Patient Information

Patient Name: _____ Today Date: _____

Address: _____ City: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell: _____

Date of Birth: _____ SS#: _____ Sex: M / F

Employer's Name: _____ Job Title: _____

Employer's Address: _____ City: _____ Zip: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

Health Insurance Information

Name of Insurance Company: _____ Insured Name: _____

ID Number: _____ Group Number: _____ Effective Date: _____

Address: _____ Phone Number: _____

Automobile Insurance Information

Name of Insurance: _____ Date of Accident: _____

Claim Number: _____ Name of Adjuster: _____

Phone: _____ Policy Number: _____

If represented by an attorney, please complete the following:

Name of Law Officer: _____ Phone: _____

Address: _____ City: _____ Zip: _____

Fax: _____ Contact Person: _____

Our office will provide insurance billing services for you if you so desire as a courtesy. Remember that you are ultimately responsible for any charges incurred in this office. It is your responsibility to pay any deductible amount, co-insurance, and or any other balances not paid by your insurance carrier. Your signature on this document indicates that you agree to pay for any outstanding bills incurred in this office. It is essential that if your insurance carrier sends you forms that need to be signed for authorization for records that you sign these documents and send the completed forms back to the carrier as soon as possible.

Patient Signature: _____ Date: _____

SHVETS Chiropractic Inc.

Patient Name: _____

ARBITRATION AGREEMENT AND INFORMED CONSENT, PAGE 1 OF 2

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as state and deferral law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: All Claims Must be Arbitrated: It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, and procedural disputes will also be determined by submission to binding arbitration, It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the health care provider including any heirs or past, present or future spouses(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and the health care provider and/or other licensed health care providers or preceptorship interns who now or in the future treat patient while employed by, working or associated with or serving as a back-up for the health care provider, including those working at the health care provider's clinic or office or any other clinic or office whether signatories to this form or not. All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the health care provider and/or the health care provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief or punitive damages. This agreement is intended to create an open book account unless and until revoked.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's pro rate share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees, or other expenses incurred by a party for such party's own benefit.

Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator. The parties consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of state and federal law, where applicable, establishing the right to introduce evidence of any amount payable as a benefit to the patient to the maximum extent permitted by law, limiting the right to recover non-economic losses, and the right to have a judgment for future damages conformed to periodic payments, shall apply to disputes within this Arbitration Agreement. The parties further agree that the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this Arbitration Agreement.

Article 4: General Provision: All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the health care provider within 30 days of signature and if not revoked will govern all professional services received by the patient and all other disputes between the parties.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment) patient should initial here. _____. Effective as the date of first professional services.

If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected y the invalidity of any other provision. I understand that I have the right to receive a copy of this Arbitration Agreement. By my signature below, I acknowledge that I have received a copy.

Notice: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRAIL. SEE ARTICLE1 OF THIS CONTRACT.

(Or Patient Representative)

Patient Signature: _____ **Date** _____

ARBITRATION AGREEMENT AND INFORMED CONSENT, PAGE 2 OF 2

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office of clinic personnel the nature and purpose of chiropractic adjustments and procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complication, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

(Or Patient Representative)

Patient Signature: _____ **Date** _____

Auto Accident History Questionnaire

PERSONAL INJURY PATIENT HISTORY

Name _____ Date _____

1. Date of accident: _____ Time: _____
2. Driver of car: _____
3. Where were you seated? _____
4. Who owns the car? _____
5. Year, make and model of car: _____
6. What was the approximate damage done to your car? _____
   _____
7. Visibility at the time of the accident was: ☐Poor ☐Fair ☐Good ☐Other ____
8. Road conditions at the time of accident: ☐Icy ☐Icy ☐Wet ☐Clear ☐Dark ☐Other, describe,: _____
9. Where was you car struck: ☐Right ☐Left ☐Rear ☐Front ☐Side
10. Type of accident: ☐Head on Collision ☐Broad-side collision ☐Front impact ☐Rear-ended by another vehicle ☐Rear end car in front ☐Non collision
11. Describe in you own words what happened to you upon impact:
    _____
    _____
    _____
12. Did you see it coming? ☐Yes ☐No
13. Did you brace on impact? ☐Yes ☐No
14. Did you have your seatbelt on? ☐Yes ☐No
15. Were shoulder harnesses worn? ☐Yes ☐No
16. Does your car have headrests? ☐Yes ☐No
17. If yes to 16 then what was the position of those headrests compared to your head before the accident?
    ☐Top of headrest even with bottom of head
    ☐Top of headrest even with top of head
    ☐Top of headrest even with middle of neck
18. Was your car braking? ☐Yes ☐No
19. Was your car moving at the time of the accident? ☐Yes ☐No
20. If yes, how fast would you estimate you were going? _____MPH
21. How fast would you estimate the other car was going? _____MPH
22. Head \ body position at the time of impact:
    ☐Head turned ☐left ☐right.
    ☐Head looking back.
    ☐Head straight forward.
    ☐Body straight in sitting position.
    ☐Body rotated ☐right ☐left
    ☐Other: _____
23. At the time of the accident, recall what parts of your head or body hit what parts on the inside of the car: _____
24. As a result of ;the accident you were: ☐rendered unconscious ☐Dazed, circumstances vague ☐Other: _____
25. Could you move all parts of you body? ☐Yes ☐No

26. If no to 25 what parts couldn't you move and why? _____

_____

27. Were you able to get out of the car and walk unaided? ☐Yes ☐No
28. If no, why not? _____
29. Did you get bleeding cuts? ☐Yes ☐No
30. If yes, where are they located and how long, in inches? _____

_____

31. Did you get bruises? ☐Yes ☐No
32. If yes, where are they located and how long, in inches? _____

_____

33. Please describe how you felt:
    - ☐Immediately after the accident: _____
    - ☐Later that day: _____
    - ☐The next day: _____
34. Check the symptoms apparent since the accident?

☐Headache	☐Neck pain	☐Mid back pain	☐Eye's sensitive to light
☐Dizziness	☐Fainting	☐Sleeping problems	☐Pain behind the ;eyes
☐Loss of smell	☐Fatigue	☐Loss of taste	☐Numbness in fingers
☐Irritability	☐Depression	☐Loss of memory	☐Numbness in toes
☐Rigging in ears	☐Tension	☐Short of breath	☐Loss of balance
☐Cold hands	☐Cold feet	☐Diarrhea	☐Constipation
☐Chest pain	☐Nervousness	☐Cold sweats	☐Anxious

☐Other: _____

35. Occupation: _____
36. Employer: _____
37. Have you missed time from work? ☐Yes ☐No
38. If yes to 37 full time off work _____ to _____
39. If yes to 37 part time off work _____ to _____
40. Did you seek medical help immediately after the accident? ☐Yes ☐No
41. If yes, how did you get there? ☐Ambulance ☐Police ☐Someone drove me ☐Drove own car ☐Other: _____
42. Doctor # 1 Name: _____
43. Date of visit (s) _____ to _____
44. Were you examined? ☐Yes ☐No
45. Were X-rays taken? ☐Yes ☐No
46. Did you receive treatment? ☐Yes ☐No What: _____
47. Did you benefit from the treatment? ☐Yes ☐No
48. Date of last treatment? _____
49. Doctor # 2 Name: _____
50. Date of visit (s) _____ to _____
51. Were you examined? ☐Yes ☐No
52. Were X-rays taken? ☐Yes ☐No
53. Did you receive treatment? ☐Yes ☐No What: _____
54. Did you benefit from the treatment? ☐Yes ☐No
55. Date of last treatment? _____

56. Doctor # 3 Name: _____
57. Date of visit (s) _____ to _____
58. Were you examined? ☐Yes ☐No
59. Were X-rays taken? ☐Yes ☐No
60. Did you receive treatment? ☐Yes ☐No What: _____
61. Did you benefit from the treatment? ☐Yes ☐No
62. Date of last treatment? _____
63. Do you have an attorney on this claim? ☐Yes ☐No
64. If yes, who? _____
Address: _____
City: _____ State: _____ Zip _____ Phone _____

Signature _____ Date: _____

NOTICE OF DOCTOR'S LIEN

ATTORNEY	DOCTOR
_____	SHVETS CHIROPRACTIC
_____	5740 WINDMILL WAY, SUIT #3
_____	CARMICHAEL, CA 95608

Patient:_____

I do hereby authorize SHVETS CHIROPRACTIC to furnish you, my attorney with a full report of her 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, to pay directly to said doctor such sums due and owing her for medical services rendered me both by reason of this accident and by reason of any other bills that are due her office on my behalf and to withhold such sums from any settlement, judgment or verdict which may be paid to you, my attorney, 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 her for service rendered me and that this agreement is made solely for said doctor's additional protection and in consideration of her contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

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

The undersigned being attorney of record for the above patient dose 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 said doctor above-named. Attorney further agrees that in the event this litigated, that the prevailing party will be awarded attorney fees and costs.

Date:_____ **Attorney's Signature**_____

SHVETS CHIROPRACTIC INC.

5740 Windmill Way, Suite 3 • Carmichael, CA 95608 • (916) 334-8884 • Fax (916) 334-3400

Doctor's Lien

Nadezhda V. Shvets, D.C.
5740 Windmill Way, Ste. #3
Carmichael, CA 95608
916-334-8884

Insurance Company:

_____
_____
_____
_____

Medical Reports and Doctor's Lien For _____

I do hereby authorize the above doctor to furnish you with a full report of his examination, diagnosis, treatment, prognosis or anything else you may need of myself in regard to the accident in which I was involved.

I hereby authorize and direct you to pay directly to Dr. Shvets such sums due and owing her for medical services rendered to me by reason of this accident any bills that are due to her office on my behalf. Furthermore, I hereby instruct and direct you to make settlement check payable to myself and Nadezhda Shvets, D.C.

I fully understand that I am directly and fully responsible to Dr. Shvets for all my medical bills submitted by her for service rendered to me and that this agreement is made solely for Dr. Shvets' additional protection and in consideration of her contingent on any settlement, judement or verdict by which I may eventually recover said fee.

Date: _____

Patient's Signature_____

ASSIGNMENT AND PAYMENT AGREEMENT

THIS AGREEMENT, entered into this date by and between _____

hereinafter called "Patient", and _____ , hereinafter called "Provider".

WHEREAS Patient desires to receive health care services from Provider and desires to assign certain rights and benefits to Provider as an inducement to cause Provider to wait for the payment of such benefits, it is hereby agreed:

1. Patient assigns to Provider any and all benefits payable by Patient's insurance or health care plan(s) as a result of charges incurred by Patient for health care services and supplies furnished by Provider. Patient also assigns to Provider any and all contractual rights Patient has against any insurance company, health care benefit plan, or any other party contractually liable to Patient for payment of health care costs incurred by Patient as a result of services rendered by Provider. This assignment of benefits and contractual rights relating to those benefits includes, but is not limited to the following described policies or plans:

_____

_____

This assignment of benefits and contractual rights to those benefits shall not exceed the total amount of charges incurred by Patient for services rendered by Provider. The total amount paid to Provider from all sources shall not exceed the total amount of Provider's billings for services. Patient agrees that payment for services rendered by Provider is due upon receipt of said services and Provider's acceptance of Patient's assignment of benefits is a convenience to Patient, and that Provider may revoke this assignment if Patient breaches this Agreement.

2. Patient hereby directs all insurers and other persons responsible for Patient's health care costs to make all payments for health care services rendered by Provider directly to Provider.

3. Patient agrees to waive any applicable statute of limitations which may at any time interfere with Provider's right to collect for services rendered to Patient.

4. Patient agrees that in the event Patient receives any check, draft, or other payment subject to this Agreement, Patient will act as fiduciary agent for Provider and will immediately deliver said check, draft or payment to Provider. Provider agrees to apply the proceeds from the check, draft, or payments to Patient's debt for services rendered.

5. A photocopy or facsimile of this document shall be as binding as the document bearing original signatures. At the time each claim is submitted, a copy of the claim will be stored for safekeeping in Patient's file and may be picked up by the Patient/insured at any time or will, upon request by Patient/insured, be mailed to a designated address.

6. Patient agrees to be responsible for any deductibles or co-payments required by the terms of any applicable insurance or health care plan. Patient further agrees to pay for any services not covered by Patient's insurance or health care plan. In the event Patient's insurance carrier or health care plan requests reimbursement of any amounts paid to Provider, Patient shall be solely responsible for any such reimbursement and agrees to hold harmless and indemnify the Provider from any such claim for reimbursement.

7. In the event that any Section or provision of this Agreement is legally void, invalid, or unenforceable, all other Sections and provision of this Agreement shall remain in full force and effect.

8. The assignments and agreements contained in this document may not be revoked by Patient without the express written consent of the Provider.

9. In the event of any default in the performance of this Assignment, all amounts due Provider shall become immediately due and payable and Patient agrees to pay all costs of collection and attorneys fees incurred by Provider in any arbitration or litigation which shall arise therefrom. From and after the date of any such breach, the amount due Provider shall bear interest at the rate of 10% per annum.

IN WITNESS WHEREOF, this Agreement has been entered into the day and year set forth below.

_____ _____

Patient Date