WOODS CHIROPRACTIC AND FUNCTIONAL MEDICINE
106 BROWNS LANE, LOUISVILLE, KY 40207
502-893-0757

Patient's First Name_____ Middle_____ Last_____ Date _____

Address _____ City _____ Zip Code _____

Home Phone _____ Cell Phone_____

E-mail _____ Social Security # _____

Employer Name _____

Job Title _____ Work Phone # _____

Date of Birth _____ Age____ Gender ☐ Male ☐ Female Handedness? R L

Weight_____ Height _____ Marital Status S M W D

Spouse's Name_____ Spouse's Date of Birth _____

Person responsible for this account_____

Health Insurance Company _____ Phone number_____

Policy/Member ID #_____ Group #_____

Address _____ City _____ Zip Code _____

Adjuster _____ Phone Number _____

Name of the insurance card hold_____ Social Security # of card holder _____

Name of their employer_____ Employer Phone #_____

Children names and ages_____

Car Insurance Company _____

Address _____ City _____ Zip Code _____

Adjuster _____ Phone #_____

Agent _____ Phone # _____

Policy # _____ Claim # _____

Drivers License # _____ State of Accident: _____

Name of Insured on your Car Policy _____ Date of Loss/Accident? _____

Medical Coverage? _____ Uninsured Motorist Coverage? _____

Underinsured Motorist Coverage?_____

Personal Injury Protection (PIP) Y N $_____

Medical expenses to date as a result of the accident? $_____

Lost wages since accident $_____

What is the repair amount of your car? $ _____

Lawyer/ Law Firm_____ Phone #_____

Address _____City _____Zip Code _____

In case of emergency, whom should we contact?_____

Phone #_____

Family physician_____ Phone #_____

Address_____ City_____ Zip Code_____

Date you first saw any Doctor after accident _____

Is this Workman's Compensation? _____Is this Personal Injury?_____

Have you received any medical treatment since your accident? Y N

Hospital_____Cost_____

Medical Doctor _____Cost_____

Chiropractor_____Cost_____

Other_____Cost_____

_____

_____

ACCIDENT QUESTIONNAIRE

Patient's Name_____ Date of incident _____Today's Date_____

DESCRIBE YOUR VEHICLE

1. **Vehicle Type** :
   a. Sports Car
   b. Coupe
   c. Sedan
   d. Sports Utility Vehicle
   e. Station Wagon
   f. Pick-up truck
   g. Bus
   h. Other: _____

   Make:_____ Year:_____
   Model:_____ Estimated Speed:_____
2. **Vehicle Size:**
   a. Compact
   b. Mid-Sized
   c. Full-Sized

DESCRIBE THE ACCIDENT

3. **Date of Accident:** _____
4. **Actions of patient's vehicle:**
   a. crossing an intersection
   b. stopped at an intersection
   c. stopped for a pedestrian
   d. stopped for traffic
   e. traveling at posted speed limit
   f. traveling faster than the posted speed limit
   g. turning
5. **How was the patient's vehicle hit:**
   a. hit head-on
   b. was hit on the left front
   c. was hit on the right front
   d. was hit on the left rear
   e. was hit on the right rear
   f. was rear-ended
   g. Other: _____
6. **Damage to patient's vehicle:**
   a. complete
   b. extensive
   c. minimal
   d. moderate
7. **Describe the second vehicle:**
   a. compact
   b. full size
   c. mid size
   d. semi trailer
   e. pick-up truck

   Make:_____ Year:_____
   Model:_____ Estimated Speed:_____
8. **Damage to the other vehicle?**
   a. complete
   b. extensive
   c. minimal
   d. moderate
9. **Weather Conditions**
   a. Clear
   b. Cloudy
   c. Drizzling
   d. Foggy
   e. Rainy
   f. Snowy
   g. Stormy
   h. Sunny
10. **Road Conditions**
    a. Damp
    b. Dry
    c. Dry with icy patches
    d. Iced over
    e. Snowed over
    f. Wet

DESCRIBE THE MOMENT OF IMPACT

11. **Body position at time of impact:**
    a. leaning forward
    b. slouched down in seat
    c. straight
    d. turned to the left
    e. turned to the right
12. **Direction body was thrown:**
    a. backward then forward
    b. forward then backward
    c. to the left
    d. to the right
    e. about the vehicle
    f. outside the vehicle
    g. under the vehicle
13. **Head position at impact:**
    a. straight
    b. tilted forward
    c. turned to the left
    d. turned to the right
14. **Direction head was thrown:**
    a. backward then forward
    b. forward then backward
    c. side to side
15. **Type of restraint:**
    a. lap belt
    b. shoulder belt
    c. shoulder lap belt
16. **Place patient was seated in the vehicle:**
    a. Driver
    b. front passenger
    c. back passenger driver side
    d. back passenger right side
    e. back passenger middle
    f. other_____
17. **Did Airbags deploy:**
    a. yes
    b. no
18. **Were you seen at a Medical Facility following your accident:**
    a. Yes
    b. No
    If so name and address of the facility:

_____

_____

Patient Signature _____

SYMPTOMS

Patient's Name_____ Date of incident _____Today's Date_____

CIRCLE ALL YOU COMPLIANTS

3. DO YOU HAVE LACERATIONS, CUTS OR BRUISING? :
   a. Head or Face
   b. Neck
   c. Seat belt bruising
   d. Cuts or bruising on your chest
   e. Cuts or bruising on arms
   f. Cuts or bruising on legs
   g. Other: _____

4. HEAD INJURIES: (now or at the time of the accident)
   a. Were you knocked out or unconscious
   b. Headaches
   c. Face pain
   d. Pupils different sizes
   e. Dizziness
   f. Difficulty walking
   g. Balance problems
   h. Room spins
   i. Disoriented Confusion
   j. Day dreaming
   k. Attention problems
   l. Hearing problems
   m. Change in sense of smell or taste
   n. Difficulty speaking
   o. Memory problems
   p. Very tired or fatigued
   q. Appetite change
   r. Sleep difficulties
   s. Visual Disturbances, blurry or double vision
   t. Flashbacks to accident
   u. Problems to read or write
   v. Problems adding or subtracting
   w. Problems learning new things
   x. Problems understanding
   y. Problems remembering numbers
   z. Difficulty Concentrating
   aa. Difficulty remembering things
   bb. Difficulty making decisions
   cc. Change in Sexual Functioning
   dd. Nausea / Vomiting
   ee. Change of personality
   ff. Wanting to be alone
   gg. Mood swings
   hh. Sadness
   ii. Agitation
   jj. Anger
   kk. Helplessness
   ll. Reduce confidence
   mm. Apathy
   nn. Irritability
   oo. Sleepiness
   pp. Frustration
   qq. Impatience
   rr. Other head related issues

   _____

5. JAW PROBLEMS:
   a. Jaw pain
   b. Clicking
   c. Pain while chewing
   d. Pain while talking
   e. Pain while yawning
   f. Pain while moving jaw from side to side

6. NECK INJURIES:
   h. Neck pain
   i. Neck pain, numbness, tingling, weakness that radiates or goes down to RIGHT shoulder, arm, forearm or hand
   j. Neck pain, numbness, tingling, weakness that radiates or goes down to LEFT shoulder, arm, forearm or hand
   k. Neck pain, numbness, tingling, weakness that radiates or goes down to RIGHT UPPER BACK
   l. Neck pain, numbness, tingling, weakness that radiates or goes down to LEFT UPPER BACK
   m. Neck pain that causes headaches
   n. Neck spasms or shoulder spasms
   o. Popping, clicking or clunking sound with neck movement

7. SHOULDER INJURIES
   h. Shoulder pain LEFT RIGHT BOTH
   i. Shoulder pain with movement L R BOTH
   j. Shoulder spasms LEFT RIGHT BOTH
   k. Sharp shoulder pain
   l. Dull shoulder pain
   m. Achy shoulder pain
   n. Pins and needles shoulder pain
   o. Shoulder pain that radiates or shoots pain into arm
   p. Other:

_____

8. UPPER ARM PAIN: RIGHT LEFT BOTH
   e. Dull
   f. Ache
   g. Sharp
   h. Stabbing
   i. Other

_____

9. ELBOW PAIN: RIGHT LEFT BOTH
   a. Dull
   b. Ache
   c. Sharp
   d. Stabbing
   e. Other

_____

10. FOREARM: RIGHT LEFT BOTH
   a. Dull
   b. Ache
   c. Sharp
   d. Stabbing
   e. Other

_____

11. WRIST PAIN: RIGHT LEFT BOTH
   a. Dull
   b. Ache
   c. Sharp
   d. Stabbing
   e. Other

_____

12. HAND PAIN: RIGHT LEFT BOTH
   a. Dull
   b. Ache
   c. Sharp
   d. Stabbing
   e. Other

_____

13. MID BACK PAIN OR UPPER BACK PAIN
   a. Upper or mid back pain
   b. Upper back pain, numbness, tingling, weakness that radiates or goes down to RIGHT shoulder, arm, forearm or hand
   c. Upper back pain, numbness, tingling, weakness that radiates or goes down to LEFT shoulder, arm, forearm or hand
   d. Upper or mid back spasms

14. LOW BACK PAIN:
   a. Low back pain
   b. Low back pain, numbness, tingling, weakness that radiates or goes down to RIGHT buttock, thigh, leg or foot
   c. Low back pain, numbness, tingling, weakness that radiates or goes down to LEFT buttock, thigh, leg or foot
   d. Low back spasms

15. PELVIC OR SACRAL PAIN
   a. Pelvic pain, numbness, tingling, weakness that radiates or goes down to RIGHT buttock, thigh, leg or foot
   b. Pelvic pain, numbness, tingling, weakness that radiates or goes down to LEFT buttock, thigh, leg or foot
   c. Sacral pain (tail bone)
   d. Coccygeal or coccyx (tail bone) pain

16. HIP PAIN: RIGHT LEFT BOTH
   a. Hip pain
   b. Hip pain, numbness, tingling, weakness that radiates or goes down to buttock, thigh, leg or foot

17. UPPER LEG PAIN: RIGHT LEFT BOTH
   a. Upper leg pain that radiates to knee
   b. Upper leg spasms

18. KNEE PAIN: RIGHT LEFT BOTH
    a. Knee pain that radiates to calf
    b. Knee pain that radiates to calf and ankle
    c. Knee pain that radiates to calf, ankle and foot
19. ANKLE PAIN: RIGHT LEFT BOTH
    a. Ankle pain that radiates to foot
    b. Ankle and foot pain
20. FOOT PAIN: RIGHT LEFT BOTH
21. CHEST PAIN
22. STOMACH PAIN
23. OTHER SYMPTOMS:

_____
_____
_____
_____

CERVICAL EXAM & EVALUATION (1 of 3 pages)

Patient's name_____ Date of Injury_____ Today's date_____

I observed the following neck difficulties during the exam:

☐ Slow Movements ☐ Holding Neck ☐ Turning Neck ☐ Tilting Neck ☐ Nodding Head

☐ Other _____

I ☐ observed ☐ did not observe abnormality of spine alignment today ☐ Single ☐ Multiple

Assistive devices ☐ are ☐ are not needed by this patient: _____

Positive General Neck Tests

☐ Compression ☐ for local pain on R L ☐ for Radicular Symptoms on ☐ R ☐ L

☐ Distraction ☐ for local pain on R L ☐ for relief or Radicular Symptoms on ☐ R ☐ L

☐ Asymmetrical ROM:

☐ Flex _____ Ext _____ R Lat _____ L Lat _____ R Rot _____ L Rot _____

☐ Other(s) _____

Motion Segment C4-5 (Nerve Root C5)

☐ Nerve Tension/Compression Signs: Spurling/Compression caused Anterolateral Shoulder

☐ Arm Radiculopathy on the ☐ R ☐ L

☐ Motor Deficit in ☐ Deltoid ☐ Biceps

☐ Sensory Deficit in ☐ Anterolateral Shoulder ☐ Upper Arm on the ☐ R ☐ L

☐ Reflex Compromise ☐ R Biceps ☐ Decreased ☐ Increased ☐ Absent

☐ L Biceps ☐ Decreased ☐ Increased ☐ Absent

☐ Atrophy Present ☐ R _____ ☐ L _____ measured mid-biceps

☐ AOMSI Present at C4-5 ☐ Non-verified ☐ Verified by ☐ Stress X-rays ☐ DMX/Fluoroscopy

☐ Translation Instability of _____% ☐ Angular of _____

☐ Disc Herniation present at C4-5 ☐ Non-Verified ☐ Verified by ☐ MRI ☐ CT

Motion Segment C5-6 (Nerve Root C6)

☐ Nerve Tension/Compression Signs: Spurling/Compression caused Lateral Forearm

☐ Hand/Thumb Radiculopathy on the ☐ R ☐ L

☐ Motor Deficit in ☐ Biceps ☐ Radial Wrist Extensors on the ☐ R ☐ L

☐ Sensory Deficit in ☐ Anterolateral Shoulder ☐ Upper Arm on the ☐ R ☐ L

☐ Reflex Compromise ☐ R Brachioradialis ☐ Decreased ☐ Increased ☐ Absent

☐ L Brachioradialis ☐ Decreased ☐ Increased ☐ Absent

☐ R Pronator teres ☐ Decreased ☐ Increased ☐ Absent

☐ L Pronator teres ☐ Decreased ☐ Increased ☐ Absent

CERVICAL EXAM & EVALUATION (2 of 3 pages)

Patient's name_____ Date of Injury_____ Today's date_____

☐ Atrophy Present ☐ R _____ ☐ L _____ measured mid-forearm

☐ AOMSI Present at C5-6 ☐ Non-Verified ☐ Verified by ☐ Stress X-Rays ☐ DMX/Fluoroscopy

☐ Translation Instability of _____% Angular of _____

☐ Disc Herniation Present at C5-6 ☐ Non-Verified ☐ Verified by ☐ MRI ☐ CT

Motion Segment C6-7 (Nerve Root C7)

☐ Nerve Tension/Compression Signs: Spurling/Compression caused ☐ Middle finger

☐ Radiculopathy on the ☐ R ☐ L

☐ Motor Deficit in ☐ Wrist Flexors ☐ Triceps ☐ Finger Extensors ☐ Ulnar Wrist Extensors on the ☐ R ☐ L

☐ Sensory Deficit in Middle Finger on the ☐ R ☐ L

☐ Reflex Compromise ☐ Triceps ☐ Decreased ☐ Increased ☐ Absent

☐ Atrophy Present ☐ R _____ ☐ L _____ measured mid-Triceps

☐ AOMSI Present at C6-7 ☐ Non-Verified ☐ Verified by ☐ Stress X-Rays ☐ DMX/Fluoroscopy

☐ Translation Instability of _____% Angular of _____

☐ Disc Herniation Present at C6-7 ☐ Non-Verified ☐ Verified by ☐ MRI ☐ CT

Motion Segment C7-T1 (Nerve Root T1)

☐ Nerve Tension/Compression Signs: Spurling/Compression caused ☐ Medial Forearm

☐ Hand (4^{th} & 5^{th} Fingers) Radiculopathy on the ☐ R ☐ L

☐ Motor Deficit in ☐ Finger Flexors ☐ Hand Intrinsics on the ☐ R ☐ L

☐ Sensory Deficit in ☐ Medial Forearm ☐ 4^{th} Finger ☐ 5^{th} Finger on the ☐ R ☐ L

☐ Atrophy Present ☐ R _____ ☐ L _____ measured mid-Forearm

☐ Translation Instability of _____% Angular of _____

☐ Disc Herniation Present at C7-T1 ☐ Non-Verified ☐ Verified by ☐ MRI ☐ CT

Motion Segment T1-2 (Nerve Root T2)

☐ Nerve Tension/Compression Signs: Spurling/Compression caused ☐ Medial Forearm

☐ Radiculopathy on the ☐ R ☐ L

☐ Motor Deficit in ☐ Hand Intrinsics on the ☐ R ☐ L

☐ Sensory Deficit in ☐ Medial on the ☐ R ☐ L

☐ Translation Instability of _____% Angular of _____

☐ Disc Herniation Present at T1-T2 ☐ Non-Verified ☐ Verified by ☐ MRI ☐ CT

CERVICAL EXAM & EVALUATION (3 of 3 pages)

Patient's name_____ Date of Injury_____ Today's date_____

This injury was caused by _____

Apportionment of Neck Impairment ☐ is ☐ is not necessary

Date of other neck injury for apportionment purposes _____

Impairment Class: ☐ No objective Findings ☐ Mild ☐ Moderate ☐ Severe ☐ Very Severe

I reviewed the following: ☐ Prior Medical Records ☐ X-Ray Films ☐ X-Ray Reports
☐ CT Films ☐ CT Reports ☐ MRI Films ☐ MRI Reports
☐ DMX Films ☐ DMX Reports ☐ EMG/NCV Reports
☐ Lab Results ☐ Other

New Clinical Studies performed today and considered in this evaluation:

☐ Neck X-Ray Films ☐ CT ☐ MRI ☐ EMG//NCV ☐ Lab work ☐ Other _____

I ☐ did ☐ did Not find inconsistencies between previous record and my exam findings

I ☐ did ☐ did Not find inconsistencies between patient's complaints and exam findings

I ☐ did ☐ did Not find inconsistencies between my observations, history, and/or exam

I ☐ did ☐ did Not find inconsistencies between symptoms reported and clinical studies

In my opinion, the reliability of exam findings today is _____%

In my opinion, the reliability of clinical studies correlation with symptoms reported is _____%

In my opinion, the reliability of clinical studies correlation with exam findings is _____%

In my opinion, the reliability of imaging reports compared to actual images is _____%

I ☐ did ☐ did Not examine and evaluate other areas of the spine today.

This patient's neck ☐ has ☐ has Not reached maximum Medical Improvement (MMI) today

Contributions of Spine Areas to Functional Disability today

Cervical _____% Thoracic _____% Lumbar _____% Pelvis _____%

Basic Diagnosis Categories for this patient's Cervical Spine today

☐ Non-Specific chronic or chronic recurrent spine pain

☐ IVD & Motion Segment Pathology ☐ Single level ☐ Multiple levels

☐ Stenosis

☐ Spine Fracture(s) or Dislocation(s)

BACK EXAM & EVALUATION (1 of 2 pages)

Patient's name_____ Date of Injury _____Today's Date_____

Area(s) examined today ☐ Upper Back ☐ Low Back ☐ Pelvis

I observed the following neck difficulties during the exam: ☐Slow movements ☐ Sitting

☐Rising from sitting to Standing ☐ Lowering from Standing to Sitting ☐Other _____

I ☐ did ☐did not observe gross abnormality of spine alignment today ☐ Single ☐Multiple

Assistive Devices ☐ are ☐ are not needed by this patient: _____

Positive General UPPER Back Tests

☐Soto Hall reproduced Thoracic Pain at (circle) T1 T2 T3 T4 T5 T6 T7 T8 T9 T10 T11 T12

☐Palpation elicited tenderness at T1 T2 T3 T4 T5 T6 T7 T8 T9 T10 T11 T12

☐Palpation revealed objective spasm(s) at T1 T2 T3 T4 T5 T6 T7 T8 T9 T10 T11 T12

☐Sensory Deficits confirmed in dermatomes T1 T2 T3 T4 T5 T6 T7 T8 T9 T10 T11 T12

☐Sensory Deficits include ☐ sharp/dull ☐ light touch ☐ hot/cold ☐ other _____

Positive General LOW Back Tests

☐Kemp's Test reproduced local facet pain at T12-L1 L1-2 L2-3 L3-4 L4-5 L5-S1 on R L

☐Milgram's Test reproduced back pain at T12-L1 L1-2 L2-3 L3-4 L4-5 L5-S1

☐Palpation elicited tenderness at T12-L1 L1-2 L2-3 L3-4 L4-5 L5-S1 on R L

☐Palpation revealed objective spasm(s) at T12-L1 L1-2 L2-3 L3-4 L4-5 L5-S1 on R L

Positive Nerve Stretch/Compression Tests

☐Kemp's Test reproduced radicular symptoms at T12-L1 L1-2 L2-3 L3-4 L4-5 L5-S1 on R L

☐Positive Straight Leg Raise reproduced radicular pain at ☐ 35-70 degrees

☐Braggard's Test confirmed and reproduced SLR radiculopathy on the ☐ R ☐ L

Positive General Pelvis Tests

☐FABERE Test reproduced joint pain at ☐ L SI ☐R SI ☐L Hip ☐ R Hip

☐Palpation elicited tenderness at ☐ over sacrum ☐ R ☐L ☐ Sciatic notch ☐ R ☐L

☐ Peritrochanter ☐ R☐ L ☐other_____

☐Palpation revealed spasms(s) ☐ over sacrum ☐ R ☐ L ☐ Sciatic notch ☐ R ☐ L

☐ Peritrochanter ☐ R☐ L ☐ other_____

BACK EXAM & EVALUATION (2 of 2 pages)

Patient's name_____ Date of Injury _____Today's Date_____

Motion Segment L3-4 (Nerve Root L4)

☐Motor deficit in Quadriceps

☐Sensory Deficit in ☐ Anterior Thigh ☐ Anterior Knee ☐ Medial leg/foot on the ☐ R ☐ L

☐Reflex Compromise ☐ R Patella ☐ Decreased ☐ Increased ☐ Absent

☐ L Patella ☐ Decreased ☐ Increased ☐ Absent

☐Atrophy Present ☐ R_____ ☐L_____ measured mid-thigh

☐AOMSI Present at L3-4 ☐ Non-Verified ☐Verified by ☐Stress X-Ray ☐ DMX/Fluoro

☐Translation Instability of _____mm Angular of _____

☐Disc Herniation Present at L3-4 ☐ Non-Verified ☐ Verified by ☐ MRI ☐ CT

Motion Segment L4-5 (Nerve Root L5)

☐Motor Deficit in extensor hallucis longus on the ☐ R ☐ L

☐Sensory Deficit in ☐ lateral thigh ☐anterolateral leg ☐ mid-dorsal foot on the ☐ R ☐L

☐Reflex Compromise ☐ R medial hamstrings ☐ Decreased ☐ Increased ☐Absent

☐ L medial hamstrings ☐ Decreased ☐ Increased ☐ Absent

☐Atrophy Present ☐ R_____ ☐ L_____ measured mid-calf

☐AOMSI Present at L4-5 ☐ Non-Verified ☐ Verified by ☐ Stress X-Ray ☐ DMX/Fluoro

☐Translation Instability of _____mm Angular of _____

☐Disc Herniation Present at L4-5 ☐ Non-Verified ☐ Verified by ☐ MRI ☐ CT

PATIENT AUTO/WORKER'S COMPENSATION INFORMATION SHEET

Patient Name: _____

Date of Accident/Injury/Loss: _____

AUTO ACCIDENT INSURANCE INFORMATION

If you have not completed an application of benefits from you auto carrier, you must do so for charges to be covered.

Auto Insurance Carrier: _____

Auto Insurance Carrier Phone #: _____ Ext. _____

Insurance Carrier Address: _____

_____

Claim Adjuster's Name: _____

Claim Number: _____

WORKER'S COMPENSATION INFORMATION

An accident report must have been filed with your employer for charges to be covered and a workers compensation form must also be completed. If our clinic is not part of your employer's worker's compensation panel, you may be required to go to a panel provider for and initial visit before requesting transfer of your case to this office. If you are unsure if we are part of your employer's panel, please ask a member of our staff for assistance.

Employer: _____

Employer's Phone #: _____ Ext. _____

Employer's Address: _____

_____

Human Resource Manager's Name: _____

Claim Number: _____

Patient: _____

Date of Accident: _____

I do hereby authorize Woods Chiropractic Health Center to furnish you, my attorney, with a full report of their examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I was recently involved.

I hereby authorize and direct you , my attorney, to pay directly to Woods Chiropractic Health Center such sums as may be due and owing them for medical services rendered me both by reason of this accident and by reason of any other bills that are due to their office and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect and compensate Woods Chiropractic Health Center. And I hereby further give a lien on my case to said doctors 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 fully understand that I am directly and fully responsible to Woods Chiropractic Health Center for all medical bills submitted by them for service rendered me and this agreement is made solely for said doctor's additional protection and in consideration of their awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

I agree to promptly notify said doctors of any change or addition of attorney(s) used by me in connection with this accident, and I instruct my attorney to do the same and to promptly deliver a copy of this lien to any such substituted or added attorneys(s).

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 doctors' interest, Woods Chiropractic Health Center will not await payment but may declare the entire balance due and payable.

Dated: _____ Patient`s Signature: _____

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 and fully compensate Dr. Thomas A. Woods Jr.. Attorney further agrees that in the event this lien is litigated that the prevailing party will be awarded attorney fees and costs.

Dated: _____ Attorney`s Signature: _____

PATIENT OFFICE POLICY

Woods Chiropractic and Functional Medicine, P.S.C | 106 Browns Lane Louisville, KY 40207 | (502) 893-0757

Patient-Doctor Agreements

The purpose of these agreements is to allow us to completely serve you and to get the best results in the shortest time possible. It is our experience that those who follow the following agreements get the best possible results.

Signing In

When you arrive, please sign in at the front desk (initials only please). You will be called and assigned a treatment room in the order that you signed in. Other patients may be called in before you because of the particular services being received that day. When you go to the assigned treatment room, place the folder in the door tray, rest, relax and he doctor will be in as soon as possible.

New Injuries

In the event that you sustain a new injury, please let the front desk as soon as possible. There may be additional paper work to be filed.

Appointments

After your visit, please stop at the front desk to make or confirm your next appointment. We have set up a specific course of treatment for you. A certain number of treatments in a set amount of time is necessary to obtain the best possible results we both desire. If you need to change a scheduled appointment, please reschedule your appointment for another time on the same day. If the same day is not possible, please be sure to make up the missed appointment within one week.

Missed appointments require a 24 hour notice. Missed appointments are subject to a cancellation fee which will be 35.00$ or higher depending on the charge of the services performed on the scheduled day. This is your responsibility and cannot be billed to your insurance company. Late arrivals need to note that precedence is given to patients who are on time for their scheduled appointment.

Progress Evaluations & Re-examinations

Progress evaluations &re-examinations will be performed periodically to determine your rate of progress and future course of treatment. A special time will be set up for your re-evaluation appointments.

_____ _____

NAME DATE

_____

SIGNATURE

FINANCIAL POLICY

Woods Chiropractic and Functional Medicine, P.S.C | 106 Browns Lane Louisville, KY 40207 | (502) 893-0757

We are committed to providing you with the best possible care. If you have medical insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policy.
Payment for your first day services are due in full at the time they are rendered. This may include charges for examination, x-rays and treatment. We accept cash, checks, Master Card or Visa. Following your examination we will discuss your charges with you.
If you have insurance, we will verify your individual coverage by your second visit so long as you provide us with a copy of your insurance card which must have a policy or group number and a phone number for us to call for verification. Upon obtaining the insurance company address we will bill the insurance company for all charges.

PAYMENT POLICY:

You must realize, however, that:

Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract. We will require payment upon each visit until your deductible is met. Once your deductible has been satisfied we will expect payment weekly of the percentage your insurance does not pay. This percentage usually ranges from 10% to 20%. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.

All co pays are due on the date of service. In case of deductibles and coinsurance, statements are sent out as soon as EOB's (Explanation of Benefits) are processed. Payments are due immediately. Our primary goal is health care and we endeavor to make the process of achieving optimum health as stress free as possible. If the patient experiences monetary constraint we do offer a payment plan of three consecutive payments which will be 30 days apart. The first payment is due immediately, the second is due 30 days later, and the third is due 30 days after that. If any payments are missed, interest of 21% will be charged on the entire amount and that balance will be due immediately.

We emphasize that as health care providers, our relationship is with you and not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we ask you to contact us immediately so we may assist in the management of your account.

I HAVE READ AND AGREE TO ABIDE BY THE ABOVE MENTIONED FINANCIAL POLICY AND FULLY UNDERSTAND ITS CONTENT.

_____ _____

NAME DATE

_____

SIGNATURE

PATIENT CONSENT FORM

Woods Chiropractic and Functional Medicine, P.S.C | 106 Browns Lane Louisville, KY 40207 | (502) 893-0757

I understand that, under the Health Insurance Portability and 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 been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact the organization at ant time at the address below to obtain a current copy of the *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.

_____ _____

NAME DATE

_____

SIGNATURE