Difficulty concentrating, mind wanders easily
- ☐ I get overwhelmed easily
- ☐ Mood swings, happy one moment then sad
- ☐ Agitation (can't sit still, need to move around)
- ☐ Sadness, tearful episodes, crying easily
- ☐ Blurry vision, had to get or change glasses
- ☐ Asking people to repeat things or hearing problem
- ☐ I make wrong turns driving or can't remember time
- ☐ I get confused easily or cannot multi-task anymore
- ☐ I have difficulty finding some words when talking
- ☐ Bright lights bother me
- ☐ I cannot pay attention as long as before
- ☐ I am eating more or less than normal
- ☐ Room spins, lightheaded or woozy feeling
- ☐ Balance problems
- ☐ I feel like my head is "Foggy"
- ☐ I have forgotten computer passwords or ATM PIN
- ☐ I have to re-read things to understand what I read
- ☐ My thinking is slowed down
- ☐ Difficulty with adding/subtracting numbers
- ☐ Fear I will never be the same again
- ☐ Difficulty learning new things
- ☐ Difficulty understanding what people say to me
- ☐ Difficulty remembering or memory problems
- ☐ Cannot take on any more responsibility
- ☐ I can't make decisions as quickly as before
- ☐ Loss of libido or lack of sexual desire
- ☐ I do not feel as confident of my abilities
- ☐ I get panic attacks, fast heartbeat, nervous
- ☐ I am more irritable than usual
- ☐ Some food or drink tastes "Funny" to me now
- ☐ I get frustrated very easily
- ☐ Difficulty planning my life or organizing my work
- ☐ Flashbacks or frightening thoughts about accident
- ☐ I have had bad dreams about the accident
- ☐ I avoid places & objects that remind me about it
- ☐ I feel emotionally numb-no interest in my hobbies
- ☐ I'm feeling strong guilt, worry or depression
- ☐ I am having trouble remembering the accident
- ☐ I am easily startled since the accident - "jumpy"
- ☐ I feel tense or "on edge" most of the time
- ☐ I am having difficulty sleeping
- ☐ I get angry easily or even yell at people now

Patient Signature _____ Dr. Signature _____

ACUTE CONCUSSION EVALUATION (ACE)

PHYSICIAN/CLINICIAN OFFICE VERSION

Gerard Gioia, PhD[1] & Micky Collins, PhD[2]
[1]Children's National Medical Center
[2]University of Pittsburgh Medical Center

Patient Name:_____
DOB: _____ Age:_____
Date:_____ ID/MR#_____

A. Injury Characteristics

Date/Time of Injury_____ Reporter: __Patient __Parent __Spouse __Other_____

1. Injury Description _____

1a. Is there evidence of a forcible blow to the head (direct or indirect)? __Yes __No __Unknown
1b. Is there evidence of intracranial injury or skull fracture? __Yes __No __Unknown
1c. Location of Impact: __Frontal __Lft Temporal __Rt Temporal __Lft Parietal __Rt Parietal __Occipital __Neck __Indirect Force
2. **Cause:** __MVC __Pedestrian-MVC __Fall __Assault __Sports (*specify*)_____ Other_____
3. **Amnesia Before (Retrograde)** Are there any events just BEFORE the injury that you/ person has no memory of (even brief)? ◯Yes ◯No Duration
4. **Amnesia After (Anterograde)** Are there any events just AFTER the injury that you/ person has no memory of (even brief)? ◯Yes ◯No Duration
5. **Loss of Consciousness:** Did you/ person lose consciousness? ◯Yes ◯No Duration
6. **EARLY SIGNS:** __Appears dazed or stunned __Is confused about events __Answers questions slowly __Repeats Questions __Forgetful (recent info)
7. **Seizures:** Were seizures observed? No◯ Yes◯ Detail_____

B. Symptom Check List*

Since the injury, has the person experienced any of these symptoms any more than usual today or in the past day?
Indicate presence of each symptom (0=No, 1=Yes). ***Lovell & Collins, 1998 JHTR***

PHYSICAL (10)		COGNITIVE (4)		SLEEP (4)	
Headache	0 1	Feeling mentally foggy	0 1	Drowsiness	0 1
Nausea	0 1	Feeling slowed down	0 1	Sleeping less than usual	0 1 N/A
Vomiting	0 1	Difficulty concentrating	0 1	Sleeping more than usual	0 1 N/A
Balance problems	0 1	Difficulty remembering	0 1	Trouble falling asleep	0 1 N/A
Dizziness	0 1	**COGNITIVE Total (0-4)** _____		**SLEEP Total (0-4)** _____	
Visual problems	0 1	**EMOTIONAL (4)**			
Fatigue	0 1	Irritability	0 1		
Sensitivity to light	0 1	Sadness	0 1		
Sensitivity to noise	0 1	More emotional	0 1		
Numbness/Tingling	0 1	Nervousness	0 1		
PHYSICAL Total (0-10) _____		**EMOTIONAL Total (0-4)** _____			
(Add Physical, Cognitive, Emotion, Sleep totals) Total Symptom Score (0-22)		_____			

Exertion: Do these symptoms worsen with:
Physical Activity __Yes __No __N/A
Cognitive Activity __Yes __No __N/A

Overall Rating: How different is the person acting compared to his/her usual self? (circle)
Normal 0 1 2 3 4 5 6 Very Different

C. Risk Factors for Protracted Recovery *(check all that apply)*

Concussion History? Y___ N___	√	**Headache History?** Y___ N___	√	**Developmental History**	√	**Psychiatric History**
Previous # 1 2 3 4 5 6+		Prior treatment for headache		Learning disabilities		Anxiety
Longest symptom duration Days__ Weeks__ Months__ Years__		History of migraine headache __Personal __Family_____		Attention-Deficit/ Hyperactivity Disorder		Depression
						Sleep disorder
If multiple concussions, less force caused reinjury? Yes__ No__				Other developmental disorder_____		Other psychiatric disorder _____

List other comorbid medical disorders or medication usage (e.g., hypothyroid, seizures)_____

D. RED FLAGS for acute emergency management: Refer to the emergency department with sudden onset of any of the following:

- * Headaches that worsen
- * Seizures
- * Focal neurologic signs
- * Looks very drowsy/ can't be awakened
- * Repeated vomiting
- * Slurred speech
- * Can't recognize people or places
- * Increasing confusion or irritability
- * Weakness or numbness in arms/legs
- * Neck pain
- * Unusual behavioral change
- * Change in state of consciousness

E. Diagnosis (ICD):

__Concussion w/o LOC 850.0 __Concussion w/ LOC 850.1 __Concussion (Unspecified) 850.9 __Other (854) _____
__No diagnosis

F. Follow-Up Action Plan Complete *ACE Care Plan* and provide copy to patient/family.

__ **No Follow-Up Needed**
__ **Physician/Clinician Office Monitoring**: Date of next follow-up _____
__ **Referral:**
__ Neuropsychological Testing
__ Physician: Neurosurgery__ Neurology__ Sports Medicine__ Physiatrist__ Psychiatrist__ Other_____
__ Emergency Department

ACE Completed by:_____

This form is part of the "Heads Up: Brain Injury in Your Practice" tool kit developed by the Centers for Disease Control and Prevention (CDC).

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PATIENT INFORMATION

Sex: (M) / (F) **Circle:** Single/ Married/ Widowed/ Minor/ Separated/ Divorced/ Partnered

Employer/School: _____

Address:_____City/State:_____Zip: _____

Employer/School Phone: _____Occupation: _____

Spouse Information:

Spouse's Name: _____ Date of Birth: _____

Spouse's Employer:_____ Phone#: _____

In Case of Emergency: _____ Phone#: _____

Relationship to patient: _____

Health Insurance Information:

Health Ins. Co.: _____

Group#: _____ Member ID#: _____

Is patient covered by additional insurance? (Y) (N) Health Ins. Co: _____

Name of Insured: _____ Phone#: _____

Date of birth: _____SS#: _____ Relationship to patient:_____

Group#: _____ Member ID#: _____

Who is your family doctor? _____

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HEALTH HISTORY: (prior to accident)

Date of Last: Physical Exam:_____Spinal X-ray:_____Blood Test:_____
Spinal Exam:_____ Chest X-ray:_____ Urine Test: _____
Dental X-ray:_____ MRI, CT-Scan, Bone Scan: _____

Please check to indicate if YOU HAVE HAD the following:

___ AIDS/HIV
___Alcoholism
___Allergy Shots
___Anemia
___Anorexia
___Appendicitis
___Arthritis
___Asthma
___Bleeding Disorders
___Breast Lumps
___Bronchitis
___Bulimia
___Cancer
___Cataracts
___Chemical Dependency
___Chicken Pox
___Diabetes
___Emphysema
___Epilepsy
___ Fibromyalgia
___Glaucoma
___Goiter
___Gonorrhea
___Gout
___Heart Disease
___Hepatitis
___Hernia
___Herniated Disc
___High Blood Pressure
___High Cholesterol
___Kidney Disease
___Liver Disease
___Lupus
___Migraine/Headaches
___Miscarriage
___Mononucleosis
___Multiple Sclerosis
___Mumps
___Osteoporosis
___Osteopenia
___Pacemaker
___Parkinson's Disease
___Pneumonia
___Polio
___Prosthesis
___Psychiatric Care
___Rheumatoid Arthritis
___Rheumatic Fever
___STD
___Stroke
___Suicide Attempts
___Thyroid Problems
___Tonsillitis
___Typhoid Fever
___Ulcers
___Vaginal Infections
___ Whooping Coughs
___ Other:_____
_____

Are you pregnant? ___ Yes ___ No ___ Due Date: _____
Exercise: ___ None ___Moderate ___Daily ___Heavy
Work Activities: ___Sitting ___Standing ___Light Labor ___Heavy Labor

Habits: ___Smoking: Packs/Day: _____ ___Alcohol: Drinks/Week: _____

___Coffee/Caffeine: Cups/Daily: _____ ___High Stress Level Reason:_____

Falls: __ Yes __No When: _____
Describe:_____
Head Injuries/Concussion: __ Yes __ No When: _____
Describe:_____
Broken Bones: __Yes __ No When: _____
Describe:_____
Dislocations: __ Yes __ No When: _____
Describe:_____
Auto Injuries/Work Injuries: __Yes __No When: _____
Describe:_____
Prior Neck/Back Surgeries: __ Yes __ No When: _____
Describe:_____
Other Surgeries: __Yes __ No When: _____
Describe:_____

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Please read, sign last page, & keep first 2 pages for your records!

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.

Treatment: Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment: Your health information may be used by staff members to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, services provided, and the medical condition being treated.

Health Care Operations: Your health information may be used as necessary to support the day to day activities and management of Anthem Chiropractic. For example, information on the services being provided may be used to support budgeting and financial reporting, and activities to evaluate and promote quality, such as training. In addition, we may also use a sign in sheet where you will be asked to provide your name and indicate your physician. We may also call your name in the waiting room when your physician is ready to see you.

Law Enforcement: Your health information may be disclosed to public health agencies to support government audits and inspections, to facilitate law enforcement investigations, and comply with government mandated reporting.

Public Health Reporting: Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other Uses and Disclosures Require Your Authorization: Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

ADDITIONAL USES OF INFORMATION

Appointment Reminders: Your health information may be used by our staff to send you appointment reminders.

Information About Treatments: Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition. We may also send you information describing other health related products and services that we believe may interest you.

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INDIVIDUAL RIGHTS

You have certain rights under federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information.
- The right to receive confidential communications concerning your medical condition and treatment.
- The right to inspect and copy your protected health information.
- The right to amend or submit corrections to your protected health information.
- The right to receive and accounting of how and to whom your protected health information has been disclosed.
- The right to receive a printed copy of this notice.

Anthem Chiropractic Duties

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We are also required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy practices and policies. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Requests to Inspect Protected Health Information

You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting the Medical Records Clerk or Office Manager. You request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

Complaints

If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

Attn: Privacy Officer
Anthem Chiropractic
10170 S. Eastern Avenue Ste 110
Henderson, NV 89052

If you feel that your privacy rights have been violated, please call the matter to our attention by sending a letter to the above listed address.

** You will not be penalized or otherwise retaliated against for filing a complaint**

Contact Person

For any further information concerning our privacy practices please contact us at:

Attn: Office Administrator
Anthem Chiropractic
10170 S. Eastern Avenue Ste 110
Henderson, NV 89052
(702) 614-6777

Anthem Chiropractic reserves the right to modify the privacy practices outlined in the notice

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I have received a copy of the Notice of Privacy Practices for Anthem Chiropractic.

Printed Name of Patient **Date**

Signature of Patient **Date**

Signature of Patient Representative **Relationship**
****Required if the patient is a minor or an adult who is unable to sign this form****

********************************For Office Use Only********************************

DOCUMENTATION OF ATTEMPT TO OBTAIN ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

An attempt was made to obtain an acknowledgement of receipt of the Notice of Privacy Practices on _____. The acknowledgement was not obtained because:

- **The patient was undergoing emergency treatment**
- **The patient declined to sign the acknowledgement**
- **Other**

Name of Patient (Print)

Name of Staff Member **Date**

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INFORMED CONSENT TO CHIROPRACTIC CARE

I hereby request and consent to the performance of Chiropractic adjustments and other Chiropractic procedures, including various modes of physiotherapy and diagnostic X-rays, on myself (or on the patient named below, for whom I am legally responsible) by the Doctor of Chiropractic named above.

I have had the opportunity to discuss with the Doctor and/ or with other office or clinic personnel, the purpose and benefits of the Chiropractic adjustments and other treatments outlined below. Various medical procedures will be reviewed and a referral will be provided if deemed medically necessary.

Though Chiropractic adjustments and treatments are usually beneficial and seldom cause any problem, I understand and am informed that there are some risks to treatment. Risks include, but are not limited to: fractures, disc injuries, strokes, bruising, dislocations, and sprains.
I understand that I may be receiving the following treatment:

HOT/COLD THERAPY, MINERAL ICE, ULTRASOUND, EMS, MANUAL/ FLEXION TRACTION, TRIGGER POINT THERAPY, VIBRATORY/ DEEP TISSUE MASSAGE, TENS, THERAPEUTIC EXERCISES, LIFESTYLE AND ERGONOMIC INSTRUCTIONS, SPINAL ADJUSTMENTS/ JOINT MOBILIZATION TECHNIQUES, POSTURAL CORRECTION, NUTRITIONAL SUPPLEMENTATION AND DIETARY RECOMMENDATIONS.

I acknowledge that no guarantee or assurance has been made by anyone regarding the Chiropractic treatment that I have requested and authorized. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction. I consent to the proposed treatment.

Signature of Patient: _____

Date: _____

Signature of Parent/ Guardian: _____ Date: _____
Required if the patient is a minor or an adult who is unable to sign this form

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MISSED APPOINTMENT POLICY

In an effort to avoid missed appointments, you will receive an automated reminder call and/or text message confirmation from our office the evening before your scheduled appointment.

Our office policy regarding missed appointments is as follows:

Any appointment cancelled with less than 24 hours' notice, including "no call- no shows", will be billed as a missed appointment. The missed appointment fee of $25.00 must be paid prior to / or at the time of your next appointment. This amount is not eligible for insurance billing and is the responsibility of the patient.

Thank you for your understanding and consideration,

Dr. Day and Your Anthem Chiropractic Team

I HAVE READ AND UNDERSTAND THE ABOVE DESCRIBED MISSED APPOINTMENT POLICY. I WILL BE RESPONSIBLE FOR ALL APPOINTMENTS NOT CANCELLED WITH 24 HOURS NOTICE, INCLUDING NO CALL- NO SHOW APPOINTMENTS. THIS WILL RESULT IN A $25.00 FEE NOT BILLABLE TO MY INSURANCE, WHICH MUST BE PAID ON OR BEFORE MY NEXT APPOINTMENT DATE.

_____ _____

Patient Signature/Guardian Date

_____

Patient Name (Please Print)

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NOTICE OF DOCTORS LIEN

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

I do hereby authorize and direct you, my attorney, to pay directly to said doctor such sums as may be due and owing him for medical services rendered to me by reason of this accident that are due his office and to withhold such sums from any 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/ her.

I further grant to Anthem Chiropractic, a lien, independent of any attorney's lien, upon any claim, settlement or judgment that I obtain or am entitled to from any insurer, corporation, or person, as a result of my accident, for the complete and total satisfaction of any and all charges I incur at Anthem Chiropractic, and I expressly direct any such insurer, corporation, or person, to pay Anthem Chiropractic any and all charges that I incur as a result of my accident. It is my intent that this lien stay in force until all of my charges at Anthem Chiropractic are satisfied, regardless of whether my attorney signs a lien with Anthem Chiropractic, my attorney withdraws, or I release or substitute one or more attorneys during the course of my injury, claim or case.

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 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.

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 will require me to make payments on a current basis.

Date of Injury: _____ _____

Printed Name of Patient

Date: _____ _____

Signature of Patient/Guardian

The undersigned being attorney of record for the above patient does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment, or verdict, as may be necessary to adequately protect said doctor, above named.

Dated: _____ _____

Attorney Signature

Please sign, date and return one copy to doctor's office. Also keep one for your records

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Dr. Derek Day, D.C.

AUTHORIZATION FOR POLICY DECLARATIONS PAGE

TO: _____

Patient Information:

Name: _____ Phone Number: _____

Address: _____

Policy Number: _____

Agent's Name: _____ Agent's Phone Number: _____

Information to be released to: **Anthem Chiropractic**

Information to be released: Declaration of insurance policy, including; limits of bodily injury, under insured limits, un insured limits, comp and collision deductible, rental car coverage limits, medical payments limits, and policy premium.

Patient Authorization & Rights:
I hereby authorize you to release the requested information to **ANTHEM CHIROPRACTIC,** I understand that I may revoke this authorization at any time and I must do so in writing. I understand that the revocation does not apply to information already released in response to this authorization. This authorization expires at my conclusion.

This Authorization allows ANTHEM CHIROPRACTIC to have direct communication with _____, along with their agents and customer service representatives. Please fax or email my declarations page to their office at anthemchiropratic@gmail.com or 702-614-6778, within the hour.

Signature of Insured or Legal Representative: _____ Date:_____

If signed by Legal Representative, Relationship to Insured: _____

Signature of Witness: _____

It is understood that a photocopy of this Authorization shall be considered as effective and valid as the original. This authorization shall remain in full force and effect for a period of 2 years from the date signed above.#
#

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ASSIGNMENT OF BENEFITS

Patient Name: _____

Claim #: _____ DOI: _____

Insured's Name: _____ SSN/ID #: _____

Relation to Patient: _____

I hereby instruct and direct the _____ Insurance Company to pay the benefits of my policy by check made out to and mailed directly to:

Anthem Chiropractic
Dr. Derek T. Day, D.C.
10170 S. Eastern Ave, Ste. 110
Henderson, NV 89052

If my policy prohibits direct payment to a doctor, then I hereby also instruct and direct you, my insurance company, to make the check out to me and mail it as follows:

C/O Anthem Chiropractic
Dr. Derek T. Day, D.C.
10170 S. Eastern Ave, Ste. 110
Henderson, NV 89052

For the professional or chiropractic/medical benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for processional services rendered. This is a direct assignment of my rights and benefits under this policy and is irrevocable, even by my attorney. Do not pay the benefits of my policy to my attorney and do not mail any benefit checks to my attorney. Said payment will not exceed my indebtedness to Dr. Derek T. Day, D.C. and I have agreed to pay, in a current manner, any balance of said professional services fees over and above this insurance payment. If my policy is and indemnity policy, I hereby direct you, my insurance company, to indemnify me against the harm that would occur should Dr. Derek T. Day, D.C. have to balance bill me for professional fees that I contracted for and that you, my insurance company, fail to pay or fail to pay in full.

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

I also authorize Dr. Derek T. Day, D.C. to release any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case. I further authorize Dr. Derek T. Day, D.C. to file a complaint on my behalf with the Nevada Insurance Commissioner.

Signature of Policyholder: _____ Date: _____

Signature of Claimant, if other than Policyholder: _____

Anthem Chiropractic
Family Practice • Injuries • Wellness
Dr. Derek Day, D.C.
10170 S. Eastern Ave. #110 Henderson, NV 89052 (702) 614.6777 fax (702) 614.6778
Website: www.drderekday.com Email: drday1@lvcoxmail.com

PENALTY OF PERJURY

I_____, declare under penalty of perjury, according to the laws of the state of Nevada, that the accident/injury dated _____is a legitimate one, not contrived or feigned in any way and that the injuries I sustained were as a result of the above-mentioned accident/incident.

I furthermore declare that I have been present and received therapy on every date that I have signed/initialed.

Date_____ _____

Signature of Patient/Guardian

_____

Print Name of Patient

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HEALTH INSURANCE WAIVER

I hereby direct you, as my medical provider, not to bill or utilize my personal health insurance for any of the treatment rendered by you and your office for injuries sustained in the incident for which I am now seeking treatment.

I believe, and have told you as my provider, that the incident was not my fault. I do not wish to be penalized in any manner for someone else's wrongdoing. My health insurance rights may be adversely affected, such as limiting my total number of office visits to a yearly maximum and if I use them for the injuries from this incident, I will lose that insurance entitlement for future office visits. Or, I do not wish to be responsible for any co-pays, deductibles or non-covered services for these same reasons. I desire, and choose, to preserve my health insurance visits and co-pays or deductibles for any similar future medical care where I can then choose to use my healthcare coverage.

Consequently, while you are allowed to bill my auto med-pay policy if med-pay is available, you are instructed not to bill my healthcare insurance. This directive is effective immediately and covers me from the date of my first visit with your office related to this incident, and continues until the conclusion of my treatment for these injuries. I make this directive voluntarily, of my own preference and without any coercion or duress of any kind by you or your staff members.

I understand that by choosing this option, I agree that I shall not rescind this directive once given unless that rescission is given in writing by me within fourteen (14) calendar days of signing this directive. Otherwise, you, as my medical provider, would likely be past the time deadline for the submission of my bills for payment to my health insurer, or I would be creating other problems for the payment of your services under my healthcare plan. I will be solely responsible to notify any attorney I now or later retain of this directive. In the event of any litigation arising under this directive, the prevailing party shall be entitled to recover their reasonable attorney's fees and costs. Venue for any litigation arising out of this incident shall be where the medical services were provided.

_____ _____

Patient Signature/Guardian Date

Patient Name: _____

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FINANCIAL AND INSURANCE ASSIGNMENT POLICY

Our office is pleased to accept your insurance assignment, as soon as your exact coverage is verified by the responsible party. We will file your claim forms and assist you in every way we can.

However, it must be fully understood that the contract is between you and your insurance company and you are fully responsible for any amount not paid by your insurance.

1. By taking your insurance on assignment we have to wait for payment, this courtesy may be withdrawn if circumstances warrant it.
2. Network vs. Out of Network: If your carrier has a "network" of providers, it is your responsibility to make sure we are in network. We can provide "out of network" care but your portion maybe higher. It is your responsibility to make sure your insurance carrier and billing information is accurate.
3. Your insurance should pay within 30 days. If you're insurance has not paid within 60 days you must pay the balance due and be reimbursed by your insurance company, when and if it pays. There will be an interest charge of 7% per annum (year) charged on all unpaid balances over 60 days.
4. We will bill your insurance on a weekly basis as long as you are receiving Chiropractic care in this office. Cash patients will pay on the date of service per our time of service fee schedule.
5. If you choose you may pay a percentage of your responsibility as you go along until the insurance check is received. We will verify your co-insurance portion prior to treatment. This office accepts cash, check or bankcard as payment.
6. Or we will bill your insurance company weekly and when we receive an insurance check, we will bill you for any balance and or interest due at the time.
7. You are required to sign an "Assignment to Pay Physician" form and any other assignment documents required by your insurance company on your first office visit.
8. Our office does NOT guarantee that your insurance will pay. We will make every attempt, at the beginning of your health care, to receive verification of your policy and what it covers. However, if for some reason your insurance claim is denied you are responsible for the full amount of your bill.
9. Our office will NOT enter into a dispute with your insurance company over your claim. This is your responsibility and obligation.
10. All special arrangements regarding finances must be signed by the Doctor and Patient and/or other representative.
11. Auto injury policy – For auto policies we bill the primary medical payment/PIP. If your care exceeds your coverage limit, we may be able to bill your health insurance or put you on our time of service plan. If you are represented by an attorney, you must sign a doctor's lien that will be forwarded to your lawyer. Please be advised that you are responsible for your bill regardless of the circumstances. Third party insurance will not reimburse our office directly, therefor third party insurance will NOT be billed.
12. Returned checks – You will be charged $25.00 for a returned check.
13. Medical records – You may request a copy of your medical records. We charge $0.60 per page when you pick them up.

If you understand and agree with all of the above policies, please sign your name below and we will accept your insurance assignment. I hereby authorize my insurance benefits to be paid directly to said doctor. I am responsible for balance due and authorize doctor or insurance co. to release my personal information to pay this claim.

(___) I wish to NOT utilize my health insurance coverage and choose to be a Cash Patient.

_____ _____

Signature of Patient/Guardian Date

Anthem Chiropractic
Family Practice • Injuries • Wellness

Dr. Derek Day, D.C.

AUTHORIZATION TO OBTAIN MEDICAL INFORMATION

Patient Name (Printed): _____

Date of Birth: _____ **Social Security Number:** _____

I authorize any physician, dentist, chiropractor, hospital, pharmacist, medical professional, health care provider, insurance company, worker compensation provider, or employer to disclose all information about past and present medical care, history, physical condition, and injuries including itemized statements to Anthem Chiropractic.

I agree that this authorization will remain valid up to one year of the signed date, unless revoked by delivery of written notice to Anthem Chiropractic.

I hereby designate the above named company and its claims personnel as my designated representative, pursuant to NCGS Sec 90-411 for the purpose of obtaining copies of my medical records, the production of which is authorized herein. It is specifically my intent that this designation provide to the company named above the benefit of the maximum fees established in NCGS Sec 90.41.

I understand that I (or my representative) am entitled to receive a copy of this authorization. A photocopy of this form may be accepted as the original.

I (or the patient named above) have received health care treatment from the following providers:

Provider Name	Phone
_____	_____
_____	_____
_____	_____

Please send records to:

Anthem Chiropractic
10170 S Eastern Ave., Ste. 110
Henderson, NV 89052
Phone: 702.614.6777
Fax: 702.614.6778

_____

Signature of Patient or Legal Representative **Relationship to Patient** **Date**

AUTHORIZATION TO OBTAIN MEDICAL INFORMATION

Patient Name: _____

Date of Birth: _____ **Social Security Number:** _____

Date of Injury: _____

I authorize any physician, dentist, chiropractor, hospital, pharmacist, medical professional, health care provider, insurance company, worker compensation provider or employer to disclose all information about past and present medical care, history, physical condition, and injuries including itemized statements to Complete Injury Management for the purpose of review and evaluation in connection with a legal claim.

I agree this authorization will remain valid until the conclusion of my claim. I understand I have the right to revoke this authorization at any time and must do so in writing.

I understand I am entitled to a copy of this authorization. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

I understand signing this authorization may not condition treatment, payment, enrollment or eligibility for benefits.

TO: _____

Name of Healthcare Provider/Physician/Facility **Phone**

Please send records to:
Complete Injury Management
7380 West Sahara Avenue, Suite 110
Las Vegas, NV 89117
Phone: 702.227.4878
Fax: 702.272.2013

Signature of Patient or Legal Representative **Relationship to Patient** **Date**