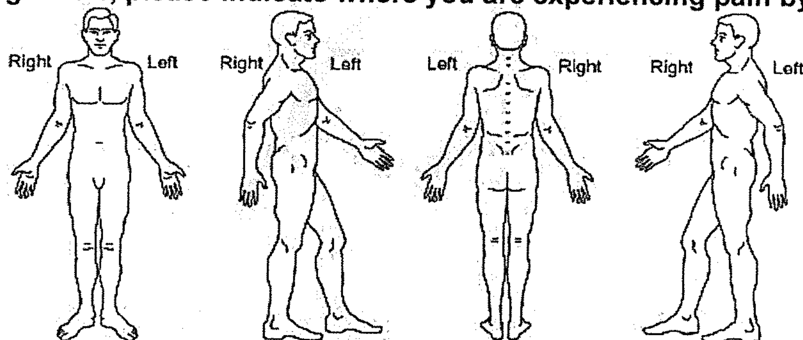
Patient Basic Information

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.



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.:

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:** ____________

ACTIVITIES OF DAILY LIVING / DUTIES UNDER DURESS — Total Health Family Clinics

NAME:________________________________ **FILE#**____________________ **DATE:**________

Work/School Job Title: ____________________ Do not work/go to school (skip this section): _____

Sitting	o No Effect	o Painful (Can Do)	o Painful (Limited)	o Unable to Perform
Standing	o No Effect	o Painful (Can Do)	o Painful (Limited)	o Unable to Perform
Bending	o No Effect	o Painful (Can Do)	o Painful (Limited)	o Unable to Perform
Lifting	o No Effect	o Painful (Can Do)	o Painful (Limited)	o Unable to Perform
Walking	o No Effect	o Painful (Can Do)	o Painful (Limited)	o Unable to Perform
Computer work	o No Effect	o Painful (Can Do)	o Painful (Limited)	o Unable to Perform
Other:				
Doctor notes:				

Home (Inside House)

Cooking	o No Effect	o Painful (Can Do)	o Painful (Limited)	o Unable to Perform
Dishes	o No Effect	o Painful (Can Do)	o Painful (Limited)	o Unable to Perform
Cleaning (scrub, mop, sweep	o No Effect	o Painful (Can Do)	o Painful (Limited)	o Unable to Perform
Vacuum	o No Effect	o Painful (Can Do)	o Painful (Limited)	o Unable to Perform
Laundry	o No Effect	o Painful (Can Do)	o Painful (Limited)	o Unable to Perform
Stairs	o No Effect	o Painful (Can Do)	o Painful (Limited)	o Unable to Perform
Playing/lifting kids (grandkids)	o No Effect	o Painful (Can Do)	o Painful (Limited)	o Unable to Perform
Sitting (TV, games, etc…)	o No Effect	o Painful (Can Do)	o Painful (Limited)	o Unable to Perform
Other:				
Doctor notes:				

Doctor Initial: _______

Home (Outside House)

Yardwork/Garden	○ No Effect	○ Painful (Can Do)	○ Painful (Limited)	○ Unable to Perform
Shopping	○ No Effect	○ Painful (Can Do)	○ Painful (Limited)	○ Unable to Perform
Carry groceries/Trash	○ No Effect	○ Painful (Can Do)	○ Painful (Limited)	○ Unable to Perform
Transportation/Driving	○ No Effect	○ Painful (Can Do)	○ Painful (Limited)	○ Unable to Perform

Other: ____________________

Doctor notes: ____________________

Social

Kids activities	○ No Effect	○ Painful (Can Do)	○ Painful (Limited)	○ Unable to Perform
Spouse/Significant other (Intimacy)	○ No Effect	○ Painful (Can Do)	○ Painful (Limited)	○ Unable to Perform
Activities with friends/family	○ No Effect	○ Painful (Can Do)	○ Painful (Limited)	○ Unable to Perform

Other: ____________________

Doctor notes: ____________________

ORIGINAL

Emotional

Frustrated by the incident	○ Yes	○ No
Avoid driving	○ Yes	○ No
Hyperalert when driving	○ Yes	○ No
Dreams/nightmares about incident	○ Yes	○ No

Other: ____________________

Doctor notes: ____________________

Exercising/Lifting Weights/Running (Cardio)/Playing Sports

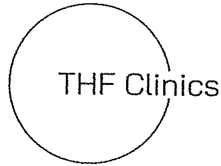
○ Did not exercise prior to incident	○ Able to fully participate	○ Painful (Can Do)	○ Painful (Limited)	○ Unable to Perform

Additional Details: ____________________

Doctor Initial: ______

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:

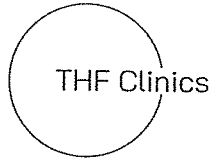
______________________________ ______________________________
Signature of Witness Date Signature of Witness Date

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.
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

I hereby IRREVOCABLY authorize:

Insurance Company: ______________________________

Claim Number: ______________________________

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

THF Clinics
6521 ANNAPOLIS ROAD
LANDOVER HILLS, MD 20784

Patient or Parent Signature: ____________________ Date: __________

Parent or Guardian of: ______________________________

TOTAL HEALTH FAMILY CLINICS

By signing below, I have read, understand and agree to 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 of Privacy Practices.
2. **Financial Responsibility:** It is understood that the statue of limitations in this state is three (3) years from the time services were performed. It is further understood that if I pursue personal injury case that due to long delays in the settlement process and/or 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 the good and valid consideration of TOTAL HEALTH FAMILY CLINICS agreement to wait for payment until a verdict is rendered, 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.

   It is further understood that if I have an Authorization and Assignment on file with TOTAL HEALTH FAMILY CLINICS and the statute of limitations has lapsed due to a pending personal injury claim and/or my attorney withdraws from the case, I hereby agree to waive the defense of statute of limitations in the event that a claim is filed against me by reason of unpaid bill, and I WILL NOT RAISE THE STATUTE OF LIMITATIONS AS A DEFENSE.

   If for any reason I decided not to purse this case or if my attorney withdraws his/her representation or I transfer my case to another attorney, I will immediately notify TOTAL HEALTH FAMILY CLINICS of the change.

   It is understood that I am responsible for the entire balance of my bill, regardless of the source of payment, the outcome of my personal injury case, the referral of any attorney or other practitioner to TOTAL HEALTH FAMILY CLINICS. TOTAL HEALTH FAMILY CLINICS expects payment of its fees for services rendered within thirty (30) days of the last date of treatment. However, if payment is not made within 30 days and a settlement or verdict is reached, the balance is due out of any proceeds of said settlement or verdict and is payable within thirty (30) days of the settlement or verdict.

   Interest at the rate of eighteen (18%) per annum will be assessed on any balance not paid when due. IF IT BECOMES NECESSARY TO PLACE THIS ACCOUNT IN COLLECTIONS, I AGREE TO BE RESPONSIBLE FOR REASONABLE ATTORNEY FEES EQUAL TO TWENTY-FIVE (25%) OF THE UNPAID BALANCE, TOGETHER WITH ADDITIONAL COSTS, EXPENSES OF COLLECTION AND INTEREST TO THE EXTENT PERMITTED BY LAW, AND POST JUDGMENT INTEREST AT THE LEGAL RATE.

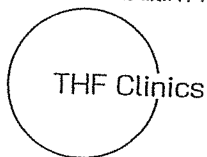
3. **Release of Information to my attorney, other providers, and insurance companies:** I authorize TOTAL HEALTH FAMILY CLINICS to release any information, pertinent to my case to any insurance company, adjustor, other healthcare providers, and attorney involved in this case; I hereby further release TOTAL HEALTH FAMILY CLINICS of a consequence thereof.
4. **Power Of Attorney: I give my power of attorney to TOTAL HEALTH FAMILY CLINICS to endorse and /or negotiate checks 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 solely for the benefit of THF CLINICS LLC.**

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

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______________________

www.TotalHealthFamilyClinic.com
ContactUs@TotalHealthFamilyClinic.com

TOTAL HEALTH FAMILY CLINIC

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

5730-A Silver Hill Rd.
District Heights, MD 20747
Phone: 301-735-5775
Fax: 301-735-3677

Informed Consent Document

PATIENT NAME: ____

To the Patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The nature of the chiropractic adjustment.

The primary treatment used by doctors of chiropractic is spinal manipulative therapy. I will use that procedure to treat you- I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis / Examination / Treatment

As a part of the analysis, examination, and treatment, you are consenting to the following procedures:

Spinal manipulative therapy (chiropractic adjustments), Rehabilitative exercises, Palpation, Vital signs, Range of motion testing, Orthopedic testing, Basic neurological testing, Muscle strength testing, Postural analysis testing, Hot/Cold therapy, Electrical muscle stimulation, Intersegmental traction

___Other (please explain)

____

____

The risks inherent in chiropractic adjustment.

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. The Doctor 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 Doctor's attention it is your responsibility to inform the Doctor.

TOTAL HEALTH FAMILY CLINIC

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

5730-A Silver Hill Rd.
District Heights, MD 20747
Phone: 301-735-5775
Fax: 301-735-3677

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE. PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW

I have read [ ] or have had read to me [ ] the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Total Health Family Clinic, and have had my questions answered to my satisfaction. By signing below, I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Dated ____________________ Dated: ____________________

Patient's Name Doctor's Name

____________________ ____________________

____________________ ____________________

Signature Signature

____

Signature of Parent or Guardian (if a minor)

Doctor's Lien

TO: Attorney/ Insurance

____

____

____

Fax #: ______________________________

Doctor
THF Clinics
6521 Annapolis Rd.
Landover Hills, MD 20784
Tel: 301-322-7777
Fax: 301-322-5151
ContactUs@TotalHealthFamilyClinic.con

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 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 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 THF Clinics to prosecute such action in its name and/or their name to compromise, settle, or otherwise resolve said claim as THF Clinics 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-name

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
THF Clinics
6521 Annapolis Rd.
Landover Hills, MD 20784
Tel: 301-322-7777
Fax: 301-322-5151
ContactUs@TotalHealthFamilyClinic.con

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 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 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 THF Clinics to prosecute such action in its name and/or their name to compromise, settle, or otherwise resolve said claim as THF Clinics 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-name

Dated __________________________ Attorney's Signature____

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