DALE E. SPRINGHILL D.C.

4045 Lake Otis Pkwy, Suite 204 • Anchorage, AK 99508 • (907) 276-3800 • Fax (907) 276-3810

Last Name: _____ First Name: _____ Int: _____

Street Address: _____ Zip: _____

Mailing Address: _____

City/State: _____ Zip: _____

Social Security #: _____ Phone: _____

Birth date: _____ Age: _____ Sex: M F Pregnant: Yes No Marital: M S W D

Occupation: _____ Employer: _____ Office Phone: _____

Address: _____ Spouse's Name: _____

Referred by: _____ Employer: _____

Purpose of this appointment: (circle one)

A) Spinal problem B) Preventive care C) Car accident D) Work accident

Other doctors seen for this condition: _____ Date of last physical exam: _____

What operations have you had: _____

Do you have any of these conditions?

Dizziness _____ Arthritis _____ Nervousness _____ Backaches _____

Headaches _____ Sinus trouble _____ Heart trouble _____ Asthma _____

Anemia _____ Diabetes _____ High blood pressure _____ Digestive disorders _____

Tuberculosis _____ Rheumatic fever _____ Other _____

Payment is expected at time of visit! Method: ☐ cash ☐ check ☐ Insurance ☐ VISA/Mastercard

Name of insured/primary card holder: _____ Insurance Co: _____

Policy Number: _____ Group No. _____

Submission Address: _____ Phone: _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. Dr. Springhill's office bills your insurance as a courtesy only. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Signature: _____ **Date:** _____

Auto Injury Information

Patient Name:_____ Date of Injury:_____

Was the vehicle you were in at fault? **Yes** **No**
Were you the driver? **Yes** **No**

Your insurance information: **(Regardless of fault – this must be complete)**

Insurance Company Name _____

Address _____ Phone No_____

Adjuster's Name _____ Phone No_____

Claim Number _____

Other Party Insurance information (if applicable)

Policy Holder's Name _____

Insurance Co. Name _____

Address _____ Phone No_____

Adjuster's name _____ Phone No_____

Claim number _____

Have you retained an Attorney? **Yes** **No**

Attorney name?_____ Attorney phone number_____

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FOR OFFICE USE ONLY

Patient Insurance: _____

Is there med pay available for our patient? **Yes** **No** If so, can you tell me how much? $_____

What is the address to send the bills? _____

If there is not med pay available, call the other party's insurance co.

Is there med pay available? If so, can you tell me how much? $_____

If this claim is a "time of settlement" payment, will you issue the check directly to the doctor or the patient?

Where may we send bills? _____

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Last Name: _____ First Name: _____ Date: _____

Date of injury: _____ Hour:_____ AM PM

If <u>auto accident</u>, please complete the following:

Were you ..... ☐ Driver ☐ Passenger ☐ Pedestrian
Were you struck from ..... ☐ Behind ☐ Front ☐ Right side ☐ Left side
Did the other car strike your car? ..... ☐ Yes ☐ No ☐ N/A
Did your car strike other auto involved? ..... ☐ Yes ☐ No ☐ N/A
Were traffic citations issued to you? ..... ☐ Yes ☐ No ☐ N/A
Were traffic citations issued to driver of other car? ..... ☐ Yes ☐ No ☐ N/A
Have you received treatment for this injury before coming here? ..... ☐ Yes ☐ No

Please explain:_____

Will your insurance company be paying in this case, or someone else's? ☐ Yours ☐ Others
Insurance company's name:_____

Telephone number: _____ Agent/adjuster's name: _____

Do you have an attorney that has advised you in this case? ☐ Yes ☐ No
Attorney's name: _____Telephone number: _____

If <u>work related</u> accident, please complete the following:

Did you report your injury to your supervisor or employer? ☐ Yes ☐ No
Were you hospitalized? ☐ Yes ☐ No If yes, name of hospital: _____
Was same body part injured before? ☐ Yes ☐ No If yes, when _____
Describe: _____
Describe injury and explain how it happened: _____
_____
_____
Have you lost any time from work? ☐ Yes ☐ No Last day worked: _____
Have you been contacted by an insurance adjuster or company representative regarding this claim? ☐ Yes ☐ No
If yes, please give name and claim number if possible: _____
Do you have an attorney that has advised you in this case? ☐ Yes ☐ No
Attorney's name: _____Telephone number: _____

Check symptoms you have noticed since accident:

☐ Dizziness	☐ Headache	☐ Depression	☐ Loss of memory
☐ Head seems too heavy	☐ Neck pain	☐ Irritability	☐ Ears ring
☐ Pins/needles in arms	☐ Neck stiff	☐ Cold sweats	☐ Ears buzzing
☐ Pins/needles in legs	☐ Mid back pain	☐ Stomach upset	☐ Face flushed
☐ Numbness in fingers	☐ Low back pain	☐ Diarrhea	☐ Loss of balance
☐ Sleeping problems	☐ Leg pain	☐ Feet cold	☐ Fainting
☐ Shortness of breath	☐ Tension	☐ Hands cold	☐ Loss of smell
☐ Nervousness	☐ Fatigue	☐ Light bothers eyes	☐ Loss of taste

List any symptoms or injuries not listed above: _____

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HIPAA NOTICE OF PRIVACY PRACTICES

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment, health care operations, and other purposes that are permitted or required by law. It also describes your rights to access and control your PHI. "Protected Health Information" is information about you that may identify you and relates to your past, present, or future health conditions and related health care services.

Your PHI may be used and disclosed by our office and others outside our office that are involved in your healthcare treatment, bill payment, support of healthcare operations (calling you by name in the office, having your patient file on the counter, or contacting you to remind you of your appointment), and other uses required by law.

We may use or disclose your PHI in worker's compensation, law enforcement, and legal proceedings without your authorization.

Other required uses and disclosures will only be made with your consent.

You may revoke this authorization in writing.

You have the right to inspect and copy your PHI. Under federal law you may not inspect or copy records pending a civil, criminal, or administrative action or proceeding.

You have the right to request a restriction of your PHI. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care. Your request must state the specific restriction requested and to whom you want the restriction to apply. We are not required to agree to your restriction request. If we believe it is in your best interest to permit use and disclose your PHI, your PHI will not be restricted. You then have the right to use another healthcare professional.

You have the right to request confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice.

You have the right to receive an accounting of certain PHI disclosures we have made.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. We will not retaliate against you for filing a complaint.

We are required by law to provide you with this notice of our legal duties and privacy practices regarding your PHI. If you have any objections to this form, please let us know.

Your signature below acknowledges that you have received this notice of our privacy practices.

Print Name: _____

Signature: _____ Date: _____

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DOCTOR'S LIEN

I do hereby authorize Dale E. Springhill, D.C. to furnish you, my attorney/insurance carrier, with a full report of his examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I was involved.

I hereby authorize and direct you, my attorney/insurance carrier, to pay directly to said doctor such sums as may be due and owing him for chiropractic services rendered me both by reason of this accident and by reason of any other bills, including interest on the unpaid balance of my account, that are due his office and to withhold such sums from any settlement, judgment or 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 my settlement, judgment or verdict which may be paid to you, my attorney, or myself as a result of the injuries for which I have been treated or injuries in connection therewith.

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

Patient's Signature: _____ Date: _____

The undersigned being attorney of record or authorized representative of insurance carrier 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 the said doctor named above.

Authorized Signature: _____ Date: _____

I hereby state and agree that a photocopy of this document will be deemed as valid and binding on all parties as the original copy.