



Dr. Donald Shiflet
Chiropractic Physician

The Back Alley Chiropractic & Massage
10515 N Oracle Rd Ste 167, Oro Valley AZ 85737 ♦ Phone (520) 877-2666 ♦ Fax (520) 877-9183
Email: thebackalleychiro@yahoo.com ♦ Website: backalleychiropractic.com

PERSONAL INJURY INTAKE & QUESTIONNAIRE

Please take the time to complete these forms to the best of your ability. If you have any questions we will be glad to help you.

Patient Full Name _____ Gender: Male Female

Home Address _____

City _____ State _____ Zip Code _____

Billing Address _____

City _____ State _____ Zip Code _____

Email Address _____

Home Phone _____ Cell Phone _____

Employer _____ Work Phone _____

Date of Birth _____ / _____ / _____ Social Security Number _____ - _____ - _____

Spouse's Name _____ Phone # _____

Emergency Contact _____ Phone # _____

Primary Care Physician _____ Phone # _____

Name of person, place, or physician who referred you so that we may thank them _____

To the best of my ability, the information I have supplied is complete and truthful. At any time, I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and may be released. I grant permission to be called or emailed to confirm or reschedule an appointment and to be sent occasional cards, letters or emails as an extension of my care in this office.

Patient or Guardian Signature _____ Date _____

ACKNOWLEDGEMENT OF HIPAA PRIVACY NOTICE

I, _____, have received a copy of this office's Notice of Privacy Practices. I understand that this information can and will be used to:

- ♦ Conduct, plan and direct my treatment and follow-up among health care providers who may be directly and indirectly involved in providing my treatment
- ♦ Obtain payment from third party payers
- ♦ Conduct normal health care operations such as quality assessments and accreditation

Patient or Guardian Signature _____ Date _____

CONSENT TO TREATMENT OF A MINOR

I, _____, hereby authorize The Back Alley Chiropractic clinic/doctor/assistants to administer chiropractic treatment as deemed necessary to my son/daughter/legal dependent _____.

This authorization shall remain effective until _____ / _____ / _____, unless sooner revoked in writing.

Patient or Guardian Signature _____ Date _____

COVERAGE INFORMATION

Self Pay Health Insurance Auto Insurance (MEDPAY) Third Party Auto Insurance Attorney

Health Insurance Company _____

Member ID # _____ Group # _____

Policy Holder Name _____ Date of Birth _____

Policy Holder Mailing Address _____

Your Auto Insurance Company _____

Policy # _____ Claim # _____

Adjustor Name _____ Phone # _____

Third Party Auto Insurance Company _____

Policy # _____ Claim # _____

Adjustor Name _____ Phone # _____

Attorney Name _____

Firm Name _____ Phone # _____

- I authorize the release of any medical or other information necessary to process my claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
- I authorize payment of medical benefits to The Back Alley Chiropractic and its physicians or supplier for services received.

Print Patient Name _____

Patient or Guardian Signature _____ Date _____

INFORMED CONSENT FOR CHIROPRACTIC TREATMENT

I hereby request and consent to the performance of chiropractic treatment (also known as CMT, chiropractic adjustments or chiropractic manipulative treatment) and any other associated procedures; physical examination, tests, diagnostic x-rays, physiotherapy, physical medicine, physical therapy procedures, etc. on me by the doctor of chiropractic named and/or other assistants and/or licensed practitioners.

I understand, as with any health care procedure, that there are certain complications that may arise during CMT. Those complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, Horner’s Syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to complications including stroke.

I do not expect the doctor to be able to anticipate all risks and complications and I wish to rely upon the doctor to exercise judgment during the course of the procedure(s) which the doctor feels at the time, based upon facts known, are in my best interest. I have had the opportunity to discuss nature, purpose and risks of chiropractic treatment and other recommended procedures with the doctor and/or with office staff and/or clinic personnel.

I have read, or have had read to me, the above explanation of the CMT. I state that I have been informed and weighed the risks involved in CMT. I have decided that it is in my best interest to receive CMT. I hereby give my consent to that treatment. I intend for this consent to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

Patient or Guardian Signature _____ Date _____

Arizona Revised Statute §20-263

(Patient information for personal injury regarding MEDPAY use)

Arizona Revised Statutes, Title 20 Insurance, Chapter 2 Transaction of Insurance Business, Article 2 Kinds of Insurance; Reinsurance; Limits of Risk, 20-263 vehicle insurance; prohibited act by insurer; hearing; penalty:

A. No insurer shall increase the motor vehicle insurance premium of an insured as a result of an accident not caused or significantly contributed to by the actions of the insured. Any insurer which increases the premium as a result of accident involvement shall notify the insured of the reason for such increase.

B. The director, after a hearing, shall order an insurer that has raised the premium of an insured in violation of subsection A to refund the amount attributable to such premium increase and shall impose a civil penalty not to exceed three hundred dollars. In determining whether an insurer has violated subsection A, the director may conduct such investigation as he deems necessary and the costs shall be paid by the insurer pursuant to section 20-159.

ACCIDENT INFORMATION

Date of Accident _____ Time _____ AM / PM (circle one)
Address/Intersection _____ City, State _____
In your own words, describe ***in detail*** how the accident occurred _____

Were you the Driver Front passenger Rear passenger Pedestrian
What direction were you traveling? North South East West
Did your car hit the other vehicle? Yes No Did the other vehicle hit your car? Yes No
If applicable, were you struck from Front Behind Driver side Passenger side
Were you Aware of the approaching impact Surprised by the impact
Is there a police/accident report? Yes No Were any traffic citations issued? Yes No
If applicable, citations were issued to You Driver of your car Driver of the other vehicle
Did you go to the hospital? Yes No -If yes, name of hospital _____
Have you lost time from work? Yes No -If yes, dates missed _____
Was your vehicle a rental car? Yes No Was your vehicle a work car? Yes No
Make/model of your car _____ Make/model of the other vehicle _____
Were you wearing your seatbelt? Yes No Did you lose consciousness? Yes No
Did your head hit anything? Yes No -If yes, what _____
Did your neck hit anything? Yes No -If yes, what _____
Did your chest hit anything? Yes No -If yes, what _____
Did your knees hit anything? Yes No -If yes, what _____
Did your feet hit anything? Yes No -If yes, what _____
How was your head positioned during the accident? _____
How was your torso positioned during the accident? _____
How were your hands positioned during the accident? _____

Please check any symptoms you have noticed since the accident

<input type="checkbox"/> Anxiety	<input type="checkbox"/> Back pain	<input type="checkbox"/> Blurred vision	<input type="checkbox"/> Chest pain	<input type="checkbox"/> Cold sweats
<input type="checkbox"/> Depression	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Fainting	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Fever
<input type="checkbox"/> Headache	<input type="checkbox"/> Hearing loss	<input type="checkbox"/> Irritability	<input type="checkbox"/> Loss of balance	<input type="checkbox"/> Loss of memory
<input type="checkbox"/> Loss of smell	<input type="checkbox"/> Loss of taste	<input type="checkbox"/> Neck Pain	<input type="checkbox"/> Neck stiff	<input type="checkbox"/> Nervousness
<input type="checkbox"/> Numbness	<input type="checkbox"/> Painful joints	<input type="checkbox"/> Pins and needles	<input type="checkbox"/> Ringing in ears	<input type="checkbox"/> Short of breathe
<input type="checkbox"/> Sleeping problems	<input type="checkbox"/> Tension	<input type="checkbox"/> Upset stomach		

Print Patient Name _____

Patient or Guardian Signature _____ Date _____

HEALTH HISTORY

Illnesses Please check any illnesses that you've **had** OR currently **have**

- | | | | | |
|---|------------------------------------|--|---|---------------------------------------|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Allergies | <input type="checkbox"/> Cancer | <input type="checkbox"/> Chicken pox/shingles | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Gout | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> HIV positive |
| <input type="checkbox"/> Multiple sclerosis | <input type="checkbox"/> Stroke | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Typhoid fever | |

Review of Systems Please check any condition that you've **had** OR currently **have**

- | | | | | |
|--|--|--|---|---|
| <input type="checkbox"/> Angina | <input type="checkbox"/> Anorexia | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Back problems | <input type="checkbox"/> Blurred vision | <input type="checkbox"/> Chronic ear infection | <input type="checkbox"/> Constipation | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Elbow/wrist pain | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Excessive bruising |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Food sensitivities | <input type="checkbox"/> Foot/ankle pain | <input type="checkbox"/> Frequent infection |
| <input type="checkbox"/> Hair loss | <input type="checkbox"/> Hay fever | <input type="checkbox"/> Headache | <input type="checkbox"/> Hearing loss | <input type="checkbox"/> Heartburn |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Hip disorders | <input type="checkbox"/> Immune disorders | <input type="checkbox"/> Kidney stones |
| <input type="checkbox"/> Knee injury | <input type="checkbox"/> Loss of smell | <input type="checkbox"/> Loss of taste | <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Low energy |
| <input type="checkbox"/> Neck pain | <input type="checkbox"/> Numbness | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Pins and needles | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Poor appetite | <input type="checkbox"/> Poor circulation | <input type="checkbox"/> Poor posture | <input type="checkbox"/> Prostate issues | <input type="checkbox"/> Ringing in ears |
| <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Shoulder problems | <input type="checkbox"/> Skin cancer | <input type="checkbox"/> Swollen glands | |
| <input type="checkbox"/> Thyroid issues | <input type="checkbox"/> TMJ issues | | | |

Operations Please check any operations that you've ever **had**

- | | | | | |
|---|---|---|---|--------------------------------------|
| <input type="checkbox"/> Appendix removal | <input type="checkbox"/> Bypass surgery | <input type="checkbox"/> Cosmetic surgery | <input type="checkbox"/> Elective surgery | <input type="checkbox"/> Eye surgery |
| <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Spine | <input type="checkbox"/> Tonsillectomy | |

Treatments Please check the treatments you've received in the **past** OR are **currently** receiving

- | | | | | |
|--|--------------------------------------|--|--|---------------------------------------|
| <input type="checkbox"/> Acupuncture | <input type="checkbox"/> Antibiotics | <input type="checkbox"/> Birth control pills | <input type="checkbox"/> Blood transfusion | <input type="checkbox"/> Chemotherapy |
| <input type="checkbox"/> Chiropractic care | <input type="checkbox"/> Dialysis | <input type="checkbox"/> Dietary supplements | <input type="checkbox"/> Herbs | <input type="checkbox"/> Homeopathy |
| <input type="checkbox"/> Hormone replacement | <input type="checkbox"/> Inhaler | <input type="checkbox"/> Massage therapy | <input type="checkbox"/> Physical therapy | <input type="checkbox"/> Other _____ |

Social History Please tell the doctor about your health habits

- | | | |
|----------------|--|-----------------|
| Alcohol use | <input type="checkbox"/> Daily <input type="checkbox"/> Weekly | How much? _____ |
| Coffee use | <input type="checkbox"/> Daily <input type="checkbox"/> Weekly | How much? _____ |
| Exercise | <input type="checkbox"/> Daily <input type="checkbox"/> Weekly | How much? _____ |
| Pain relievers | <input type="checkbox"/> Daily <input type="checkbox"/> Weekly | How much? _____ |
| Soft drinks | <input type="checkbox"/> Daily <input type="checkbox"/> Weekly | How much? _____ |
| Tobacco use | <input type="checkbox"/> Daily <input type="checkbox"/> Weekly | How much? _____ |
| Water intake | <input type="checkbox"/> Daily <input type="checkbox"/> Weekly | How much? _____ |

To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern. Inaccurate information could be dangerous to my health. If there is any change in my medical status I will notify the chiropractor immediately. I authorize the chiropractor and staff to perform any necessary services needed during diagnosis and treatment.

Print Patient Name _____

Patient or Guardian Signature _____ Date _____

OFFICE POLICY

Appointments

We value the time we have set aside to see you. The Back Alley Chiropractic is a multiple provider office and we must often schedule overlapping appointments according to the service requested and depending on the treatment required.

Walk-ins are **always** welcome, however, appointments will be seen first.

If you are late for your appointment, we will do our best to accommodate you.

We strive to minimize wait time, however, emergencies do occur and will take priority over a scheduled visit. We appreciate your understanding.

If you have not been seen in our office in 6 months or longer, or if you have a new or different injury, a re-exam will be carried out and charged to you or your insurance carrier. If you have not been seen in our office in 3 years or longer, you are considered a new patient.

Self-Pay Patients

We welcome patients whose insurance companies are out-of-network, do not provide chiropractic benefits, or are uninsured.

All payments are to be paid in full at the time services are rendered.

Insurance **cannot** be used when opting for a pay-at-time-of-service discount.

FINANCIAL POLICY

Payment We accept cash, check, and debit, Visa, MasterCard and Discover. There is a minimum fee of \$25 charged for returned checks.

Insured By request, as a courtesy to our patients, we will submit your medical claim to your insurance carrier. Patient balances are billed immediately upon receipt of your carriers EOB. Your remittance is due immediately upon receipt of our bill.

Self-Pay We offer a pay-at-time-of-service discount for all patients. If you fail to provide payment at the time services are rendered, you will be responsible for and billed for 100% of the professional fee.

Delinquent Accounts Unpaid balances are past due at 30 days. Balances left unpaid may receive a second and third notice prior to final notice, mailed at 30-day intervals. The Back Alley utilizes an outside collection agency. Balances over 120 days past due may be submitted to our collection agency.

Medicare We accept Medicare assignment. As a Medicare patient you are responsible for your deductible and co-insurance. If you have secondary or supplemental insurance we will bill it for you. Medicare non-covered services are due at the time of service.

Workers Compensation If you are here as a result of a work related injury; we will require information regarding your health insurance and your employers Workers Compensation insurance.

Personal Injury Claims We bill third party insurance carriers **only** on a lien basis. Please notify our staff of your personal injury immediately. You will be asked to complete forms specific to personal injury as well as a consent and notice for medical lien.

INSURANCE POLICY & PROCEDURES

The Back Alley Chiropractic fully complies with all our insurance contracts. It is not our custom to balance bill amounts not allowed by your insurance policy. It is your responsibility to update us with your current insurance information. **If you fail to notify us of a change in carrier, termination of coverage, and/or exceeded benefits, you will be 100% responsible for payment per your insurance policy's allowable amount.**

The Back Alley Chiropractic strives to contract with all local insurance plans. In special cases this may not be possible. Out-of-network coverage often requires a referral or pre-authorization by a Primary Care Physician (PCP). **It is your responsibility to know if a referral or pre-authorization is required to see specialists.** If a referral is required, it is up to you to arrange the submission per your insurance carrier by your PCP. If a referral is not received, you will be 100% responsible for payment.

The Back Alley Chiropractic does its best to verify and interpret your benefits and eligibility with regard to chiropractic and therapeutic procedures. Occasionally we are given incorrect information and can make mistakes. You are responsible for balances owed if your Explanation of Benefits (EOB) shows a different amount owed from your verification. **Any questions about balances owed should be directed to your insurance carrier's member services.**

According to your insurance carrier, you are responsible for co-pays, deductibles and/or co-insurances. **Co-pays, deductibles and/or co-insurances are fees that cannot be waived or discounted.** You will be responsible for your portion of the bill, which is due at the time of service, unless other arrangements have been requested in advance.

If your insurance carrier is to be billed prior to payment collection, once we receive an EOB from your insurance carrier an itemized bill will be sent to you with any balance owed per your insurance plan.

Any insurance you may have is an agreement between you and your insurance carrier and you are financially responsible for the payment of any services rendered. According to your insurance carrier, verification of benefits is not a guarantee of payment and final determination will be made for payment **after** a claim is received.

The Back Alley is committed to providing the best treatment for our patients. Our professional fees are usual and customary per local state and federal rate tables.

I have read and understand the above policies and agree to accept responsibility for any and all payment(s) due as outlined.

Print Patient Name _____

Patient or Guardian Signature _____ Date _____



Dr. Donald Shiflet
Chiropractic Physician

The Back Alley Chiropractic & Massage
10515 N Oracle Rd Ste 167, Oro Valley AZ 85737 ♦ Phone (520) 877-2666 ♦ Fax (520) 877-9183
Email: thebackalleychiro@yahoo.com ♦ Website: backalleychiropractic.com

PATIENT CONSENT FOR NOTICE AND CLAIM OF MEDICAL LIEN

Patient Full Name _____

Date of Accident _____ Claim # _____

State of Accident _____ Provider _____

I, _____ (Patient), the undersigned, hereby consent to examination, treatment, procedures and services performed by any and all providers at The Back Alley Chiropractic and Massage (Provider), including emergency treatment.

Patient hereby authorizes, _____ (Attorney), (if applicable) to keep Provider advised of the progress of Patient's court case at reasonable intervals. Patient further authorizes and directs Attorney to pay Provider directly any sums due for medical services rendered to Patient. Patient directs Attorney to withhold such funds from any settlement, claim, judgment, verdict or result of said claim. Patient hereby notifies Attorney that Patient is giving Provider a lien on these benefits or settlement proceeds.

Patient understands that a copy of the Notice and Claim of Medical Lien will be filed with the Pima County recorder Office pursuant to A.R.S. §33-932. In consideration for Provider having agreed to treat me without payment at the time of service, this lien is irrevocable and can only be satisfied by full payment of all sums due for medical services rendered. Patient authorizes Provider to notify Attorney of this lien at Provider's discretion. Patient understands that any settlement, claim, judgment or verdict proceeds cannot be disbursed to Patient without first satisfying this lien.

Should a dispute arise regarding payment of Provider's charges, Patient authorizes and directs Attorney to hold in escrow all monies sufficient to satisfy this lien until the dispute can be resolved. Patient acknowledges that it would be a violation of Attorney's ethical duties to disburse the disputed funds prior to resolution of the lien dispute.

Patient understands and agrees that even though this lien has been given, Patient remains personally responsible for payment in full of Provider's fees for all services rendered. Patient is solely responsible to make appropriate arrangements for payment of such fees, including but not limited to insurance benefits. Patient acknowledges that this obligation to pay Provider's fees is not dependent on the outcome of Patient's court case.

I, the undersigned, understand that if the settlement, claim, judgment or verdict does not cover my entire bill at The Back Alley Chiropractic and Massage, I am still responsible for the remainder and payment of the charges. The bill is not contingent on any settlement, claim or judgment which I may eventually recover.

Patient or Guardian Signature _____ Date _____

----- Attorney's Acceptance of Provider's Lien -----

Being the attorney of record or authorized representative, I acknowledge receipt of my client's consent to Notice and Claim of Medical Lien and agree to honor the same.

Attorney Name _____

Attorney Signature _____ Date _____

Firm Name _____

Phone # _____ Fax # _____

Mailing Address _____