Kenny Family Chiropractic & Injury Center

3418 Sonoma Blvd
Vallejo, Ca. 94590
707-552-2252

Patient Application Form

Welcome to our clinic. We specialize in assisting our patients to achieve their highest level of health through our spinal and postural corrections programs, which allows us to achieve superior corrections compared to other systems.

Please fill out the following information completely so the doctors can let you know if we can accept your case. Please feel free to ask any questions if you need assistance. We look forward to serving you.

_____

Patients Name

_____

Patients Signature

_____

Date

Kenny Family Chiropractic

Personal Injury Questionnaire

INFORMATION ABOUT YOU

Name_____ Phone_____ Email _____
Address_____ City_____ State_____ Zip_____
Age_____ Birth date_____ Sex: ( ) M ( ) F S/S#_____
Employer's Name_____ Employer's Address_____
Your Auto Ins. Co._____ Policy #_____ Agent's Name_____
Name on Policy (if other than self)_____ Policy #_____
Claim #_____ Phone #_____
Responsible Party's Name (Other Car)_____ License #_____
Other Car Auto Ins. Co._____ Phone #_____
Address_____ City_____ State_____ Zip_____
Policy Holder's Name_____ Claim #_____
Where there any witnesses? Y_____ N_____ Name_____
Have you notified your insurance of this accident? Y_____ N_____

INFORMATION ABOUT YOUR ATTORNEY

Name_____ Phone_____ Fax_____
Address_____ City_____ State_____ Zip_____

INFORMATION ABOUT YOUR ACCIDENT

1. Date of Accident_____ Time of Day_____
2. Were you: ( ) Driver ( ) Front seat passenger ( ) Back seat passenger
3. Number of people in your vehicle?_____ Were you wearing your seat belts ( ) Y ( )N
4. What direction where you headed? ( ) North ( ) South ( ) East ( ) West
5. What direction was the other vehicle headed? ( ) North ( ) South ( ) East ( ) West
6. Were you struck from: ( ) Behind ( ) Front ( ) Left Side ( ) Right Side
7. Approximate speed of your car _____mph Other car_____mph
8. Describe the damage to your car: _____
9. Were the police notified? ( ) Yes ( ) No
10. In your own words, please describe the accident:

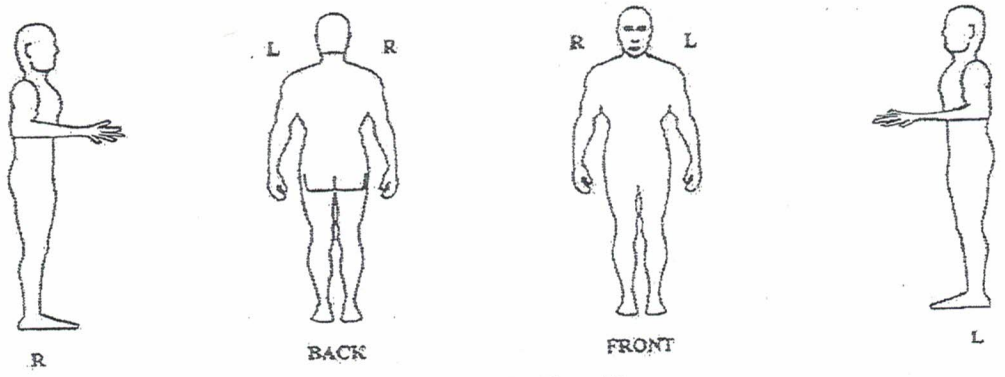
_____

_____

11. Have you had an estimate of damage to the vehicle?_____
12. Please describe how you felt:
    a. Immediately after the accident_____
    b. The Next Day_____
13. Where were you taken after the accident?_____
14. Have you been treated by another doctor since the accident? ( ) Y ( ) N
    If yes whom?_____
15. Since the injury occurred, are your symptoms : ( ) Improving ( ) Getting Worse ( ) Same

AREA(S) OF COMPLAINT

Place "X's" on the area(s) where you have pain and draw lines to where it radiates:



Did you have any of the above complaints before your injury? Yes No

Are you experiencing any of the following since your injury? (mark all that apply)

___Headaches
___Neck Pain
___Anxiety
___Fatigue
___Sore throat
___Knee Pain
___Hip Pain
___Blurry vision
___Rapid heartbeat
___Urinary difficulties
___Skin problems
___Memory lapses
___Chest Pain
___Mid Back Pain
___Dizziness/Loss of balance
___Blood/Lymph disorders
___Digestive Problems
___Breathing Problems
___Hot/Cold Flashes
___Low Back Pain
___Ankle/Foot Pain
___Indigestion
___Shoulder Pain
___Elbow Pain
___Wrist/Hand Pain
___Upper Back Pain
___Weight Loss/Gain

TREATMENT INFORMATION

Did you go to the Emergency Room? (Yes / No) If yes, when? _____

Name of the Hospital Emergency Room: _____

List any medications that you were given: _____

List any instructions that you were given: _____

From the following list, circle the treatment(s) that you received at the Emergency Room:

Exam / X-Ray / MRI / CT Scan / Back Brace / Neck Brace / Home Instructions / Other_____

List all the doctors that you have seen as a result of your injuries (other than at the ER):

	Date	Doctor	Treatment
1.			
2.			
3.			

Do you have any future appointments with any doctor regarding your injuries? (Yes / No)

If yes, when and with whom? _____

Patient/Guardian Signature_____ Date _____

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HIPAA Patient Consent Form

Our notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing the consent. The terms of the notice may change. You can contact our office for an updated copy.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or healthcare operations. We are not required to agree with these restrictions.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and healthcare operations. You have the right to revoke this consent in writing signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent.

_____ ____/____/____

Signature Date

Kenny Family Chiropractic

Informed Consent to Chiropractic Treatment

The nature of chiropractic treatment: The doctor will use his/her hands or a mechanical device in order to move your joints. You may feel a "click" or "pop", such as the noise when a knuckle is "cracked", and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound or dry hydrotherapy may also be used.

Possible Risks: As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or minor complications.

Probability of risks occurring: The risks of complications due to chiropractic treatment have been described as "rare", about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke, has been estimated at one in one million to one in twenty million, and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered "rare".

Other treatment options which could be considered may include the following:

- *Over-the-counter analgesics.* The risks of these medications include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases.
- *Medical care,* typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.
- *Hospitalization* in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.
- *Surgery* in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

Unusual risks: **I have had the following unusual risks of my case explained to me.**

I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and herby give my full consent to treatment.

_____ _____ _____

Printed Name **Signature** **Date**

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both doctor and patient to be working toward the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: an adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A sate of optimal physical, mental and social well-being, not merely the absence of infirmity.

Vertebral Subluxation: A misalignment of one or more of 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than the vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis, or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it; nor do we offer advice regarding treatment prescribed by others. Therefore, you understand that seeking advice from another type of health care provider should not interfere with the vertebral subluxation corrective care provided by this office.

OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxation

I,_____ have read and fully understand the above statements.
PRINT NAME

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I, therefore, accept chiropractic care on this basis.

X_____ X_____
SIGNATURE **DATE**

PREGNANCY RELEASE

This is to certify, to the best of my knowledge, that I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been evaluation. I have been advised that x-ray can be hazardous to an unborn child.

X_____ X_____
SIGNATURE **DATE OF LAST MENSTRUAL(CYCLE)**

CONSENT TO EVALUATE AND ADJUST A MINOR CHILD

I, _____ being the parent or legal guardian of _____ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

X_____ X_____
SIGNATURE DATE

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

TO: _____

ADDRESS: _____

I, _____ request the following information:

☐ X-rays ☐ History ☐ Records ☐ Diagnosis ☐ Treatment ☐ Reports ☐ Billings

concerning my: ☐ Accident ☐ Injury ☐ Illness ☐ Other _____

To be released to:

Kenny Family Chiropractic
3418 Sonoma Blvd.
Vallejo, CA 94590
ph# (707) 552-2252 fax# (707) 552-2268

For the purpose of: _____

According to Section 123.110 of The California Health & Safety Code, these records/films must be provided within 15 days of your receipt of this notice.

Signed: _____ Date: _____

☐ Patient ☐ Spouse ☐ Parent ☐ Guardian

A110

KENNY CHIROPRACTIC, INC.
3418 Sonoma Blvd
Vallejo, Ca 94590
707 552-2252 fax 707 552-2268

PI FINANCIAL ARRANGEMENT

We would like to take a moment to welcome you to our office and to assure you that you will be receiving the very best care available for your condition. To familiarize you with the financial policy of our office, I would like to explain how your medical bills will be handled. Please check the statement that applies to you and sign the bottom.

☐ Med Pay Coverage: (Code 491. The rating plan of a motor vehicle liability insurer shall not provide for an increase in the premium if based upon an accident in which the insured is not at fault, in any manner, as determined by wither the accident report or the insurer. In the event the
Insurer determines that it's insured is at fault contrary to an accident report's specific finding that the insured is not at fault, the insurer shall reach it's conclusion only after an investigation.)
We will bill your auto insurance courtesy. (Requirement: Must have medical pay under policy.)

☐ Attorney:
We can refer you or if you have one in mind, so you can retain an attorney to represent you and submit all medical records including billing statements to attorney at the end of your care to guarantee our medical lien.

☐ Cash Payments:
You agree to pay for your care in advance and then later you can seek reimbursement by the responsible party, only after you have finished your care.

☐ Credit Card on file and copy of drivers license:
We will keep you credit card on file and it will be charged every 4th week for the full regular and customary fees.

We believe this clear definition of our PI financial policy will allow us all to concentrate upon the most important issue of your Health and well being.

I have read and agree to the above.

_____ _____

Patient's Signature Date

Kenny Family Chiropractic
3418 Sonoma Blvd.
Vallejo, CA 94590
ph#(707) 552-2252 fax#(707) 552-2268

NOTICE OF DOCTOR'S LIEN

Patient: _____ Date of Accident: _____

I do hereby authorize Dr. Jerry M. Kenny, D.C. to furnish you, my attorney, with a full report of his examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I was recently involved.

I hereby authorize and direct you, my attorney, to pay directly to said doctor such sums as may be due and owing him for the medical service rendered me both by reason of this accident and by reason of any other bills that are due his office and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect and fully compensate 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 witch 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 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 payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

I agree to promptly notify said doctor of any change or addition of attorney(s) used by me in connection with this accident, and I instruct my attorney to do the same and to promptly deliver a copy of this lien to any such substituted attorney(s).

Please acknowledge this letter by signing below and returning to the doctor's office. I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment and may declare the entire balance due and payable.

_____ _____

DATED PATIENT'S SIGNATURE

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, judgment, or verdict, as may be necessary to adequately protect and fully compensate said doctor above-named. Attorney further agrees that in the event this lien is litigated, that the prevailing party will be awarded attorney fees and costs.

_____ _____

DATED ATTORNEY SIGNATURE

POWER OF ATTORNEY TO ENDORSE CHECKS

KNOW ALL MEN BY THESE PRESENT: That the undersigned has made, constituted and appointed, any of these present does hereby make, constitue and appoint the office of:

KENNY FAMILY CHIROPRACTIC

And any of it's duty authorized agents and employees as and to be the undersigned's true and lawful Attorney in Fact for, and in the undersigned name, place and stead to endorse any and all cheks, drafts, or money orders which are made payable to the undersigned alone or to the undersigned and the said office of:

KENNY FAMILY CHIROPRACTIC

Which checks drafts or money orders are to pay for Chiropractic services or the like which may have been made by the office of:

KENNY FAMILY CHIROPRACTIC

At the request or within the knowledge and approval of the undersigned and/or the maker of the check, draft or money order.

The undersigned by these presents does thus give and grant unto the said office of

KENNY FAMILY CHIROPRACTIC

The full power and authority to do and perform all and every act and thing whatsoever requisite and necessary to be done in and about the premised as fully to all intents and purposes as the undersigned might or could do personally present in so far as the endorsing and cashing of said check are concerned.

The undersigned does hereby ratify and confirm any and all actions taken by the office of

KENNY FAMILY CHIROPRACTIC

As Attorney In Fact, in accordance with this special power of attorney and shall do or cause to be done by virtue of these presents.

IN WITNESS WHEREOF the undersigned have hereunto set their hand, this

_____Day of _____

_____
Signature of Patient

_____
Patient's Full Name

_____
Witness to Patient's Signature

_____
Witness's Full Name

ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO DOCTOR

Patient Name: _____

Address: _____

City: _____ State _____ Zip: _____

Employer: _____

Claim or Group # _____

SS# or ID# _____

I hereby instruct the above named Insurance Company to pay by check made out to and mailed directly to:

Kenny Family Chiropractic
3418 Sonoma Blvd.
Vallejo, CA 94590
ph# (707) 552-2252
fax#(707) 552-2268

If my current policy prohibits direct payment to the doctor, then I hereby instruct and direct you to make out the check to me and mail it as follows:

C/0

Kenny Family Chiropractic
3418 Sonoma Blvd.
Vallejo, CA 94590
ph#(707) 552-2252
fax#(707) 552-2268

for professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional fees for non-covered services and/or fees, over and above the insurance payment or as required by my insurance policy.

A photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney for the purpose of securing payment under this policy of insurance.

Dated at _____ County, this _____ day of _____

_____ _____

Signature of Policy Holder Witness

_____

Signature of Claimant, if other than Policyholder

THIRD PARTY MEDICAL LIEN AND ASSIGNMENT

PATIENT: _____

CLAIM #: _____

DATE OF INJURY: _____

I hereby authorize and direct _____ Insurance Company, to pay to Dr. _____ such sums as may be due and owing him/her for medical/chiropractic services rendered me by reason of the accident and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect and fully compensate said doctor. And I hereby further request that payment be made directly to said doctor which would otherwise be paid to myself, as the result of the treatment charges injured for injuries in connection therewith. This is a direct assignment of my rights and benefits under this claim.

I fully understand that I am directly and fully responsible to said doctor for all medical bill submitted by him/her for services rendered me and that this agreement is made solely for said doctor's protection and in consideration of his/her awaiting payment. And I further understand that such payments are not contingent on any settlement, judgment or verdict which I may eventually recover.

Please acknowledge your agreement to this request by signing below and returning to the doctor's office below. I have been advised that if you do not wish to cooperate in protecting the doctor's interest, the doctor will not await payment, but may declare the entire balance due and payable by me.

_____ _____

Date Patient's Signature

The undersigned insurance company 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 and fully compensate said doctor above and below named and make payment payable directly to said doctor.

_____ _____

Date Signature of Insurance Company Representative

_____

Print First and Last Name

_____

Insurance Company Name

Please date, sign and return one copy to the doctor's office below.

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Vallejo, CA 94590
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