WELCOME

PATIENT INFORMATION

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

City _____

State _____ Zip _____

E-mail _____

Sex ☐ M ☐ F Age _____

Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Occupation _____

Patient Employer/School _____

Employer/School Address _____

_____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to
Name of Insurance Company(ies)

Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____
Date Relationship to Patient

PHONE NUMBERS

Home Phone (_____) _____

Cell Phone (_____) _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____

Relationship _____

Home Phone (_____) _____

Work Phone (_____) _____

ACCIDENT INFORMATION

Is condition due to an accident? ☐ Yes ☐ No

Date _____

Type of accident ☐ Auto ☐ Work ☐ Home ☐ Other

To whom have you made a report of your accident?
☐ Auto Insurance ☐ Employer ☐ Worker Comp. ☐ Other

Attorney Name (if applicable)

_____

PATIENT CONDITION

Reason for Visit _____

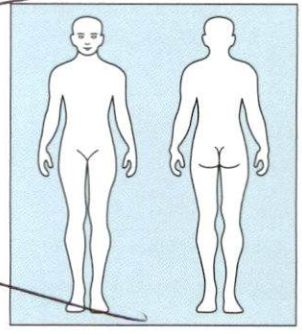
When did your symptoms appear? _____

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting
☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other



How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities or movements that are painful to perform ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

HEALTH HISTORY

What treatment have you already received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therapy

☐ Chiropractic Services ☐ None ☐ Other _____

Name and address of other doctor(s) who have treated you for your condition _____

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_____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Alcoholism	☐ Yes ☐ No	Emphysema	☐ Yes ☐ No	Measles	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No
Allergy Shots	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No	Migraine Headaches	☐ Yes ☐ No	Sexually Transmitted Disease	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Fractures	☐ Yes ☐ No	Miscarriage	☐ Yes ☐ No		
Anorexia	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Mononucleosis	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Appendicitis	☐ Yes ☐ No	Goiter	☐ Yes ☐ No	Multiple Sclerosis	☐ Yes ☐ No	Suicide Attempt	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	Gonorrhea	☐ Yes ☐ No	Mumps	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Gout	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Bleeding Disorders	☐ Yes ☐ No	Heart Disease	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Breast Lump	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No	Parkinson's Disease	☐ Yes ☐ No	Tumors, Growths	☐ Yes ☐ No
Bronchitis	☐ Yes ☐ No	Hernia	☐ Yes ☐ No	Pinched Nerve	☐ Yes ☐ No	Typhoid Fever	☐ Yes ☐ No
Bulimia	☐ Yes ☐ No	Herniated Disk	☐ Yes ☐ No	Pneumonia	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	Polio	☐ Yes ☐ No	Vaginal Infections	☐ Yes ☐ No
Cataracts	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Prostate Problem	☐ Yes ☐ No	Whooping Cough	☐ Yes ☐ No
Chemical Dependency	☐ Yes ☐ No	High Cholesterol	☐ Yes ☐ No	Prosthesis	☐ Yes ☐ No	Other _____	
Chicken Pox	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No		
				Rheumatoid Arthritis	☐ Yes ☐ No		

EXERCISE

☐ None
☐ Moderate
☐ Daily
☐ Heavy

WORK ACTIVITY

☐ Sitting
☐ Standing
☐ Light Labor
☐ Heavy Labor

HABITS

☐ Smoking Packs/Day _____
☐ Alcohol Drinks/Week _____
☐ Coffee/Caffeine Drinks Cups/Day _____
☐ High Stress Level Reason _____

Are you pregnant? ☐ Yes ☐ No Due Date_____

Injuries/Surgeries you have had	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

MEDICATIONS

_____
_____
_____

Pharmacy Name_____

Pharmacy Phone (_____) _____

ALLERGIES

VITAMINS/HERBS/MINERALS

VEHICLE ACCIDENT INFORMATION

PATIENT INFORMATION

Date_____

Patient Name_____

Date of Accident_____ Time of Accident_____ ☐ a.m. ☐ p.m.

Please describe the accident in your own words:_____

_____

_____

_____

Were you the: ☐ Driver ☐ Front Passenger ☐ Rear Passenger ☐ Pedestrian

How many people were in the accident vehicle?_____

ACCIDENT SITE

Road/Street Name_____

City/State_____

Nearest intersection with road/street_____

Driving conditions ☐ Dry ☐ Wet ☐ Icy ☐ Other _____

Which direction were you headed? _____

Speed you were traveling?_____

IMPACT

Did your car impact another vehicle? ☐ Yes ☐ No

Did your car impact a structure? ☐ Yes ☐ No

If yes, explain_____

_____

Did any part of your body strike anything in the vehicle?

☐ Yes ☐ No If yes, explain_____

Was impact from :

☐ Front ☐ Rear ☐ Left ☐ Right ☐ Other_____

At the time of impact were you:

☐ Looking straight ahead ☐ Looking to the right
☐ Looking to the left ☐ Looking down
☐ Looking up

Were both hands on the steering wheel? ☐ Yes ☐ No

If no, which hand was on the wheel? ☐ Right ☐ Left

Was your foot on the brake? ☐ Yes ☐ No

If yes, which foot was on the brake? ☐ Right ☐ Left

Were you: ☐ Surprised by impact ☐ Braced for impact

VEHICLE

Make and model of vehicle you were in:

_____

Were you wearing a seatbelt? ☐ Yes ☐ No

If yes, what type? ☐ Lap ☐ Shoulder

Was vehicle equipped with airbags? ☐ Yes ☐ No

If yes, did it/they inflate properly? ☐ Yes ☐ No

Did your seat have a headrest? ☐ Yes ☐ No

If yes, what was the position of the headrest?

☐ Low ☐ Midposition ☐ High

OTHER VEHICLE
(if applicable)

Make and model of other vehicle_____

Which direction was other vehicle headed?_____

Speed other vehicle was traveling_____

POLICE

Did the police come to the accident site? ☐ Yes ☐ No

Were there any witnesses? ☐ Yes ☐ No

Was a police report filed? ☐ Yes ☐ No

Was a traffic violation issued? ☐ Yes ☐ No

If yes, to whom?_____

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PATIENT CONDITION

Were you unconscious immediately after the accident? ☐ Yes ☐ No If yes, for how long?_____

Please describe how you felt immediately after the accident:

_____

_____

TREATMENT

Did you go to the hospital? ☐ Yes ☐ No

When did you go? ☐ Immediately after accident ☐ Next day ☐ 2 days or more after the accident

How did you get to the hospital? ☐ Ambulance ☐ Private transportation

Name of hospital_____ Name of doctor_____

Diagnosis_____

_____

Treatment received_____

X-rays taken_____

SYMPTOMS/INJURIES

Have you been able to work since this injury? ☐ Yes ☐ No How many work days have you missed?_____

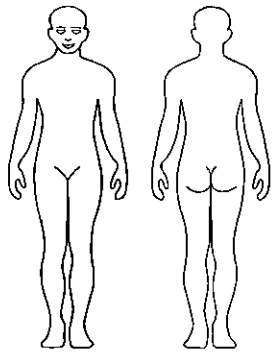
Prior to the injury were you able to work on an equal basis with others your age? ☐ Yes ☐ No

If you have had any of the following symptoms since your injury, please ☑ check:

☐ Arm/shoulder pain	☐ Feet/toe numbness	☐ Neck pain
☐ Back pain	☐ Hand/finger numbness	☐ Neck stiff
☐ Back stiffness	☐ Headaches	☐ Shortness of breath
☐ Chest pain	☐ Irritability	☐ Sleep difficulty
☐ Dizziness	☐ Jaw problems	☐ Stomach upset
☐ Ear buzzing	☐ Leg pain	☐ Tension
☐ Ear ringing	☐ Memory loss	☐ Vision blurred
☐ Fatigue	☐ Nausea	

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.



Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain)_____

Type of pain:

☐ Sharp	☐ Dull	☐ Throbbing	☐ Numbness
☐ Aching	☐ Shooting	☐ Burning	☐ Tingling
☐ Cramps	☐ Stiffness	☐ Swelling	☐ Other_____

How often do you have this pain?_____

Is it constant or does it come and go?_____

Does it interfere with your: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Movements that are painful to perform: ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____

Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

Auto Injury Centers, Inc. Notice of Privacy Practices

Auto Injury Centers, Inc. , under the HIPPA Standards for Privacy of Individually Identifiable Health Information (The Privacy Rule), modified on August 14, 2002 will:

- Collect information that is relevant and necessary to carry out our role.
- Explain at the time of the information is being collected, why it is needed, and how it will be used.
- Ensure that records are used only for the reasons given or seek the person's permission when another purpose for their use is considered necessary or desirable.
- Provide adequate safeguards to protect the records from unauthorized access and disclosure.
- Allow people to see the records kept on them and provide them with the opportunity to correct inaccuracies in their records.
- Provide records to an entity, medical doctor or facility in order to coordinate your care.
- Obtain information needed to confirm your insurance benefits and obtain payment for services.
- Release information to your Insurance Plan at their request for billing or their administrative purposes.
- Release records when they are requested by you or your representative.
- Release records to certain government authorities as permitted or required by law to investigate or regulate health related issues such as child abuse, communicable diseases and prescription drugs.
- Certain lawyers and parties in a law suit if a patient's medical condition is an issue in a law suit.

Akers Chiropractic is to protect our patients privacy (Private Healthcare Information) at the same time providing them with the most efficient and effective care possible.

Authorization will be given to the person/persons written in if you should request them to have access to your Private Healthcare Information:

☐ I permit _____ to have access to my scheduling information.

☐ I permit _____ to have access to scheduling and billing information.

Please acknowledge you have read and understood the above description and understand that in order to give you the most efficient care, any and all records regarding a healthcare issue will be forwarded to the facility or physician we refer you to.

Printed Name: _____ Date: _____

Signature: _____ Witness: _____

INFORMED CONSENT TO CHIROPRACTIC CARE

As a patient in our office, you have the right to know about the type of treatment we will use, and complications/side-effects, as well as alternatives to chiropractic care and their complications. This form is intended to inform you of these prior to treatment and receive your written consent for you or your minor child.

The primary treatment used by Chiropractic Physicians is the adjustment or manipulation of the joints of the body to include motion. The doctor will use the procedure most appropriate to treat your condition as well as ancillary treatments such as prescribing exercises, and using therapeutic modalities.

The nature of the Chiropractic Adjustment: I will use my hands and/or mechanical device upon your body in such a way as to move the joints to restore normal function. This procedure may cause an audible "click" or "pop" sound similar to what you feel when you pop your knuckles. You may feel or sense movement of this joint, which usually gives you a very pleasant sense of relief. If a traditional spinal adjustment is inappropriate for your condition, there is other less forceful and gentler type of adjustments that may be used.

The possible risk involved in the Chiropractic Adjustment: Serious complications to chiropractic treatment are rare. However, these may include fractures, disc injuries, dislocations, muscle strain, ligamentous sprain, and nerve injuries. Some patients may feel some stiffness or soreness following the first few days of treatment, which is considered normal.

The probability of serious complications occurring: Fractures, especially of the ribs, are rare occurrences and generally result from some underlying weakness of the bone such as osteoporosis. If you suffer from osteoporosis, please tell your doctor and care steps will be taken to adjust your spine. Stroke has been the subject of much study and debate within the health professions. Manipulation of the neck has been associated with other injuries to the arteries in the neck leading to a stroke in rare instances. Studies have estimated this occurrence rate to be between 1 in 1 million to 1 in 3 million adjustments. To put this in perspective, your chances of being hit by lightning are reported to be 1 in 3 million. We employ tests in our examination, which are designed to identify possible risk factors for stroke, and we combine this with your medical history and our clinical skills to determine if you are a candidate for cervical manipulation. Disc injuries are frequently successfully treated by chiropractic adjustments, yet occasionally chiropractic treatment may aggravate the problem and rarely surgery may become necessary to treat a disc injury. If necessary, we will refer you to a neurosurgeon or for an MRI exam. These problems are also rare with no reliable statistics to quantify their probability.

Ancillary treatments: In addition to chiropractic adjustments (manipulation of the joints), I intend to use the following treatments as needed to treat your condition:

- *Ice or Heat Packs: these may be used in the office or recommended for home use. Both may, in rare cases, irritate or burn the skin.
- *Myofascial release, Active Release Technique, and Trigger Point Therapy, which may, in rare cases, cause local bruising and soreness.
- *Electrical Stimulation: this therapy consists of a mild electrical current, which helps relax tight muscles, blocks pain, reduces swelling, and facilitates healing. There are no known side-effects other than discomfort if the settings are too high. At any time, if any of these procedures are uncomfortable, you are to notify the doctor and/or staff immediately and this procedure will be modified or discontinued.
- *Therapeutic and rehabilitative exercises, Active Release Technique, Neuromuscular Re-education, and Post Isometric Relaxation (PIR): these may be used to re-educate your muscles to restore normal functions and muscular balance. Every precaution is used to prevent injury. Injuries are rare and are usually from the patient "over doing it" or over stretching. Please follow your doctor's recommendations carefully.

Initial: _____ Date: _____

Alternative Medical Treatment Risks are:

- *Self-administered over the counter NSAIDS may cause gastro-intestinal problems and bleeding of liver and kidney disease i.e: Aspirin, Ibuprophen, Aleve, etc.

- *Prescription muscle relaxants and painkillers can produce undesirable side effects and addiction. They can also make you drowsy and impair your motor skills.

- *Hospitalization and bed rest has the additional risk of exposure to communicable disease, loss of muscle tone and strength at the rate of 4% per day. It is very expensive, and research has shown bed rest has no benefit in helping back pain patients. In fact, it may make your condition worse.

- *Back or neck surgery poses many risks, such as: infections, allergic reactions, disfiguring scars, severe loss of blood, loss of function of any limb, organ paralysis, paraplegia or quadriplegia; brain damage; cardiac arrest; death; loss of bladder; bowel or sexual function; increased or continued pain or numbness; injury to vessels in the abdomen; post-operative bleeding; unstable spine requiring fusion; and infection.

- *Injections of pain medications: The risk inherent in using injections or surgery included adverse reactions to anesthesia or the injected medication, iatrogenic (caused by a doctor) problems, hospitalization and possible convalescent time.

The Risks and Dangers of Remaining Untreated: Remaining untreated allows the formation of adhesions and reduced joint motion, which sets 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. Disc degeneration, joint arthritis, nerve damage and muscle weakness may progress if your spinal problem goes untreated.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE INFORMATION

I have read, or have had read to me, the above information. I have had an opportunity to ask my questions, and all my questions have been answered fully and satisfactorily. By signing below, I consent to the treatment plan. I intend this consent form to cover the entire course of treatment for my present condition and for any further condition(s) for which I seek treatment in this office. Having considered the nature and risks of chiropractic care, I hereby give my consent to be treated.

Patient's Name (Printed)	Patient Signature	Date

***If you are a minor, or if you are being represented by another party:**

Name of Parent or Guardian (printed)	Signature of Parent or Guardian	Date

Witness:

Name of Witness (Printed)	Signature of Witness	Date

AUTO INJURY CENTERS, INC.
Terry Akers D.C.
2931 N Tenaya Way Suite 106
Las Vegas, NV 89128
Phone: (702) 822-1212

ACKNOWLEDGEMENT-HEALTH INSURANCE

I, _____ hereby affirmatively instruct the provider not to bill my health insurance and forward the billing to my attorney to be paid from settlement resulting from the personal injury suffered on _____.

In addition, I understand that prior authorization may be required or the account may become stale dated and the provider will not be able to bill the health insurance, therefore any future disclosure of health insurance coverage to _____ or its assignee will not be considered.

Dated this _____ day of _____, 20____

_____
Patient Signature

_____
Patient Name (PLEASE PRINT)

AUTO INJURY CENTERS, INC.
2931 N Tenaya Way Suite 106
Las Vegas, NV 89128
Phone (702) 822-1212
Fax (702) 839-0964

ATTENTION PARENTS, GUARDIANS & GUESTS

To ensure the highest quality of care to all of our patients, children may not be left unattended in the hallways, bathroom, therapy area, or exam rooms.

If small children accompany you to your appointment, please provide adult supervision (other than yourself) during your appointment.

If your child is able to sit quietly on their own in the front waiting area they are welcome to watch children's programming while you receive your treatment.

Therapy is a time for our patients to relax as most of our patients are suffering from pain. In order to respect the courtesy of others, nobody other than the treating patient will be allowed in the therapy area.

Thank You

SIGNATURE OF PATIENT: _____

PRINTED NAME: _____

DATE: _____

Treating Doctor: DR. TERRY AKERS

MEMBER NAME: _____

MEMBER SS#: _____

PATIENT NAME: _____

PATIENT DOB: _____

Please indicate by checking yes or no if you have health benefits (insurance) available through the H.E.R.E.I.U./Culinary/ABPA Fund.

_____ YES _____ NO

The following are covered under the plan:

Local 226	Culinary
Local 369	Musicians
Local 165	Bartenders
Local 720	Stage Hands

Signature: _____ Date: _____

AUTO INJURY CENTERS, INC.
2931 N. Tenaya Way, Suite 106
Las Vegas, NV 89128

Dr. Terry Akers
Chiropractic Physician

Tel (702) 822-1212
Fax (702) 839-0964

DOCTOR'S LIEN

TO: Attorney/Insurance Carrier

_____
_____
_____
_____

RE: Patient records and doctor's lien

I do hereby authorize the above doctor to furnish you, my attorney/insurance carrier with a full report of his case history, examination, diagnosis, treatment, and prognosis of myself in regard to my accident/illness which occurred /began on _____.

I hereby give a lien to said doctor on any settlement, claim, judgment, or verdict as a result of said accident/illness, and authorized and direct you, my attorney/insurance carrier, to pay directly to said doctor such sums from such settlement, claim, judgment, or verdict as may be necessary to protect said doctor adequately.

I fully understand that I am directly and fully responsible to said doctor for all chiropractic bills submitted by him for services rendered me, and that this agreement is made solely for said doctor's additional protection and in consideration of his awaiting payment. And I further understand that such a payment is not contingent on any settlement, claim, judgment, or verdict by which I may eventually recover said fees.

_____ Date_____
Patient Signature

_____Date_____
Patient Name (Please Print)

The undersigned, being attorney of record or authorized representative of insurance carrier for the above patient does hereby acknowledge receipt of the above lien, and does agree to honor the same to protect adequately said above named doctor.

_____Date_____
Authorized Signature

NOTICE: Please date, sign and return original to above doctor's office.

AUTO INJURY CENTERS, INC.
2931 N. Tenaya Way, Suite 106
Las Vegas, NV 89128

Dr. Terry Akers
Chiropractic Physician

Tel (702) 822-1212
Fax (702) 839-0964

DOCTOR'S LIEN

TO: Attorney/Insurance Carrier

_____
_____
_____
_____

RE: Patient records and doctor's lien

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Patient Signature

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_____Date_____
Authorized Signature

NOTICE: Please date, sign and return original to above doctor's office.

Auto Injury Centers, Inc.

Dr. Terry Akers
CHIROPRACTIC PHYSICIAN

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

This is to authorize that medical information regarding: _____
Patient Name

_____ _____
Social Security # Date of Birth

Be forwarded from: _____
Physician or Facility Name Phone/Fax

_____
Street Address City State Zip

To: Auto Injury Centers, Inc.
2931 N. Tenaya Way, Ste. #106
Las Vegas, NV 89128
Phone: (702) 822-1212
Fax (702) 839-0964

Information Requested:

- ☐ X-Rays (type) _____ (date taken) _____
- ☐ X-Ray/ MRI Reports _____
- ☐ Copies of chart notes _____
- ☐ Laboratory/Pathology reports _____
- ☐ EMG or other special reports _____
- ☐ Billing & Full Records _____
- ☐ All Available/ other _____

_____ _____ _____
Date Authorizing signature Relationship to patient