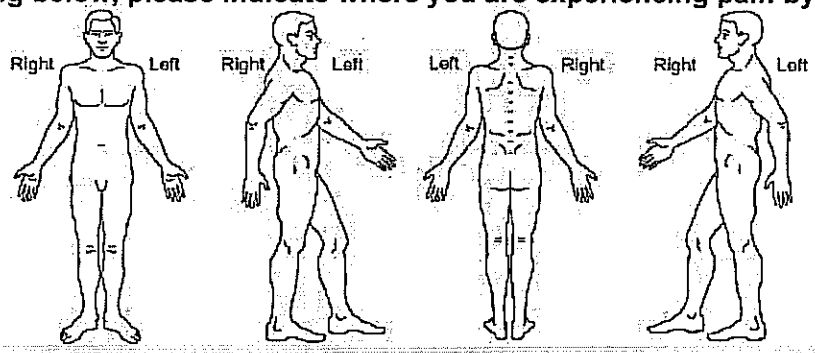
Patient Basic Information

Personal Information:

First Name:	Last Name:	Mid. Init.:
Address:	City, State, Zip:	
Cell Phone:	Work Phone:	Social Security #:
Date of Birth: Age: Martial Status:	Date of Injury/Onset:	Sex: Male / Female
Email Address:	Occupation:	
Employer's Name and Address:		
In case of emergency: Contact: _____ Relationship: _____	Phone #: _____ By signing, you are giving us authorization to contact this person X_____	What are your complaints?

On the drawing below, please indicate where you are experiencing pain by drawing an X.



DOCTORS USE ONLY:

What is your condition due to? A) Auto Accident, Date: _____ B) Work Injury, Date: _____ C) Other Accident (Specify) _____ D) Unknown

When did your pain start? _____ Since the date of accident, the symptoms are:

A) Improving B) Getting Worse C) About the same D) Come and go with activities

What reduces your complaints/pain? A) Rest B) Medications C) Hot/Cold Packs & Showers D) Other: _____

Have you seen any of the following for this condition? A) Chiropractor B) Medical Doctor C) Hospital D) Other: _____

Name: _____ Date Consulted: _____ Were X-Rays taken? (Y / N) Area: _____

Any fractures? : (Y / N) What were the findings of the examination? _____

Did any of the providers give you a disability slip for work? (Y / N) If yes, until what date? _____

Are you taking any medication(s)? (Y / N) Who prescribed it? _____

Name of medicines? _____ Did you take any today? (Y / N)

Are you currently under any doctor's care for any other conditions? (Specify what condition and the name of the doctor):

_____

Have you lost time from work or school due to these complaints? (Y / N) From: _____ to: _____

Female patients only: Are you pregnant? (Y / N) First day of Last Menstrual Period: _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. I authorize payment from my insurance carrier directly to this office with the understanding that all payments will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient's or Parent's Signature: _____ Date: _____

Automobile & Other Accident Description

Please **CIRCLE/WRITE** the answer to the questions below. If you do not know the answer to any of the questions, do not answer that question.

Print Name: _____

Briefly describe the accident: _____

_____

_____

1. Your Vehicle Type

Car Station Wagon
Mini Van Pickup Truck
SUV Bus
Other: _____
Type and year: _____
_____

2. Your position in vehicle

Driver Front Passenger
Left Rear Passenger
Right Rear Passenger
Mid Rear Passenger
Other: _____

3. What was your vehicle doing at the time of the accident?

Stopped at intersection Stopped in traffic Stopped at light
Making a right turn Making a left turn Parked
Proceeding along Slowing down Accelerating
Other: _____

4. Details of Accident

Date of Accident:
_____

Who hit who/what?
You hit other vehicle
Other vehicle hit you
You hit... (object): _____

5. Road Conditions/Point of Impact

Point of Impact
Head-On Driver's Side Passenger's Side Rear-End
Other: _____

Did air bags deploy? Yes No If yes, which side?: _____
Did your vehicle have a trailer hitch? Yes No

6. During the accident:

Did your body strike the inside of your vehicle? Yes No
If yes, describe: _____
Did you lose consciousness during the injury? Yes No
If yes, for how long?: _____
Were any of the vehicle windshields broken? Yes No
If so, which one?: _____
Were you shaken or shocked after the accident? Yes No
Were you cut or bruised? Yes No
If so, where?: _____

7. Emergency Room?

Where did you go after the accident?
Home Work Hospital ER Urgent Care Primary Doctor
Name of Hospital/Clinic: _____
How did you get there?
Drove self Somebody else Ambulance Police
Were X-Rays done? Yes No
Body parts X-rayed? _____
The X-rays revealed: _____
Medications: _____

8. Body Position, etc.: DOCTORS USE ONLY:

Did you see the accident coming? Yes No
Were you braced for the impact? Yes No
Did you have a seat belt on? Yes No
Did your head whip: Forward & Backward ,
Side to Side , Backward & Forward

What was the position of your headrest at the time of the impact?
Even with the top of head Even with the bottom of head Middle of head
What was the direction of your head at the time of the impact?
Facing straight forward Turned to the right Turned to the left
Other: _____
How were you holding the steering wheel at the time of the impact?
Both Hands Left Hand Right Hand None

If this was a slip & fall injury or pedestrian accident, describe: _____

_____

_____

Patient's or Parent's Signature: _____ **Date:** _____

TOTAL HEALTH FAMILY CLINIC

6521 Annapolis Rd.
Landover Hills, MD 20784

Tel: 301-322-7777
Fax: 301-322-5151

Authorization For Release Of Confidential Information

Patient Name: _____ Birthdate: _____

Address: _____ S.S.# _____

_____

*Please include: Doctor's Notes, Nurses Notes, X-ray results

I hereby authorize _____ to release to
(Hospital/Program/Doctor)

Total Health Family Clinic
6521 Annapolis Rd.
Landover Hills, MD 20784

the medical records only pertaining to the dates of _____, which I understand may include psychiatric information, drug and alcohol information, HIV information and/or other information of a sensitive nature.

I understand that this consent is voluntary and that I may revoke this authorization at any time (except to the extent that action based on this consent has already been taken) by written, dated, and signed communication to the hospital/program. This consent will expire one year from the date signed, unless otherwise stated as follows:

_____

I understand that I may refuse to sign this authorization. If I refuse, the identified records will not be disclosed. Whether I sign or refuse to sign, my treatment will not be affected.

_____ _____
Signature of Patient Date signed

_____ _____
Signature of Parent, Guardian, or Legal Representative Witness

If signed by other than patient, state relationship and reason for patient's inability to sign:

_____

_____

Verbal consent requires signature of two witnesses:

_____ _____
Signature of Witness Date Signature of Witness Date

Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and will no longer be protected by the Health Insurance Portability and Accountability Act

A copy of this authorization has been _____ accepted _____ rejected by the patient/representative.

TOTAL HEALTH FAMILY CLINIC

6521 Annapolis Rd.	5730-A Silver Hill Rd.	4701 Randolph Rd. Suite 101	8630 Fenton St. Suite 900
Landover Hills, MD 20784	District Heights, MD 20747	Rockville, MD 20852	Silver Spring, MD 20910
301-322-7777	301-735-5775	240-221-2666	240-670-8221
301-322-5151 Fax	301-735-3766 Fax	240-221-2667 Fax	240-670-8233 Fax

I hereby IRREVOCABLY authorize:

Insurance Company: _____

Claim Number: _____

To pay all the payments for **MEDICAL BILLS** at Total Health Family Clinic directly to them and not anyone else. **Please mail payments directly to their address and made payable to:**

TOTAL HEALTH FAMILY CLINIC
6521 ANNAPOLIS ROAD
LANDOVER HILLS, MD 20784

Patient or Parent Signature: _____ Date: _____

Parent or Guardian of: _____

TOTAL HEALTH FAMILY CLINIC

6521 Annapolis Rd.	5730-A Silver Hill Rd.	4701 Randolph Rd. Suite 101	8630 Fenton St. Suite 900
Landover Hills, MD 20784	District Heights, MD 20747	Rockville, MD 20852	Silver Spring, MD 20910
301-322-7777	301-735-5775	240-221-2666	240-670-8221
301-322-5151 Fax	301-735-3766 Fax	240-221-2667 Fax	240-670-8233 Fax

By signing below, I agree that I have heard and understand all the information provided on this page.

1. **Acknowledgment of Receipt of Notice of Privacy Practices:** I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

2. **Financial Responsibility:** It is understood that the statute of limitations in this state is three (3) years from the time services were performed. It is further understood that because of long delays in trial dockets, many cases are not tried or settled until a date that is beyond three (3) years after services were performed. In light of this possibility and in exchange for TOTAL HEALTH FAMILY CLINIC agreement to wait for payment until a verdict is rendered or a settlement is reached, I hereby agree to waive the defense of statute of limitations in the event that a claim is filed against me by reason of an unpaid bill, and I WILL NOT RAISE THE STATUTE OF LIMITATIONS AS A DEFENSE

   If for any reason I decided not to pursue this case or if my attorney drops me or I transfer my case to another attorney, I will immediately notify TOTAL HEALTH FAMILY CLINIC of the change.

   it is understood that I am responsible for the entire balance of my bill, regardless of the source of payment or the outcome of my case. TOTAL HEALTH FAMILY CLINIC expects payment of its fees for services rendered from the proceeds of any recovery. Balances are due and payable within thirty (30) days of any settlement or verdict. Interest at the rate of eighteen (18%) per annum will be assessed on any balance not paid within thirty (30) days of settlement or verdict. IF IT BECOMES NECESSARY TO PLACE THIS ACCOUNT IN COLLECTIONS, I AGREE TO BE RESPONSIBLE FOR REASONABLE ATTORNEY FEES EQUAL TO 25% OF THE UNPAID BALANCE, TOGETHER WITH ADDITIONAL COSTS AND EXPENSE OF COLLECTION TO THE EXTENT PERMITTED BY LAW.

3. **Release of Information to my attorney, other providers, and insurance companies:** I authorize this clinic to release any information, pertinent to my case to any insurance company, adjustor, my other providers, and attorney involved in this case; I hereby release this clinic of a consequence thereof.

4. **Power Of Attorney: I give my power of attorney to TOTAL HEALTH FAMILY CLINIC to endorse and/or negotiate checks made payable in my name from insurance companies and/or other entities in regards to services that were rendered to me by providers at TOTAL HEALTH FAMILY CLINIC. Such payments are intended for the benefit of TOTAL HEALTH FAMILY CLINIC.**

Patient's Name: _____ **Date:** _____/_____/_____

Patient's or Parent's or Guardian's Signature: _____

TOTAL HEALTH FAMILY CLINIC

6521 Annapolis Rd.
Landover Hills, MD 20784
301-322-7777
301-322-5151 Fax

5730-A Silver Hill Rd.
District Heights, MD 20747
301-735-5775
301-735-3766 Fax

4701 Randolph Rd. Suite 101
Rockville, MD 20852
240-221-2666
240-221-2667 Fax

8630 Fenton St. Suite 900
Silver Spring, MD 20910
240-670-8221
240-670-8233 Fax

PATIENT CONTRACT

We at **Total Health Family Clinic** would like to take this opportunity to welcome you to our facility and thank you for making us your healthcare provider. If you are happy with the services provided to you in our office, please take a couple of our brochures and business cards and refer your family friends and coworkers that may be in need of our services. Your referrals will be highly appreciated.

SCHEDULING: For us to deliver the best possible care, it is important that you arrive for your scheduled appointments on time. Not only does this make office run smoother, it also allows us to provide you with the attention you deserve. If you are unable to make it to a scheduled appointment, please contact our office as soon as possible **(preferably at least 24 hours in advance)** to reschedule. Prior to leaving the office, make sure you have scheduled your next appointment at the front desk. Be advised that if you show up unscheduled, we reserve the right to refuse treatment to you. We will, however, make an effort to see you.

INSTRUCTIONS:

1. Perform the Therapeutic Home Exercises as prescribed (number of repetitions, number of times per day,etc.) For your convenience, illustration pages will be provided when available.
2. Avoid activities that aggravate your symptoms (e.g. Prolonged sitting, standing, or walking).
3. Take medications as prescribed by the doctor.
4. Notify the clinic of any changes in your symptoms, including new complaints.
5. Notify the clinic of address or phone number changes.
6. Go to an emergency room immediately if any of the following symptoms occur:
   - sudden dizziness, blurred vision, or vomiting.
   - sudden weakness of your arms, hands, or legs.
   - sudden numbness, tingling, or loss of feeling in your arms or legs.

Thank you in advance for your cooperation.

By signing below you affirm that you have read and will abide by the terms set forth in this contract.

Signature_____ Date_____

TOTAL HEALTH FAMILY CLINIC

6521 Annapolis Rd.	5730-A Silver Hill Rd.	4701 Randolph Rd. Suite 101	8630 Fenton St. Suite 900
Landover Hills, MD 20784	District Heights, MD 20747	Rockville, MD 20852	Silver Spring, MD 20910
301-322-7777	301-735-5775	240-221-2666	240-670-8221
301-322-5151 Fax	301-735-3766 Fax	240-221-2667 Fax	240-670-8233 Fax

CONSENT TO CHIROPRACTIC EXAMINATION AND CARE

I hereby authorize Total Health Family Clinic ("the Practice") and its licensed doctors and assistants, based on my complaints and the history I have provided, to undertake an examination and provide an evaluation and treatment plan which may include chiropractic adjustments (provided manually or with the use of an instrument) and other tests and procedures considered therapeutically appropriate. I also wish to rely on the Practice doctors to make those decisions about my care, based on the facts then known, that they believe are in my best interest.

The nature and purpose of the chiropractic examination and evaluation, the chiropractic adjustments and the other procedures that may be recommended during the course of my care have been explained and described to my satisfaction.

Based on current findings, Practice doctors have discussed my diagnosis and treatment plan, the benefits and expected improvement with the proposed treatment and the reasonable alternatives to the proposed treatment. They have also explained the cost of my proposed care (or provided me with a current fee schedule) and to the extent practicable the costs of reasonable alternatives to the proposed treatment.

To aid the understanding of my condition and the reasons for the proposed course of care, the Practice doctors have answered my questions regarding the planned treatments and course of care that I will receive. Practice doctors have also explained that my diagnosis and treatments may change during the course of care and that they will advise me of material changes in my diagnosis and treatment options and answer any additional questions that I may have at any time.

I have also been advised that although the incidence of complications associated with chiropractic services is very low, anyone underdoing adjusting or manipulative procedures should know of rare possible hazards and complications which may be encountered or result during the course of care. These include, but are not limited to, fractures, disk injuries, dislocations, sprains, and those which relate to physical aberrations unknown or reasonably undetectable by the doctor. The Practice will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to the Practice's attention, it is your responsibility to inform the doctors.

I understand and accept that:

1. I have the right to withdraw from or discontinue treatment at any time and that the Practice doctors will advise me of any material risks in this regard.
2. That neither the practice of chiropractic nor medicine is an exact science and that my care may involve the making of judgments based upon the facts known to the doctor during the course of my care.
3. That it is not reasonable to expect the doctor to be able to anticipate or explain all risks and complications or an undesirable result does not necessarily indicate an error in judgment or treatment.
4. The Practice does not guarantee as to results with respect any course of care or treatment.
5. My care and treatment will not be observed or recorded for any non-therapeutic purpose without my consent.

I have read this Consent (or have had it read to me) and have also had an opportunity to as questions about the Consent and understand to my satisfaction the care and treatment I may receive. My signature below acknowledges my consent to the examination, evaluation and proposed course of care and treatments by the Practice.

_____ _____

Witness Patient's Printed Name

_____

Patient's Signature

Doctor's Notes:

Patient counseled by:

Discussion_____

DOCTOR'S LIEN

TO: Attorney/Insurance

_____

_____

_____

Fax #: _____

Doctor
Total Health Family Clinic
6521 Annapolis Rd.
Landover Hills, MD 20784
Tel: 301-322-7777
Fax: 301-322-5151
ContactUs@TotalHealthFamilyClinic.com

Re: Reports and Doctor's Lien

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

DATE OF ACCIDENT: _____

I hereby authorize and direct you, my attorney/insurance, to pay directly to said doctor such sums as may be due and owing him/her for medical services rendered me both by reason of this accident and by reasons of any other bills that are due his/her office and to withhold such sums from any settlement, judgement r verdict as may be necessary to adequately protect said doctor. And I hereby further give a lien on my case to said doctor against any and all proceeds of any settlement, judgement or verdict which may be paid to you, my attorney/insurance 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 said doctor for all medical bills submitted by him for service rendered me and that this agreement is made solely of said doctor's additional protection and in consideration of his awaiting payment. And I further understand that such payment is not contingent on any settlement, judgement or verdict by which I may eventually recover said fee.

In the event that any insurance company which is obligated by contract, statute or laws to make a payment on my behalf to said doctor for professional services refuses to make such payment upon demand by said doctor, I hereby assign and transfer to said doctor the cause of action that exists in my favor against such company. I authorize Total Health Family Clinic to prosecute such action in its name and/or their name to compromise, settle, or otherwise resolve said claim as Total Health Family Clinic sees fit.

Dated _____

Patient's Signature _____

Print Name _____

Parent/Guardian For: _____

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, judgement or verdict as may be necessary to adequately protect said doctor above-named.

Dated _____ **Attorney's Signature** _____

Attorney: Please date, sign, and return one copy to our office along with a LETTER OF REPRESENTATION

DOCTOR'S LIEN

TO: Attorney/Insurance

_____

_____

_____

Fax #: _____

Doctor
Total Health Family Clinic
6521 Annapolis Rd.
Landover Hills, MD 20784
Tel: 301-322-7777
Fax: 301-322-5151
ContactUs@TotalHealthFamilyClinic.com

Re: Reports and Doctor's Lien

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

DATE OF ACCIDENT: _____

I hereby authorize and direct you, my attorney/insurance, to pay directly to said doctor such sums as may be due and owing him/her for medical services rendered me both by reason of this accident and by reasons of any other bills that are due his/her office and to withhold such sums from any settlement, judgement r verdict as may be necessary to adequately protect said doctor. And I hereby further give a lien on my case to said doctor against any and all proceeds of any settlement, judgement or verdict which may be paid to you, my attorney/insurance 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 said doctor for all medical bills submitted by him for service rendered me and that this agreement is made solely of said doctor's additional protection and in consideration of his awaiting payment. And I further understand that such payment is not contingent on any settlement, judgement or verdict by which I may eventually recover said fee.

In the event that any insurance company which is obligated by contract, statute or laws to make a payment on my behalf to said doctor for professional services refuses to make such payment upon demand by said doctor, I hereby assign and transfer to said doctor the cause of action that exists in my favor against such company. I authorize Total Health Family Clinic to prosecute such action in its name and/or their name to compromise, settle, or otherwise resolve said claim as Total Health Family Clinic sees fit.

Dated _____

Patient's Signature _____

Print Name _____

Parent/Guardian For: _____

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, judgement or verdict as may be necessary to adequately protect said doctor above-named.

Dated _____ **Attorney's Signature** _____

Attorney: Please date, sign, and return one copy to our office along with a LETTER OF REPRESENTATION