NAME: _____ DATE: _____ CLAIM NUMBER: _____

ENTERPRISE CHIROPRACTIC CLINIC
Doctor Albert Noble

Welcome to Our Clinic

Initial Visit Form

GENERAL INFORMATION (all clients fill out)

Patient Information:

First Name MI Last Name	Today's Date
Street address (No PO Box)	How did you hear about us?
City State Zip	Social Security # Driver's License #
Home Phone	Sex: Marital Status: Date of Birth: M [ ] F [ ] [ ] Single [ ] Married [ ] Div. [ ] Wid.
Work/Cell Phone:	Emergency Contact Name & # Phone:
Cell Phone Carrier (Verizon, Sprint, etc.):	E-mail Address:

Insurance Information:

Name of Insured Date of Birth	Date injury occurred (date of accident)
Your Relationship with Insured	Policy # Claim # / ID #
Insurance Company Name	Accident/Injury type (choose one) [ ] work [ ] motor vehicle accident [ ] other (please explain):
Insurance Claims/Billing Address	
City State Zip	

CURRENT & PAST MEDICAL INFORMATION

Date of last Physical Exam: _____ Name of Doctor: _____ [ ] Do not recall when I had my last physical exam	Any current **diagnosis** being monitored by another Doctor? [ ] No [ ] Yes If yes, Please explain:
Have you had any **surgeries**? [ ] No [ ] Yes [ ] Do not recall **If Yes**, What type(s) and date(s)?	Have you ever been **hospitalized**? [ ] No [ ] Yes [ ] Do not recall **If Yes**, When, and what for?
Have you had any previous **accidents/traumas/falls**? [ ] Do not recall [ ] No [ ] Yes Date: _____ **If Yes**, Is the injury resolved? [ ] No [ ] Yes **If No**, do you have the same or similar conditions? [ ] Do not recall [ ] No [ ] Yes **If Yes**, explain any differences in intensity/frequency/duration of the pain you feel currently:	Have you had any previous **work-related** injuries? [ ] No [ ] Yes Date: _____ [ ] Do not recall **If Yes**, Is the injury resolved? [ ] No [ ] Yes **If No**, do you have the same or similar conditions? [ ] Do not recall [ ] No [ ] Yes **If Yes**, explain any differences in intensity/frequency/duration of the pain you feel currently:
List any **medications** you are currently taking and explain any side-effects: [ ] None [ ] Insulin [ ] Cortisone [ ] Nerve Pills [ ] Antidepressants [ ] Shoe lifts /Orthotics [ ] Blood pressure medication [ ] Vitamins/supplements [ ] Pain killer/muscle relaxants [ ] Aspirin-how often? _____ Any other medications: _____ List any known side effects: _____	Please list any **allergies**: [ ] none [ ] dairy products [ ] soy [ ] eggs [ ] mold [ ] peanuts [ ] perfume [ ] shell fish [ ] wheat [ ] pet dander [ ] poison ivy [ ] pollen [ ] smoke [ ] strawberries [ ] other_____ Please explain your reaction:

NAME: _____ DATE: _____ CLAIM NUMBER: _____

FOR AUTO RELATED ACCIDENTS ONLY: (MVA clients only) [ ] *Not Applicable – Skip to next section*

Date of injury: _____
Please describe the incident:

How many vehicles were involved in the accident: _____
Auto: Year_____ Make: _____ Model: _____
Does your car have headrests? [ ] No [ ] Yes Did the airbag deploy? [ ] No [ ] Yes
Damage: [ ] minor [ ] major [ ] totaled [ ] approx. $ _____ worth
Where was the accident? [ ] intersection [ ] stop light [ ] stop sign [ ] straight road [ ] driveway [ ]parking lot [ ]freeway intersection with turn lane
If at a light, was it: [ ] green [ ] red [ ] yellow [ ] green turn arrow [ ] red turn arrow [ ] yellow turn arrow
Street surface: [ ] dry [ ] wet [ ] slick [ ] icy [ ] gravel [ ] other

I was seated: [ ] Driver's seat [ ] Passenger in the front seat
[ ] Passenger in the back seat on/in the [ ] Left [ ] Right [ ]Center
I was wearing: [ ] a seat/lap belt [ ] a shoulder harness

I was: [ ] Owner of the vehicle [ ] Pedestrian
[ ] motorcycle driver/passenger [ ] Involved with an uninsured driver/vehicle

My body was positioned: [ ]looking straight ahead [ ] looking downward doing something else [ ] turned to the left/right(please circle) [ ] looking at oncoming traffic [ ] looking in the rear view mirror [ ] other-please specify: _____

Did you have any warning before the impact? [ ] No [ ] Yes
Did you brace (tense up your body) before impact? [ ] No [ ] Yes

Did you hit your head? [ ] Do not recall if I did or did not hit my head
[ ] Yes [ ] No
If Yes, what part of your head? [ ] back of head [ ] face [ ] forehead
[ ] nose [ ] right side of head [ ] left side of head
What did you hit it against? [ ] steering wheel [ ] head rest [ ] side panel
[ ] console [ ] seat [ ] dashboard
[ ] door [ ] back of driver's seat [ ] pavement
[ ]other-please explain: _____

Did you hit any other body parts? [ ] No [ ] Yes
If Yes, please select all that apply:
[ ] chest—on what? _____
[ ] abdomen---on what? _____
[ ] shoulder/arm: [ ] right [ ] left—on what? _____
[ ] elbow: [ ] right [ ] left—on what? _____
[ ] hand/wrist: [ ] right [ ] left—on what? _____
[ ] hip/thigh: [ ] right [ ] left—on what? _____
[ ] knee: [ ] right [ ] left—on what? _____
[ ] shin: [ ] right [ ] left—on what? _____
[ ] foot/ankle: [ ] right [ ] left—on what? _____

What area(s) on your car were hit?
[ ] front driver side corner [ ] rear driver side corner [ ] driver side
[ ] front passenger corner [ ] rear passenger corner [ ] passenger side
[ ] front bumper [ ] rear bumper [ ] rear trailer [ ] head on collision
[ ]other:

Was there a secondary impact? [ ] No [ ] Yes
If yes, with what (another car, tree, etc.)?
What area on your car was hit in the secondary impact?

ACCIDENT & INJURY INFORMATION ONLY [ ] *Not Applicable – Skip to next section*

As a result of the accident, were you (select all that apply): [ ] Rendered unconscious [ ] Shaken but could function [ ] Vague about what happened [ ] Dazed
[ ] Able to get up/out of car and walk unassisted
[ ] Unable to move certain body parts (list parts and why) : _____
[ ] Bruised (describe injuries): _____
[ ] Bleeding (describe injuries): _____

Were you seen by Emergency Medical Staff (ambulance) at the scene?
[ ] No [ ] Yes

Did you visit a hospital ER? [ ] No [ ] Yes
If Yes, what was the hospital name? _____
What areas were checked / treated? _____

Have x-rays been taken? [ ] No [ ] Yes
If Yes, where were they taken? _____
What views/body parts? _____

Have you made any follow-up visits for your injuries? [ ] No [ ] Yes
If yes, where at? _____

Did the pain occur more than 2 weeks ago? [ ] No [ ] Yes
If Yes, please explain why you did not come to get examined and treated sooner: _____

Did you report this incident to your insurance company or appropriate personnel?
[ ] No [ ] Yes

Have you retained an attorney to represent you for this accident?
[ ] No [ ] Yes

If yes please provide the following for our records:
Attorney Name: _____
Attorney Address: _____
Phone Number: _____

NAME: _____ DATE: _____ CLAIM NUMBER: _____

SYSTEMS REVIEW - Please review the following lists of conditions. If you have had a condition in the past, check the "Past" box. If you currently have a condition, check the "Now" box.

Past	Now	GENERAL		Past	Now	GASTRO-INTESTINAL		Past	Now	EYE EAR NOSE THROAT	
[ ]	[ ]	Headaches	784.0	[ ]	[ ]	Poor Appetite	783	[ ]	[ ]	Poor vision	368.9
[ ]	[ ]	Fever	780.6	[ ]	[ ]	Poor Digestion	536.8	[ ]	[ ]	Crossed Eyes	378.9
[ ]	[ ]	Chills	780.9	[ ]	[ ]	Excessive Hunger	994.2	[ ]	[ ]	Pain in Eyes	379.91
[ ]	[ ]	Night Sweats	780.8	[ ]	[ ]	Belching or Gas	787.3	[ ]	[ ]	Deafness	389.9
[ ]	[ ]	Fainting	780.2	[ ]	[ ]	Nausea	787	[ ]	[ ]	Earache	388.7
[ ]	[ ]	Dizziness	780.4	[ ]	[ ]	Vomiting	78	[ ]	[ ]	Ear Noises	388.3
[ ]	[ ]	Convulsions	780.3	[ ]	[ ]	Vomiting Blood	578	[ ]	[ ]	Ear Discharge	388.6
[ ]	[ ]	Loss of Sleep	780.52	[ ]	[ ]	Pain over Stomach	536.8	[ ]	[ ]	Nasal Obstruction	478.1
[ ]	[ ]	Fatigue	780.7	[ ]	[ ]	Constipation	564	[ ]	[ ]	Nose Bleeds	784.7
[ ]	[ ]	Nervousness	799.2	[ ]	[ ]	Diarrhea	558.9	[ ]	[ ]	Sore Throat	462
[ ]	[ ]	Weight Loss	783	[ ]	[ ]	Colon Troubles	789	[ ]	[ ]	Hoarseness	784.49
[ ]	[ ]	Pain/Numb limbs	782	[ ]	[ ]	Hemorrhoids/Piles	455.6	[ ]	[ ]	Hay Fever	477.9
[ ]	[ ]	Allergy	995.3	[ ]	[ ]	Liver Trouble	785.1	[ ]	[ ]	Asthma	493.9
[ ]	[ ]	Wheezing	786.09	[ ]	[ ]	Jaundice	782.4	[ ]	[ ]	Frequent Colds	460
[ ]	[ ]	Neuralgia	729.2	[ ]	[ ]	Gall Bladder Trouble	575.9	[ ]	[ ]	Enlarged Thyroid	240.9
								[ ]	[ ]	Tonsillitis	463
								[ ]	[ ]	Sinus Troubles	686.9

Past	Now	FOR WOMEN ONLY		Past	Now	MUSCLES & JOINTS		Past	Now	CARDIO-VASCULAR	
[ ]	[ ]	Painful Periods	786.2	[ ]	[ ]	Weakness		[ ]	[ ]	Rapid Heart	783
[ ]	[ ]	Excessive Flow	626.2	[ ]	[ ]	Twitching		[ ]	[ ]	Slow Heart	427.89
[ ]	[ ]	Irregular Cycles	626.4	[ ]	[ ]	Stiff Neck		[ ]	[ ]	High Blood Pressure	401.9
[ ]	[ ]	Hot Flashes	627.2	[ ]	[ ]	Backache	722.10	[ ]	[ ]	Low Blood Pressure	458.9
[ ]	[ ]	Cramps/Backache	625.3	[ ]	[ ]	Swollen Joints	719	[ ]	[ ]	Pain over Heart	786.51
[ ]	[ ]	Miscarriage	634.9	[ ]	[ ]	Tremors	781	[ ]	[ ]	Heart Trouble	438
[ ]	[ ]	Vaginal Discharge	623.5	[ ]	[ ]	Foot Troubles	729.5	[ ]	[ ]	Ankle Swelling	719.07
[ ]	[ ]	Pregnancy		[ ]	[ ]	Painful Tail Bone	724.79	[ ]	[ ]	Poor Circulation	459.9
				[ ]	[ ]	Pain between Shoulders	724.5	[ ]	[ ]	Varicose Veins	
				[ ]	[ ]	Hernia	553.9	[ ]	[ ]	Strokes	436
				[ ]	[ ]	Spinal Curvature	737.3				

Past	Now	SKIN OR ALLERGIES		Past	Now	GENITAL/URINARY		Past	Now	RESPIRATORY	
[ ]	[ ]	Skin Eruptions	368.9	[ ]	[ ]	Frequent Urination	788.3	[ ]	[ ]	Chronic Cough	786.2
[ ]	[ ]	Itching	698.9	[ ]	[ ]	Pain on Urination	788.1	[ ]	[ ]	Spitting Blood	786.3
[ ]	[ ]	Bruise Easily	287.8	[ ]	[ ]	Blood in Urine	599.7	[ ]	[ ]	Spitting Phlegm	933.1
[ ]	[ ]	Dryness	701.1	[ ]	[ ]	Kidney Infection	592	[ ]	[ ]	Chest Pain	786.50
[ ]	[ ]	Boils		[ ]	[ ]	Bed Wetting	788.3	[ ]	[ ]	Difficulty Breathing	786.09
[ ]	[ ]	Sensitive Skin	782	[ ]	[ ]	Can't control Urination	788.1				
[ ]	[ ]	Hives/Allergy	708.9	[ ]	[ ]	Prostate Trouble	601.9				
[ ]	[ ]	Eczema	692.9								
[ ]	[ ]	Medicines									

CHECK ANY CONDITIONS OR DISEASES YOU HAVE HAD:

[ ] Appendicitis	541	[ ] Anemia	285.9	[ ] Heart Disease	429.9	[ ] Arthritis	716.9
[ ] Pneumonia	541	[ ] Measles	285.9	[ ] Goiter	429.9	[ ] Epilepsy	716.9
[ ] Rheumatic Fever	541	[ ] Mumps	285.9	[ ] Influenza	429.9	[ ] Mental Disorder	716.9
[ ] Polio	541	[ ] Chicken Pox	285.9	[ ] Pleurisy	429.9	[ ] Lumbago	716.9
[ ] Tuberculosis	541	[ ] Diabetes	285.9	[ ] Alcoholism	429.9	[ ] Eczema	716.9
[ ] Whooping Cough	541	[ ] Cancer	285.9	[ ] Venereal Disease	429.9		

FAMILY HISTORY

	Diabetes	Heart	Kidney	Cancer	Back	None
Mother: [ ] Living [ ] Deceased	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Father: [ ] Living [ ] Deceased	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Brothers: How Many? ( )	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Sisters: How Many? ( )	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]

General Family History:

[ ] Alcoholism	[ ] Anemia	[ ] Arteriosclerosis	[ ] Arthritis
[ ] Emphysema	[ ] Epilepsy	[ ] Glaucoma	[ ] High Cholesterol
[ ] Thyroid disease	[ ] Multiple sclerosis	[ ] Osteoporosis	[ ] Stroke
[ ] Asthma	[ ] High Blood Pressure		

HABITS Are you currently?

		None	Light	Mod.	Heavy
Tobacco	_____pack(s) / day	Sugar	[ ]	[ ]	[ ]	[ ]
Alcohol	_____drink(s) / day	Salty foods	[ ]	[ ]	[ ]	[ ]
Coffee	_____cup(s) / day	Stress	[ ]	[ ]	[ ]	[ ]
Soft drinks	_____cup(s) / day	Exercise	[ ]	[ ]	[ ]	[ ]
Sleep	_____hour(s) / day					
Water	_____oz(s) / day					

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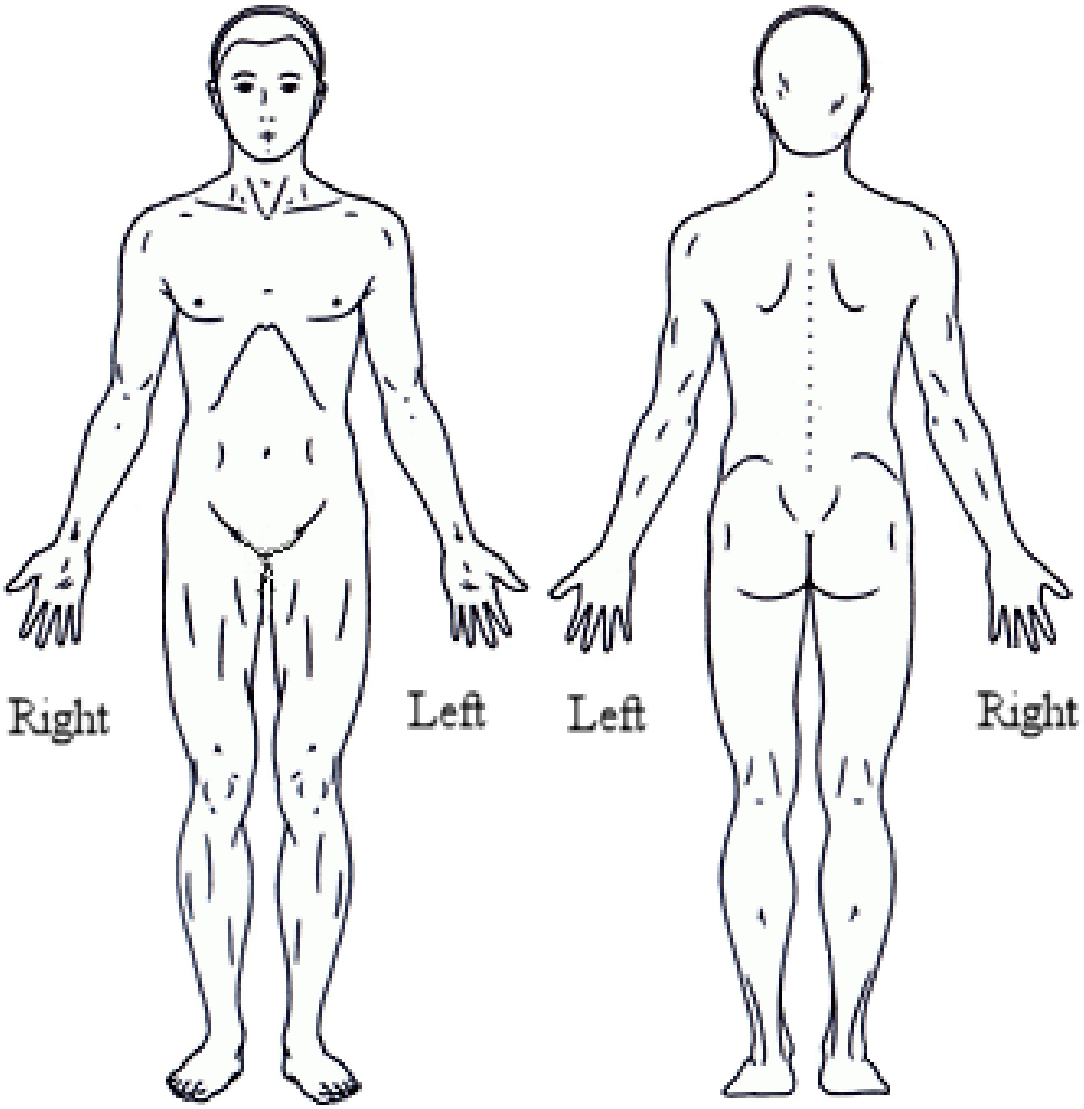
PAIN INDEX AND LOCATION CHART

Please circle ALL areas where you are feeling pain (be specific as possible), and indicate the QUALITY of the pain using the following symbols:

Numb	Burning	Pins & Needles	Shooting Pain	Aching/Dull	Stabbing
- - - - - - - -	# # # # # #	0 0 0 0 0 0 0	x x x x x x	* * * * * *	/ / / / / / / /



Please mark the pain scale from 0 to 10 for each area. 1-4 uncomfortable, 5-6 distressing, 7-8 affecting daily activities, 9-10 unbearable (crying, screaming)

Neck-Shoulder-Arm Pain
On a scale of zero to 10, I rate my Discomfort as follows
(_____)
0 5 10
No pain Severe pain

Mid Back Pain
On a scale of zero to 10, I rate my Discomfort as follows
(_____)
0 5 10
No pain Severe pain

Low Back and Leg Pain
On a scale of zero to 10, I rate my Discomfort as follows
(_____)
0 5 10
No pain Severe pain

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CURRENT MEDICAL SYMPTOMS (Cont'd)

How and when did each area of pain or symptoms begin?
[ ] day of motor vehicle accident
[ ] day after motor vehicle accident
[ ] other-please explain: _____

How long/regularly do you experience the pain or symptoms in each area?
[ ] all the time [ ] during the day [ ] during the night [ ] more than 6 hours
[ ] less than 1 hour [ ] in intervals-how long each time? _____
[ ] other-please explain: _____

What makes the symptoms in each area better? [ ] *nothing*
[ ] certain movements - in what direction? _____
[ ] certain body positions – which ones? _____
[ ] heat [ ] ice [ ] massage [ ] muscle relaxants [ ] rest [ ] stretching
[ ] bed rest [ ] elevation [ ] activity [ ] aspirin
[ ] other-please explain:_____

What makes the symptoms in each area worse? [ ] *nothing*
[ ] certain movements - in what direction? _____
[ ] certain body positions – which ones? _____
[ ] certain daily activities – which ones? _____
[ ] walking [ ] standing [ ] sitting [ ] reaching overhead [ ] looking up
[ ] climbing stairs [ ] going down stairs [ ] lifting
[ ] other-please explain:_____

Associated Symptoms: please mark all that you have noticed since this incidence

Face / Jaw / Ear: [ ] Jaw clicking [ ]Grinding teeth at night [ ] Teeth problems [ ] Ringing in ears [ ] Plugged ears [ ] Fluid in Ears [ ] Facial pain [ ] Facial Numbness [ ] Face Flushed

Thinking: [ ] Difficulties with Memory [ ] Forget ATM/phone #s [ ] Difficulty thinking [ ] Concentration Problems [ ] Writing problem [ ] Loss of attention

Emotions: [ ] Emotional difficulty [ ] Personality Changes [ ] Relationship difficulty [ ] Anxiety [ ] Uncoordinated [ ] Depression [ ] Irritable [ ] No longer care

Senses: [ ] Aggravated by noise [ ] Lights bother eyes [ ] Change of smell or taste [ ] Blurred Vision [ ] Intolerance to Cold [ ] Intolerance to Heat [ ] Loss of Taste [ ] Loss of Balance [ ] Sexual Dysfunction [ ] Feet Cold [ ] Hands Cold

Other: [ ] Upset Stomach [ ] Intolerance to Alcohol [ ] Restlessness [ ] Shortness of Breath [ ] Other (please list):

Neck, head, and arm pain ONLY: please mark all that apply
[ ] neck stiffness [ ] headaches [ ] dizziness
[ ] jaw pain / pain with chewing
[ ] weakness in grip strength [ ] other weakness (please describe below)
[ ] pain shooting down the arms—[ ] R [ ] L
How far down the arm? _____
[ ] numbness or tingling—[ ] R [ ] L
In the [ ] arm [ ] forearm [ ] hand [ ] fingers (which ones?_____)
[ ] other (please describe) _____

Low back and leg pain ONLY: please mark all that apply
[ ] catching/locking [ ] changes in bowel habits (please describe below)
[ ] changes in bladder habits (please describe below)
[ ] stumbling more often than normal [ ] weakness (please describe below)
[ ] pain shooting down the legs—[ ] R [ ] L
How far down the leg? _____
[ ] numbness or tingling—[ ] R [ ] L
In the [ ] groin [ ] thigh [ ] shin [ ] calf [ ] foot
[ ] toes (which ones? _____) [ ] other (please describe) _____

Please describe any daily activities that are more difficult to perform as a result of this injury.

TYPE OF CARE

People go to a Chiropractor for a variety of reasons. Your Doctor will consider your needs and desires when recommending your treatment program. Please check the type of care you desire so that we may be guided by your wishes whenever possible:
[ ] Comprehensive Care – to bring your body to the highest optimum health
[ ] Corrective Care – to relieve symptoms and correct fundamental problem
[ ] Symptomatic Care – to relieve the symptoms, but not to correct the fundamental problem
[ ] Maintenance Care – to maintain your current level of health
[ ] Annual Physical Exam or D.O.T.
[ ] Check here if you want the Doctor to select the type of care appropriate to your condition

DATE: _____ SIGNATURE: X_____

NAME: _____ DATE: _____ CLAIM NUMBER: _____

FINANCIAL AGREEMENT (*Please read and sign*)

I authorize my insurance company to issue payment directly to this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions.

We will call to verify eligibility and benefits as a courtesy to our patients. As the insurance policy is a contract between the patient and the insurance company, we cannot guarantee these benefits. Any amount that the insurance company does not cover becomes the responsibility of the patient, regardless of any reduction, denials or arbitrary determination of usual and customary fees. We advise our patients to verify their own insurance.

In order to have insurance billing privileges extended to me, I understand that I must: report my accident to my auto insurance company claims office and provide the auto insurance company with all necessary PIP (Personal Injury Protection) applications.

I have read, understand, and agree to the financial agreement stated above.

_____ X_____

Date Patient Signature, or Parent/Legal Guardian for patient under 18 years

_____ _____

Date Witness' Signature

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OUR CANCELATION POLICY & OFFICE NOTICE

An appointment is a commitment by yourself and the Doctor to set aside time to treat you. Therefore, we request that our patients notify us at least 24 hours in advance when canceling or rescheduling an appointment so that we may make the appointment available to those who need it.

We reserve the right to charge a Missed Appointment Fee of $25.00 to those patients who miss their appointment without notifying us, or who cancel/ reschedule an appointment with less than 24-hour notice. This fee is not covered by insurance and will need to be paid by the patient.

So as not to inconvenience those who arrive at their appointed time, late comers may receive shortened treatment at the regular treatment fee. Those who arrive for their scheduled appointments will be served first.

Also, we are not responsible for lost or stolen personal items. We are not responsible for your children or any children that might be with you during your visit. We are not responsible for any injuries that occur at home from doing exercises the Doctor gives you.

We value your business and strive to ensure that we are always available to you when you need us. Thank you.

I understand and agree to the above:

X_____

Patient Signature Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES & Motor Vehicle Collision General Precautions and Instructions

I, _____ (your name), acknowledge that I have received, reviewed, understand, and agree to the Notice of Privacy Practices of Enterprise Chiropractic and the Motor Vehicle Collision General Precautions and Instructions, which describes the Practice's policies and procedures regarding the use and disclosure of any of my Protected Health Information created, received or maintained by the Practice and provides instructions for care at home.

X_____

Patient Signature Date

_____

Print Name

For Office Use Only

The Practice has made a good-faith effort to obtain an acknowledgement of _____'s receipt of our Notice of Privacy Practices. In an effort to obtain it, the Practice has attempted to provide patient with a Notice of Privacy Practices in the following manner: ☐ Personally ☐ Mail ☐ Phone Follow-up ☐ Other _____

In spite of these efforts, the Practice has been unable to obtain a signed acknowledgement of receipt for the following reasons:

☐ Patient unavailable ☐ Patient physically unable ☐ Patient unwilling. Signature/Date_____

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ENTERPRISE CHIROPRACTIC CLINIC
Doctor Albert Noble

IRREVOCABLE DOCTOR'S LEIN AND ASSIGNEMNT OF RIGHT TO RECOVERY

In consideration and exchange for not having to immediately pay a debt owed and in consideration for receiving future care at or by the Clinic and Doctor on whose letterhead this document is printed (hereinafter "Clinic"), I, the undersigned, hereby assign and convey to the Clinic a legal and equitable interest in any and all causes of action or rights of recovery I may have arising out of that certain accident or injury-producing event which occurred on or about _____ , to the full extent of the cost and treatment provided or to be provided to me by the Clinic.

I hereby authorize and direct my attorney(s) to hold in trust, and to pay directly to the Clinic such sums as may be due and owing the Clinic for treatment and other professional services rendered me both by reason of this accident and by reason of any other bills that are due the Clinic and to withhold such sums from any given, grant and convey a lien on my case to the Clinic against any and all proceeds of any and all causes of action, settlements, judgments or verdicts which may be paid to or through my attorney, or myself, as the result of injuries or conditions for which I have been treated by the Clinic.

If no attorney is trusted with my case, I understand that the insurance will directly pay the Clinic for all services rendered as a result of this accident and any other bills that are due.

I fully understand that I am directly and fully responsible to the Clinic for all bills incurred for services rendered me and that this agreement is made solely for the Clinic's additional protection and in consideration contingent on any settlement, judgment or verdict by which I may eventually recover. I am personally responsible for my bills, regardless of the outcome of any legal claim or cause.

I fully understand that if my attorney(s) does/do not protect the Clinic's interest, the Clinic may require me to make payments on a current basis. The Clinic may also bring a cause of action against my attorney(s) for failing to honor this binding and irrevocable agreement between me and the Clinic.

I further understand and agree that the Clinic *is not* responsible for paying any of my attorneys' fees and the Clinic *does not* agree to pay my attorney fees for honoring this agreement between me and the Clinic.

"I HAVE READ AND FULLY UNDERSTAND THIS DOCUMENT, AND I AM VOLUNTARILY SIGNING THIS DOCUMENT. I AM DIRECTING MY ATTORNEY(S) TO PROTECT THE CLINIC'S AND DOCTOR'S INTEREST AT TIME OF SETTLEMENT, AND I AM ASSIGNING AND CONVEYING CERTAIN LEGAL RIGHTS TO THE CLINIC. I ALSO KNOW I MAY *NOT* REVOKE THIS AGREEMENT AT ANY TIME WITHOUT PRIOR WRITTEN AUTHORIZATION FROM THE CLINIC. I UNDERSTAND THAT, AMONG OTHER THINGS, THIS IS A BINDING AND ENFORCEABLE CONTRACT, ASSIGNMENT AND LEIN.

_____ X_____ _____
Print Patient Name Patient Signature Date

_____ X_____ _____
Print Lawyer/Adjuster Name Lawyer/Adjuster Signature Date

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INFORMED CONSENT (Revision II. August 2011)

Chiropractors have been providing great health care services to patients for more than 100 years. Many patients with acute and chronic spine-related and extremity disorders and joint stiffness, arm and leg complaints, and other musculoskeletal conditions or injuries have benefited by having chiropractic care. In order for the chiropractor to determine what types of treatment may be beneficial to you, it is necessary to perform a physical examination of your spine and other joints. Identifying subluxations or abnormal joint function is achieved by looking at x-rays and/or during the examination which involves moving various joint(s) or areas of your body in specific directions to determine how well each of the painful or restricted joints or bony structures of your body moves or is positioned when compared to the normal population. Spinal manipulation, a procedure that involves the application of controlled mechanical forces to specific joint structures, has the goal of improving and restoring normal joint motion of the spine and other joints. Better joint alignment and motion improves the function and health of the joint and nerves and thus reduces inflammation and reduces related symptoms. After treatment, most of our patients experience increased flexibility, feel less pain and other symptoms, and are able to return to their normal physical activities at work and home. The goal of chiropractic care is to improve and normalize the quality of joint motion in the affected areas of your body, to encourage you to adopt good lifestyle habits such as exercise and good nutrition, and assist you during the recovery process. Rejecting chiropractic care may lead to progression of joint restrictions and symptoms and further compromise your ability to perform activities at home and work.

There are various alternative types of non-chiropractic treatment available for patients, who have your type of conditions (s), including: acupuncture, physical therapy, or seeking care from a medical doctor.

It is not reasonable to expect the doctor to anticipate, or explain, all possible risks of a given procedure on any particular visit and I wish to rely on the doctor to exercise professional judgment during my course of treatment to be in my best interest. An undesirable result does not necessarily indicate an error in judgment or improper treatment some patients may experience short term increase of pain and other symptoms or muscle and ligaments strains or sprains as a result of manipulation and manual therapy techniques such as joint mobilization or deep massage. Some rare complications of chiropractic care could include sprain/strain, fracture, disc injury, dislocations, nerve injuries and cerebral vascular accidents. These are extremely rare and not expected in this case. I understand my condition and the recommended treatment plan as it was explained to me. I understand that this plan is based upon my current findings and appropriate treatment guidelines but may change according to daily treatment needs and/or service availability.

I voluntarily consent to the performance of chiropractic examination, manipulation and other chiropractic procedures, on myself (or the patient named below, for whom I am legally responsible) by said chiropractor (see below), his/her preceptor (s), and/or other licensed doctors of chiropractic who now or in the future provide chiropractic treatment for me. This consent includes other doctors of chiropractic that are employed by, associated with, or serve as back-up for said chiropractor, whether or not their names are listed on this form. I understand that the results from the chiropractic treatment are not guaranteed for my condition. The doctor has discussed the goals and potential benefits of the proposed treatment, other alternative types of treatment for my condition and the associated risks by having chiropractic examination and procedures. I have had the opportunity to read this form and understand the above statements, accept the risks mentioned, and hereby consent and agree to the recommended chiropractic treatment over the entire course of treatment for my present condition and any future conditions for which I seek treatment.

SIGNATURE OF PATIENT OR RESPONISIBLE PARTY: X_____

NAME: _____RELATIONSHIP:_____

Indicate your name and relationship (parent/guardian/personal representative) if signing for a patient (minor):

OFFICE WITNESS SIGNATURE: _____DATE: _____

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Portland, OR 97213
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(503) 639-2052

NAME: _____ DATE: _____ CLAIM NUMBER: _____

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION-RECORDS

Last name:	MI:	First Name:	
Home Address:	City:	State:	Zip:
Date of Birth:	Social Security/ID Number:		

The 1996 Health Insurance Portability and Accountability Act (HIPAA) require that all health care providers comply with the patient privacy and security laws (45 CFR Parts 160, 164). Patient confidentiality and privacy/security applies to any protected health information (PHI) contained within the medical records. Federal Law now require signed and dated authorization from patients in several aspects of patient care, transmission of medical information, confidentiality, and patient rights relating to their release of medical records.

LIST PURPOSE(S) FOR WHICH THE INFORMATION IS NEEDED: _____

AUTHORIZATION EXPIRATION. Without my express revocation, this authorization will expire 12 months from the date signed: (1) upon satisfaction of the need for disclosure; (2) on date (supplied by patient) _____ ; (3) under the following conditions (examples: case closure, termination of plan benefits, ECT) _____

RELEASE AUTHORIZATIONS (Patient, please initial the following section(s) that apply to you.

_____ Initial. Doctor/Medical Facility. I authorize release of entire set of my medical records including: intake forms, history, diagnosis, treatment, consultation, neurological/laboratory/radiologic scan or test results, disabilities, billing information, reports, correspondence, and medical records from other sources to the following doctor/facility/person:
List Name/Address: _____

_____ Initial. Insurance-Medical Plans. I authorize said doctor to communicate with, send updated billing, reports, and release all medical records necessary to process this claim to the following insurance companies and/ or governmental agencies listed below:
List: _____

_____ Initial. Attorney. I authorize said doctor to communicate with my retained attorney (paper, electronic, and oral). I further authorize the release of reports, all medical and treatment records, billing records photos, and other records necessary to process my claim. This authorization is valid until the case is closed or at the conclusion of litigation and said doctors bills have been fully paid.
Name of attorney: _____ Number of attorney: _____
Date of Injury: _____

_____ Initial. Family/ Friend. I authorize said doctor to communicate with the following friend/family member about my health condition and recommendations. Name of person(s): _____ Number of person: _____

_____ Initial [ ] Yes [ ] No: [Special Limitations for Release of Sensitive Protected Health Information.] I specifically authorize the release of HIV/AIDS test results, sexually transmitted or communicable disease notes (such as Hepatitis or venereal diseases), drug, alcohol, or substance abuse or treatment notes, behavioral, mental health disabilities or developmental disability, (including mental retardation), abuse, neglect or domestic violence, sickle cell anemia, government research, or genetic testing information. The recipient is prohibited from redisclosing such sensitive PHI information without my authorization unless permitted by state and Federal law. List any other special restrictions that you want limited (e.g., psychiatric/psychological records):_____

AUTHORIZATION

- ✓ I certify that this request has been made freely, voluntarily and without coercion and that the information is accurate.
- ✓ I voluntarily authorize and request that my health information (including paper, oral, and electronic interchange) be released to the above sources as set forth on this form.
- ✓ I can revoke this authorization at any time by giving my written revocation in writing to said doctor's office. My revocation is not effective as to disclosures already made and actions already taken in reliance upon this authorization.
- ✓ The disclosing health care provider/plan may NOT condition treatment, enrollment in the health plan or eligibility for benefits on whether I sign this authorization.
- ✓ Information disclosed under this authorization may be re-disclosed by the recipient and may no longer be protected by federal and state law.
- ✓ I have the right to request a list of doctors, facilities, and/or government agencies which have been sent my medical records.

_____ X_____
(Date) (Signature of Patient)

_____ X_____
(Date) (Signature of person authorized by law)

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NAME: _____ DATE: _____ CLAIM NUMBER: _____

REQUEST FOR MEDICAL RECORDS

Patient Identification:	Social security: Medical record No:	Date of Birth:

Request Records From (Name and address of Doctor/ Facility where patient's medical records are presently located):

Name:	
Address:	

SEND THE SPECIFIED AND AUTHORIZED MEDICAL RECORDS TO:

Doctor's Name:	Dr. Albert Noble D.C. Enterprise Chiropractic Clinic
Address:	10576 SE Washington St, Portland, OR, 97213
Telephone:	503-252-5320

WHAT MEDICAL RECORDS ARE AUTHORIZED TO DISCLOSE AND MAIL:

[ ] All Medical Records
[ ] X-Ray/MRI/CT reports
[ ] EMG, SSEP, Nerve Conduction, Laboratory tests, Diagnostic Test Report.
[ ] Other _____

SPECIFIC DATES AUTHORIZED FOR RECORDS RELEASE

Medical records from (insert date) _____ to (insert date) _____

PURPOSE OF RELEASE OF INFORMATION

[ ] At request of above patient
[ ]Other:

I hereby request and authorize disclosure of the above protected health information in my medical records kept at your office or facility to be photocopied, released and mailed to above doctor/facility at the indicated address for the specified dates. I understand that the Health Insurance Portability and Accountability Act (HIPAA) apply to my medical records and protected health information. I expect the holder of my medical records to mail my specified medical records as soon as reasonably possible, not to exceed 30 days if kept on-site, and 60 days if stored off-site, once this request has been received. This authorization may be revoked by me, at any time, by advising the doctor's office (privacy officer) of this revocation in writing, except to the extent a source of information has already relied on it. I have been advised that if I choose to not sign this authorization that it will not have any adverse effect on my treatment, eligibility for benefits, enrollment, or payment.

EXPIRES: This authorization is good for 12 months from the date signed for the disclosure of the information described above.

*This authorization does not apply to any record/notes regarding HIV/AIDS, communicable disease, alcohol or drug treatment, mental health information, behavioral health care, domestic violence, genetic testing, and psychiatric or psychotherapy notes.

PATIENT NAME (Print clearly): _____

INDIVIDUAL AUTHORIZING DISCLOSURE (Signature): _____ DATE: _____

If not signed by patient, specify basis for your authority to sign: [ ] Parent of minor, [ ] Guardian

This general and specific authorization to disclose was developed to comply with the provisions regarding disclosure of medical information under HIPAA: 45 CFR Parts 160and 164, 42 CFR part 2, 38 CFR parts 99 and 300, and State Law.

PATIENTS COPY

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NAME: _____ DATE: _____ CLAIM NUMBER: _____

ENTERPRISE CHIROPRACTIC
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY

Our practice is dedicated, and we are required by applicable federal and state laws, to maintain the privacy of your health information. These laws also require us to provide you with this Notice of Our Privacy Practices, and to inform you of your rights, and our obligations, concerning your health information. We are required to follow the privacy practices described below while this Notice is in effect. This Notice is effective as of 04/15/03, and will remain in effect until we replace it.

CHANGES TO NOTICE:

We reserve the right to change this Notice and the Privacy Practices described below at any time in accordance with applicable law. Prior to making significant changes to our Privacy Practices, we will alter this Notice to reflect the changes, and make the revised Notice available to you upon request. Any changes we make to our Privacy Practices and/or this Notice may be applicable to health information created or received by us prior to the date of the changes.

You may request a copy of our Notice at any time. For more information about our Privacy Practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

PERMITTED USES AND DISCLOSURES OF HEALTH INFORMATION:

A. TREATMENT, PAYMENT, and HEALTH CARE OPERATIONS: You should be aware that during the course of our relationship with you, we will likely use and disclose health information about you for treatment, payment, and health care operations. Examples of these activities are as follows:

- Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

- Payment: We may use and disclose your health information to obtain payment for services we provide to you.

- Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare Operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, and other business operations.

B. AUTHORIZATIONS: You may specifically authorize us to use your health information for any purpose or to disclose your health information to anyone, by submitting such an authorization in writing. Upon receiving an authorization from you in writing we may use or disclose your health information in accordance with that authorization. You may revoke an authorization at any time by notifying us in writing. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those permitted by this Notice.

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NAME: _____ DATE: _____ CLAIM NUMBER: _____

ENTERPRISE CHIROPRACTIC
NOTICE OF PRIVACY PRACTICES (Cont'd)

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

C. DISCLOSURES TO FAMILY AND PERSONAL REPRESENTATIVES: We must disclose your health information to you, as described in the Patient Rights section of this Notice. Such disclosures will be made to any of your personal representatives appropriately authorized to have access and control of your health information. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare only if authorized to do so. In the event of your incapacity or in emergency circumstances, we will disclose health information based on a determination using our professional judgment, disclosing only health information that is directly relevant to the person's involvement in your healthcare.

D. MARKETING: We will not use your health information for marketing communications without your written authorization.

E. USES OR DISCLOSURES REQUIRED BY LAW: We may use or disclose your health information when we are required to do so by law, including for public health reasons (e.g., disease reporting). In some instances, and in accordance with applicable law, we may be required to disclose your health information to appropriate authorities if we reasonably believe that you are the possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes.

F. PATIENT AND THIRD PARTY PROTECTION: Only as permitted by law, we may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

G. LAW ENFORCEMENT / NATIONAL SECURITY: Under certain circumstances we may disclose health information relating to members of the Armed Forces to military authorities. Under certain circumstances we may also disclose health information relating to inmates or patients to correctional institutions or law enforcement personnel having lawful custody of those individuals. We may disclose health information in response to judicial proceedings and law enforcement inquiries as permitted by law and to authorized federal official's health information required for lawful intelligence, counterintelligence, and other national security activities.

H. APPOINTMENT REMINDERS: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS:

A. ACCESS TO RECORDS: Upon submission of a written request to us, you have the right to review or receive copies of your health information, with limited exceptions. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may request that we provide copies in a format other than photocopies and we will use the format you request if it is readily available. We will charge you a reasonable cost-based fee relating to the production of such copies. If you request copies, we will charge you $0.25 for each page, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a reasonable cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice if you are interested in receiving a summary of your information instead of copies.

NAME: _____ DATE: _____ CLAIM NUMBER: _____

ENTERPRISE CHIROPRACTIC
NOTICE OF PRIVACY PRACTICES (Cont'd)

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

B. ACCOUNTING OF CERTAIN DISCLOSURES: Upon written request, you have the right to receive a list of instances in which we, or our business associates, disclosed your health information for purposes, other than treatment, payment, healthcare operations and other activities authorized by you, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

C. RESTRICTIONS AND ALTERNATIVE COMMUNICATIONS: You have the right to request that we place additional restrictions on our use or disclosure of your health information for treatment, payment and healthcare operations purposes. Depending on the circumstances of your request we may, or may not agree to those restrictions. If we do agree to your requested restrictions, we must abide by those restrictions, except in emergency treatment scenarios. You have the right to request that we communicate with you about your health information by alternative means or to alternative locations (e.g., at your place of business rather than at your home). Such requests must be made in writing, must specify the alternative means or location, and must provide satisfactory explanation how payments will be handled under the alternative means or location you request.

D. AMENDMENTS TO RECORDS: You have the right to request that we amend your health information. Such requests must be made in writing, and must explain why the information should be amended. We may deny your request under certain circumstances.

E. ELECTRONIC NOTICES: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form as well.

QUESTIONS AND COMPLAINTS:
If you want more information about our Privacy Practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made or any decision we may make regarding the use, disclosure, or access to your health information you may complain to us using the contact information listed below. You also may submit a written complaint to the U.S. Department of Health and Human Services.

Please direct any of your questions or complaints to:

CONTACT: Dr. Albert Noble, Enterprise Chiropractic Clinic
FAX: 503-639-2052
E-MAIL: info@drnoble.net

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NAME: _____ DATE: _____ CLAIM NUMBER: _____

GENERAL PRECAUTIONS AND INSTRUCTIONS

Strong and very rapid forces may be involved in your automobile accident. It is important that you watch for any new symptoms that might be a sign of hidden injury and/or increased inflammation. It is normal to feel soreness, pain, and tightness in your body, often getting worse the second or third day. However, more severe pain and new symptoms such as numbness, tingling, balance issues, and weakness in your arms and legs should be reported to your doctor as soon as possible. Although you may have a lot of soreness, stiffness, and/or pain, most people recover over time.

As a result of a motor vehicle collision, some people feel a general sense of stress or anxiety which can lead to trouble sleeping or irritability. Some people feel like avoiding driving in vehicles for some time. In the majority of cases, these feelings go away within a few days or weeks.

AVOID NEW INJURIES

It is important for the first week or two weeks to avoid any high-risk physical activities or contact sports that may re-injure you and cause new injuries. Avoid excessive jarring activities or extreme physical activities, such as heavy lifting.

HOME CARE

It is important to comply with the home recommendations that the doctor gives you. Your doctor will be giving you advice about how important it is to keep physically active during the healing process.

- Do not sit-up in bed watching TV or reading or sit on soft couches. Firmer chairs are advised.
- Avoid twisted positions with your neck and back
- Lie on the floor or bed with your legs and knees bent with a pillow under your knees to reduce back pain
- Change your body position every 30 minutes for the next week
- Do slow and gentle stretches 4-6 times a day for 1-2 minutes. Do not push into moderate or severe pain. Stretches can include sitting shoulder rolls, lying on the floor and gently holding each knee to the chest, and general flexibility motions for the neck and back. As you feel better the stretches can be increased.
- Take short walks every day (start with level surface) for 5-10 minutes and repeat 3-4 times each day. Work up to longer walking periods and gradually increase your walking speed and time. The goal is to get you walking an hour a day. Once you feel better then you can walk up hills.
- Avoid sitting/standing or any awkward positions for prolonged periods for the next two weeks.
- Use good posture and proper body mechanics over the next few weeks.
- Getting an extra 30-60 minutes of extra sleep a night is recommended for the first week. Make certain to get restful sleep.
- Use ice for the following 3-4 days. Place a thin towel between the ice pack and your skin and keep the ice on for the prescribed length of time. Do not fall asleep with ice pack on. Neck: ice for 10-15 minutes Back: ice for 20-30 minutes.

GOALS OF THIS OFFICE

The primary goal of this office is to restore your ability to return to your normal pre-injury physical activities of daily living; including work, home, sports, and recreational activities. Our office focuses on improving joint and soft-tissue function by providing appropriate therapies to injured areas thus assisting your body in healing, reducing pain levels and aiding in your recovery. Your active participation at home and work is important in the recovery process and your compliance with the appointments and exercise recommendations will improve your outcome.

MONITORING YOUR PROGRESS IS IMPORTANT TO OUR OFFICE

Our office staff will periodically ask you to fill out additional paperwork that is designed to document your response to spinal manipulation and other therapies/procedures. Your responses allow our office to determine if your treatment outcome is on track, if your treatment needs to be changed or modified, if further testing is indicated, if a consultation by another health care provider is needed, or if a referral is indicated.

FOLLOW-UP APPOINTMENTS

It is important that you keep all of your appointments and follow all home instructions, including exercise, stretching, use of ice, and watching your posture. Call your doctor if you have any problems. If you miss or do not show-up for two appointments, our office will need to talk to you about your absence and find some way to work with your schedule. If four scheduled appointments are missed the office may refer you to another provider, depending upon circumstances.

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NAME: _____ DATE: _____ CLAIM NUMBER: _____

DYANOMETER READINGS
For Personnel only

Left Hand	Right Hand
1.) _____	1.) _____
2.) _____	2.) _____
3.) _____	3.) _____

Average for Left Hand: _____
Average for Right Hand: _____

PHYSICAL EXAMINATION

Height: _____ Weight: _____ B.P. ____/____Pulse: _____

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