



Auto Accident Registration Form

Jimmy Labrecque, DC

Please Print

Patient Name (First, Middle, Last) _____ Date of Birth: _____

Preferred Name: _____ Gender: *Male Female* | Marital Status: *Married Single Child Divorced*

If child, List Mother's Name: _____ Father's Name: _____

Patient's Home Address: _____ City: _____ State: _____ Zip: _____

Cell #: _____ Home #: _____ Email: _____

Occupation: _____ Employer Name: _____

Emergency Contact: _____ Phone #: _____ Relationship: *Spouse Other*

GUARANTOR/ RESPONSIBLE PARTY: Check if same as patient

Name: _____ Date of Birth: _____ Relationship: *Spouse Other*

Address: _____ City: _____ State: _____ Zip: _____

Phone #: _____ Cell Home DL #: _____ State: _____

Employer: _____ Phone: _____ SS#: _____

Auto Accident Insurance:

Insurance Company: _____ PIP 3rd Party

Date of Accident: _____

Adjuster Name: _____

Adjuster Phone #: _____ EXT: _____

Claim #: _____

Assignment of Benefits

I hereby assign all medical benefits and hereby authorize my insurance carrier, including Medicare, private insurance, and any health plan, to issue payment(s) directly to Restoration Integrated Health for medical services rendered to myself and/or my dependents. I understand that ultimately, I am responsible for any amount(s) not covered by insurance. I hereby authorize Restoration Integrated Health to: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims, pursue appeals on denied or partially paid claims that are generated in the course of examination or treatment. A photocopy or scan of this document is considered as valid as the original. This order will remain in effect until revoked by me in writing.

Printed Name: _____ Relationship to Patient: _____

Signature of Patient/Guardian: _____ **Date:** _____



Auto Accident & Consultation Report

1. Location of Accident: _____ City: _____
2. Date of Accident: _____ Time of Accident: _____ Police Report: YES NO
3. Were you the:(circle) DRIVER PASSENGER
4. Were you wearing a seatbelt?(circle) YES NO
5. Did your vehicle airbags deploy?(circle) YES NO
6. Where were you struck? (circle) FRONT RIGHT SIDE LEFT SIDE BEHIND
7. What was your body position upon impact? _____
8. Direction of Travel: _____
9. Other car's direction: _____
10. Type/Model of car you were in: _____
11. Other car Model/Type: _____
12. Did your car strike the other vehicle involved?(circle) YES NO
13. Other car strike yours? (circle) YES NO
14. As a result of the accident, were traffic citations issued to you?(circle) YES NO
15. Were citations issued to the driver of the other car?(circle) YES NO
16. How did the accident occur? _____

17. How did you feel immediately after the accident: _____
18. Did you go to the Emergency Room or Hospital?(circle) YES NO
19. Were you taken to the ER or Hospital by Ambulance?(circle) YES NO
20. Have you received any treatment for your injuries?(circle) YES NO
If YES, from Whom, Where & What Type of Care? _____

21. Were you hospitalized as a result of your injuries?(circle) YES NO ;if yes, for how long? _____
22. Name and City of Hospital: _____
23. Have you had an MRI, XR, etc as a result of this accident?(circle) YES NO
If so, Where & When? _____
24. Were you off work as a result of your injuries(circle) YES NO
If yes, what was the first day you were unable to work? _____
25. Have you returned to work?(circle) YES NO ;if so give date _____

Patient/ Guardian Signature: _____

Physician Signature: _____

DOS: _____

Date: _____



Patient Name: _____ **DOB:** _____

Primary Complaint: _____

Secondary Complaint: _____

Indicate on the diagram the location and sensation
of your symptoms using the acronyms below:

O= Other

B=Burning

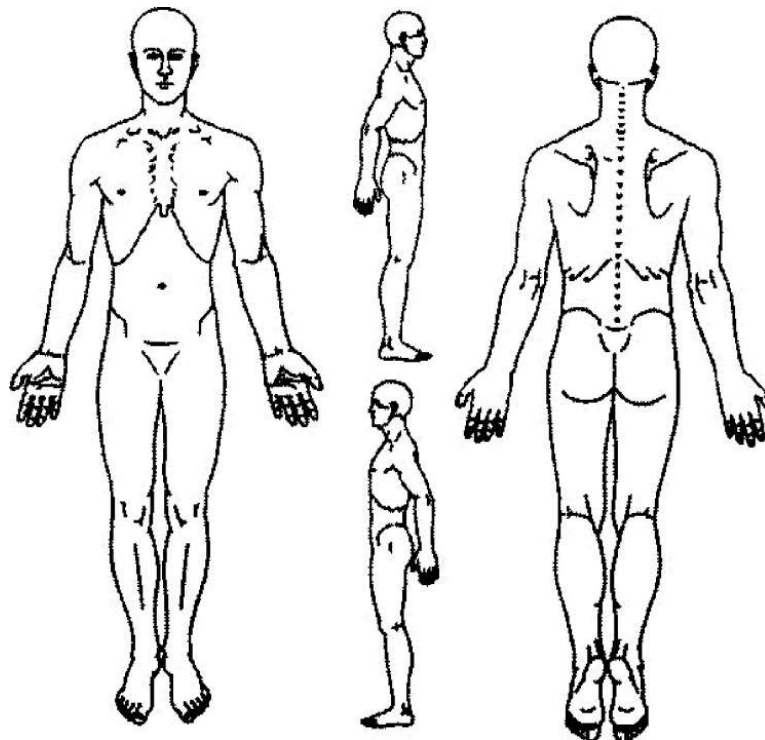
A=Aching

S=Stabbing

P= Pins & Needles

N=Numbness

D=Decreased Motion/Stiffness



Circle symptoms you have noticed since the accident:

Neck Pain	Shoulder Stiffness / Pain	Lt	Rt	Both
Neck Stiffness	Pins/Needles in Arms	Lt	Rt	Both
Head feels heavy	Hands Cold	Lt	Rt	Both
Mid Back Pain	Finger Numbness	Lt	Rt	Both
Mid Back Stiffness	Elbow/Hand Stiffness	Lt	Rt	Both
Lower Back Pain	Toe Numbness	Lt	Rt	Both
Lower Back Stiffness	Foot Pain/Stiffness	Lt	Rt	Both
Loss of Balance	Knee Pain/Stiffness	Lt	Rt	Both
	Hip Pain & Stiffness	Lt	Rt	Both

Upset stomach

Headache

Loss of Memory

Light bothers eye's

Dizziness

Fatigue

Ringin in Ears

Diarrhea

Jaw Pain/Clicking

Cold Sweats

Sleeping Problems

Tension

Nervousness

Fainting

Irritability

Constipation

Patient or Guardian's Signature: _____

DOS: _____

Relationship to patient: ☐ Self ☐ Other: _____

Physician Signature: _____

Date: _____

Patient Name: _____ **DOB:** _____**Functional Assessment:** Check any activities of life that your current conditions are affecting:

Lifting	Grasping/ Squeezing	Standing
Pushing	Over Head Reaching	Doing Chores
Pulling	Walking	Driving
Carrying	Concentrating	Sexual Activity
Bending	Doing Yard work	Reading
Squatting	Exercise	Running
Twisting	Sleeping	Sit to Stand
Rolling over	Dressing	Other: _____
Climbing	Sitting	

List Your Past Surgical History: _____

List Your Past Medical History: _____

Doctors Notes:

Patient or Guardian's Signature: _____ **DOS:** _____Relationship to patient: ☐ Self ☐ Other: _____**Physician Signature:** _____ **Date:** _____



X-Ray Explanation & Consent

Jimmy Labrecque, DC

Pt. Name: _____ Preferred Name: _____ DOB: _____

The purpose of x-rays taken in this office are to analyze and diagnose potential conditions requiring medical treatment.

By signing below, I understand that the doctor examining and analyzing the x-rays will meet with me (the patient or patient's representative) at a later date to discuss any and all findings. If I am informed of any "unusual finding" during the review of the x-rays, I understand that I must then make a determination to seek additional advice, diagnosis, or treatment for said "unusual finding".

FEMALE

Consent to evaluate(please check box):

MINOR

Pregnancy Release:

Minor child's first day of last menstrual cycle was on _____ (date)

Minor child is NOT pregnant

Minor child's has not begun this reproductive process

I, Parent/Legal Guardian, of child, hereby acknowledge the necessity for diagnostic x-rays and grant permission for my child to receive such necessary diagnostic x-rays.

ADULT WOMAN

Pregnancy Release:

First day of my last menstrual cycle was on _____ (date)

I am not pregnant

I am no longer subject to this reproductive cycle

MALE

Consent to evaluate(please check box):

MINOR

ADULT

Initial: _____

I hereby acknowledge the necessity diagnostic x-rays and consent receive such necessary diagnostic x-rays.

By my signature below I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I, therefore, do hereby consent to have the diagnostic x-ray examination my healthcare provider has deemed necessary in my minor child's case

Printed Name: _____

Date: _____

Signature of Parent/Guardian: _____

Relationship to Patient:
(please circle)

Mother

Father

Legal Guardian

Self

Pt. Name: _____ Preferred Name: _____ DOB: _____

Consent to Treat

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care. We may conduct some diagnostic or examination procedures, if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care and therapeutic exercises centrally involve what is known as a chiropractic adjustment and active stretching and strengthening. We use our hands, or an instrument, to reposition anatomical structures such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological function and overall well-being. It is important that you understand, as with all types of health care approaches, results are not guaranteed and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including but not limited to: muscle spasms, aggravating and/or temporary increase of symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains.

With respect to strokes, there is a rare but serious condition known as an "arterial dissection" that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis. Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately, a percentage of these patients will experience a stroke. The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related to 1 in 1,000,000 to 1 in 2,000,000 cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1,219 events per 1,000,000 persons per year and the risk of death has been estimated as 104 per 1,000,000 users.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

My signature below represents that:

- I have read, or have had read to me, the above consent.
- I appreciate that it is not possible to consider every possible complication to care.
- I have also had an opportunity to ask questions about this consent and, by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance.
- I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.
- I hereby request and consent to the performance of chiropractic manipulation and manual therapy techniques and other chiropractic procedures, including various modes of physical therapeutic modalities and procedures and diagnostic X-rays, where warranted, on me (or on the patient named below, for whom I am legally responsible) by the doctor(s) of chiropractic practicing at this facility now, or in the future.
- I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest. Additionally, the explained the risks associated with my refusal of treatment have been discussed with me by a licensed provider of this facility.

Signature of Patient/Guardian: _____ Date: _____

Printed Name: _____ Relationship to Patient: _____



HIPAA Privacy Authorization Form

Jimmy Labrecque, DC

Patient Name: _____

Date of Birth: _____

Authorization for Use or Disclosure of Protected Health Information

(Required by the Health Insurance Portability and Accountability Act – 45 CFR Parts 160 and 164)

This authorization affects your rights regarding the privacy of your personal healthcare information. You have the right to receive a copy of this HIPAA Privacy Authorization Form. **Please read it carefully before signing.**

Disclosure of Protected Health Information

I do not authorize this office to discuss or release my medical records or private information to anyone, including family members, or any entity.

***This option is not available for our minor patients; we must have written documentation indicating the adult caregiver(s) with whom we may discuss the child's care.**

I hereby authorize and give permission to this office to use and/or disclose my protected health information described below for the purpose(s) of treatment and care to the family member(s) or friend(s) listed below:

Person #1: _____ Relationship: _____

☐ I hereby authorize the release of my **COMPLETE** Health Record to the individual listed above

☐ I hereby authorize the release of my **PARTIAL** Health Record to the individual listed above.

Exclusions: Mental health records, Communicable , Alcohol/drug abuse treatment ; Other: _____

Person #2: _____ Relationship: _____

☐ I hereby authorize the release of my **COMPLETE** Health Record to the individual listed above

☐ I hereby authorize the release of my **PARTIAL** Health Record to the individual listed above.

Exclusions: Mental health records, Communicable , Alcohol/drug abuse treatment ; Other: _____

Patient Communication.

I understand the office must use one or more means of communication to keep me informed on all matters which relate to my treatment, appointments, billing/financial, feedback requests, and office operations and notifications.

☐ I hereby authorize the office to communicate with me via text, phone calls, email, and postal mail

☐ I do not authorize the office to contact me at my work, SMS text or email

This authorization shall be in force until properly revoked by me at which time this authorization expires.

To revoke my authorization, I must submit a Revocation of Authorization Notice to this office. Attn: Medical Records Manager.

This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct or as permitted by law.

Restoration Integrated Health and its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the

above information to the extent indicated and authorized herein.

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that information used or disclosed according to this authorization may be disclosed by the recipient and may no longer be protected by HIPAA, federal or state law.

I understand that my treatment, payment, enrollment or eligibility for benefits will not be affected by my signing/not signing this release.

Printed Name: _____ Relationship to Patient: _____

Signature of Patient/Guardian: _____ Date: _____

Pt. Name: _____ Preferred Name: _____ DOB: _____

Patients have the RIGHT

- ☐ to be treated with dignity and respect.
- ☐ to fair treatment, regardless of race, ethnicity, creed, religious belief, sexual orientation, gender, age, health status, or source of payment for care.
- ☐ to have their treatment and other patient information kept private. Only by law may records be released without patient permission.
- ☐ to access care easily and in a timely fashion.
- ☐ to a candid discussion about all their treatment choices, regardless of cost or coverage by their benefit plan.
- ☐ to share in developing their plan of care.
- ☐ to the delivery of services in a culturally competent manner.
- ☐ to information about the organization, its providers, services, and role in the treatment process.
- ☐ to information about provider work history and training.
- ☐ to information about clinical guidelines used in providing and managing their care.
- ☐ to know about advocacy and community groups and prevention services.
- ☐ to freely file a complaint, grievance, or appeal, and to learn how to do so.
- ☐ to know about laws that relate to their rights and responsibilities.
- ☐ to know of their rights and responsibilities in the treatment process, and to make recommendations regarding the organization's rights and responsibilities.

Patients have the RESPONSIBILITY

- ☐ to treat those giving them care with dignity and respect.
- ☐ to give providers the information they need, in order to provide the best possible care.
- ☐ to ask their providers questions about their care.
- ☐ to help develop and follow the agreed-upon treatment plans for their care, including the agreed-upon medication plan.
- ☐ to let their provider know when the treatment plan no longer works for them.
- ☐ to tell their provider about medication changes, including medications given to them by others.
- ☐ to keep their appointments. Patients should call their providers as soon as possible if they need to cancel visits.
- ☐ to let their provider know about their insurance coverage, and any changes to it.
- ☐ to let their provider know about problems with paying fees.
- ☐ not to take actions that could harm others.
- ☐ to report fraud and abuse.
- ☐ to openly report concerns about quality of care.
- ☐ to let their provider know about any changes to their contact information (name, address, etc).

Patients have the RIGHT and the RESPONSIBILITY to understand and help develop plans and goals to improve their health.

I have read and understood these rights and responsibilities.

Signature of Patient/Guardian: _____ Date: _____

Pt. Name: _____ Preferred Name: _____ DOB: _____

Office Insurance Policy

Our office is pleased to accept your insurance to cover a portion of your care. We will file your claim and assist you in every way that we can. However, it must be fully understood that the contract is between you and your insurance company. You are fully responsible for all charges incurred at this office whether or not covered or paid by your insurance company.

1. Since by taking your insurance on assignment we have to wait for payment. This courtesy may be withdrawn at any time. By accepting your insurance, our office is granting credit. In the event of default to pay, insurance or patient fees, reasonable collection charges or attorney fees will be forwarded to the patient.
2. Our office does not guarantee that your insurance will pay. We will make every attempt at the beginning of your care to verify your insurance coverage. If for some reason your insurance claim is denied after our attempts to recover the compensation for services rendered to you, you will be responsible for the full amount of your bill.
3. Our office will not enter into a dispute with your insurance company over your claim. This is your responsibility and obligation.
4. Only the functional care amount will be billed to the insurance company. Most insurances companies do not cover all charges or the full amount of the charges.
5. The office manager, patient, and/or guardian must sign, in advance, all special arrangements regarding finances. You are responsible for paying your portion of the care plan on the specified dates listed on the financial care agreement.
6. All x-rays and patient records are to remain permanent record of this office. The fee paid for treatment x-rays is for analysis only. The film itself is property of this office.

I understand and agree that health & accident insurance policies are an arrangement between me & an insurance company. Furthermore, I understand that this office will prepare any necessary reports and forms to assist in making collections from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. However, I clearly understand and agree that I am personally responsible for payment of all services rendered to me. I also understand that if I suspend or terminate care at this office, any outstanding charges for professional services rendered to me will be immediately due and payable. I agree that I will be responsible for all attorney and legal fees if legal action becomes necessary to collect this account. Furthermore, I authorize this office to obtain a credit report if deemed necessary.

Signature of Patient/Guardian: _____ Date: _____

Printed Name: _____ Relationship to Patient: _____