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Comprehensive Health and Chiropractic Centre

Family Practice – **Personal Injury**

555 South Rancho Santa Fe Road, Ste. 102
San Marcos, CA 92069
(760) 736-0286 · (760) 736-3113

PERSONAL DATA	Date:__________ Chart Number:______________________ Date of Accident: ___________________ Home phone:______________________________ Cell phone: ________________________________ Last Name:________________________________ First Name:_________________________ M.I.___ Address: ____ City: _____________________ State:________ Zip:___________ Work Phone: __________________ Birthdate:______________ Age:_______ Sex: M F Height:_________ Weight: ________ Please check one: ❑Minor ❑Single ❑Married ❑Divorced ❑Separated ❑Widowed SSN:_________/______/___________ Your Driver's Lic.#:__________________________ Are you/have you been disabled from work?____ E-mail address: ____ We call you before your appointment to remind you of the appointment. Would you like to be reminded by: (please check your choice) ❑Telephone ❑E-mail ❑ Text ❑None If telephone number is selected, which number? 1) Home 2) Cell 3) Work (please circle your choice) We send text messages (i.e., Happy Birthday) Would you like to receive these messages? ❑ Yes ❑No Would you like to receive our newsletter by e-mail? ❑ Yes ❑No
BUSINESS DATA	Business phone:_________________________ Business/Employer:____ Type of work:____________________________________ Address:____ City: __________________________________ State:________ Zip:___________
FAMILY DATA	Spouse's name:_________________________ Social Security #____________________________________ Business phone:_________________________ Business/Employer:____ Type of work:____________________________________ CHILDRENS NAMES Name_________________ Age:_____ Name_________________ Age:_____ Name_________________ Age:_____ Name_________________ Age:_____
EMERGENCY CONTACT	Name and address of nearest relative not living with you: Name:____ Relationship: ______________________ Phone# (Cell) _________________ (Home) _____________________ (Work) ______________________
REFERRAL	Referred to this office by:____

PERSONAL INJURY QUESTIONNAIRE

2

AUTO INSURANCE INFORMATION

Who is the insured person on your policy? ________________________________

Name of your insurance company: ____

Address: ____
(street) (city) (state) (zip)

Phone # of ins. co.: ______________________________________

Policy #: ____

Accident Claim #: ______________________ Who was at fault? Name: ____

(patient _________ insured _________ other __________________

Have you contacted an insurance adjuster or representative regarding this claim ❒No ❒Yes

Is there medical payments coverage: ❒No ❒Yes

If yes, Name of Adjuster: ____

What is the med-pay limit? ____

Have you filed an accident injury report? ❒No ❒Yes

3

OTHER PARTIES' INSURANCE COMPANY (if applicable):

Company: ____

Address: ____ Phone #: ____

Policy #: ____ Claim #: ____

4

ATTORNEY

Have you engaged the services of an attorney? ❒No ❒Yes If yes, please fill in the following:

Attorney: ____

Address: ____

City: _________________________ State: __________ Zip: ___________________ Phone: _________________

CHCC Name: ____________________________________ Date: ________________ Signature: ___________________

PERSONAL INJURY QUESTIONNAIRE

5

MEDICAL INSURANCE INFORMATION

Name of Insured ____________________ Relationship to patient ____________________
Birth Date ____________ SS# ____________ Date employed ____________
Address ____________________ City ____________ State ________ Zip ________
Insurance Co. ____________________ Phone# ( ) ________ - ________
Insurance Address ____________________ City ____________ State ___ Zip ________
Group# ____________________ Member ID# ____________________
How much is your deductible? ____________ How much have you met? ____________

Do you have additional Insurance? NO YES

Name of Insured ____________________ Relationship to patient ____________________
Birth Date ____________ SS# ____________ Date employed ____________
Address ____________________ City ____________ State ________ Zip ________
Insurance Co. ____________________ Phone# ( ) ________ - ________
Insurance Address ____________________ City ____________ State ___ Zip ________
Group# ____________________ Employer# ____________________
How much is your deductible? ____________ How much have you met? ____________
Maximum annual benefit? ____________________

6

VEHICLE ACCIDENT INFORMATION

ACCIDENT SITE

Road/Street Name: ____________________
City/State ____________________
Nearest intersection with road/street ____________
Driving conditions ❒Dry ❒Wet ❒Icy ❒Other ________
Which direction were you headed? ____________
( ) North ( ) East ( ) South ( ) West
Speed you were traveling? ____________

VEHICLE

Make and model of vehicle you were in:
____
Were you wearing a seatbelt? ❒Yes ❒No
If yes, what type? ❒Lap ❒Shoulder
Was vehicle equipped with airbags? ❒Yes ❒No
If yes, did it/they inflate properly? ❒Yes ❒No
Did your seat have a headrest? ❒Yes ❒No
If yes, what was the position of the headrest?
❒Low ❒Midposition ❒High

OTHER VEHICLE (if applicable)

Make and model of other vehicle:
____
Which direction was other vehicle headed? ____________
( ) North ( ) East ( ) South ( ) West
Speed other vehicle was traveling ____________

IMPACT

Did your car impact another vehicle? ❒Yes ❒No
Did your car impact a structure? ❒Yes ❒No
If yes, explain ____________________
____
Did any part of our body strike anything in the vehicle? ❒Yes ❒No
If yes, explain ____________________
____
Was impact from: ❒Front ❒Rear ❒Left ❒Right ❒Other ________
At the time of impact were you:
❒Looking straight ahead ❒Looking to the right
❒Looking to the left ❒Looking down
❒Looking up
Were both hands on the steering wheel? ❒Yes ❒No
If no, which hand was on the wheel? ❒Right ❒Left
Was your foot on the brake? ❒Yes ❒No
If yes, which foot was on the brake? ❒Right ❒Left
Were you: ❒Surprised by impact ❒Braced for impact
Were you: ( ) Driver ( ) Passenger ( ) Front Seat ( ) Back Seat
Number of people in your vehicle? ________

POLICE

Did the police come to the accident site? ❒Yes ❒No
Were there any witnesses? ❒Yes ❒No
Was a police report filed? ❒Yes ❒No
Was a traffic violation issued? ❒Yes ❒No
If yes, to whom? ____________________

 Name: ____________________ Date: ____________ Signature: ____________

PERSONAL INJURY QUESTIONNAIRE

ACCIDENT INJURY

In your own words, please describe accident: ____

____

____

____

____

Were you knocked unconscious? ❒No ❒Yes If yes, for how long? ____________________

Did you have any physical complaints BEFORE THE ACCIDENT? ❒No ❒Yes If yes, please describe in detail: __________

____

____

Do you have any congenital (from birth) factors which relate to this problem? ❒No ❒Yes If yes, please describe: __________

____

Do you have any previous illnesses that relate to this case? ❒No ❒Yes If yes, please describe:

Have you ever been involved in an accident before? ❒No ❒Yes If yes, please describe, including date(s) and type(s) of accidents, as well as injury(ies) received: ____________________

____

Please describe how you felt:

DURING the accident: ____________________

IMMEDIATELY AFTER the accident: ____________________

LATER THAT DAY: ____________________

THE NEXT DAY: ____________________

How did you feel? ❒Confused ❒Weak ❒Dazed ❒Nervous ❒Other ____________________

Have you missed work due to this accident/injury? ❒Missed No Work ❒Limited Work Activity

a. ❒Missed Work From ____/____/____ To: ____/____/____

b. Last Day Worked: ____________

c. Type of Employment: ____________________

d. Present Salary: ____________

e. Are you being compensated for time lost from work? ❒No ❒Yes If yes, please state type of compensation you are receiving: ____________

Prior to the injury were you able to work on an equal basis with others your age? ❒No ❒Yes

❒Other ____________________

PERSONAL INJURY QUESTIONNAIRE

8 FOR THIS INJURY

TREATMENT

Did you go to the hospital? ❒Yes ❒No

When did you go? ❒Immediately after accident ❒Next Day ❒2 days or more after the accident

How did you get to the hospital? ❒Ambulance ❒Private Transportation

Name of hospital: ____________________ Name of Doctor: ____________________

Diagnosis ____________________

____

Treatment received ____________________

____

X-rays taken ____________________

Did you self-treat your symptoms? ❒Ice ❒Heat ❒Bed Rest ❒Over-the-counter medication ❒Other ____________

If there were lacerations (cuts), where were they?

{Check the appropriate box(es)}

	Left/Right	Left/Right
❒Head	❒/❒Shoulders	❒/❒Buttocks
❒Neck	❒/❒Arms	❒/❒Hips
❒Upper/Mid Back	❒/❒Elbows	❒/❒Thighs
❒Lower Back	❒/❒Forearms	❒/❒Knees
❒Pelvis	❒/❒Wrists	❒/❒Legs
❒Chest/Rib Cage	❒/❒Hands	❒/❒Ankles
❒Abdomen		❒/❒Feet
❒Other ____________		

If x-rays were taken, what body part(s)?

{Check the appropriate box(es)}

	Left/Right	Left/Right
❒Head	❒/❒Shoulders	❒/❒Buttocks
❒Neck	❒/❒Arms	❒/❒Hips
❒Upper/Mid Back	❒/❒Elbows	❒/❒Thighs
❒Lower Back	❒/❒Forearms	❒/❒Knees
❒Pelvis	❒/❒Wrists	❒/❒Legs
❒Chest/Rib Cage	❒/❒Hands	❒/❒Ankles
❒Abdomen		❒/❒Feet
❒Other ____________		

9 CURRENT COMPLAINTS

TREATMENT

Since this injury occurred, are your symptoms: ( ) Improving ( ) Getting Worse ( ) Same

CHECK SYMPTOMS YOU HAVE NOTICED SINCE ACCIDENT:

❒Headache	❒Irritability	❒Numbness in Toes	❒Face Flushed	❒Feet Cold
❒Neck Pain	❒Chest Pain	❒Shortness of Breath	❒Buzzing in Ears	❒Hands Cold
❒Neck Stiff	❒Dizziness	❒Fatigue	❒Loss of Balance	❒Stomach Upset
❒Sleeping Problems	❒Head Seems Too Heavy	❒Depression	❒Fainting	❒Constipation
❒Back Pain	❒Pins & Needles in Arms	❒Lights Bother Eyes	❒Loss of Smell	❒Cold Sweats
❒Nervousness	❒Pins & Needles in Legs	❒Loss of Memory	❒Loss of Taste	❒Fever
❒Tension	❒Numbness in Fingers	❒Ears Ring	❒Diarrhea	❒Leg Pain
❒Arm/Shoulder Pain	❒Back Stiffness	❒Jaw Problems	❒Nausea	❒Blurred Vision

❒ Symptoms Other Than Above ____________________

Since your accident/injury have you suffered from any of the following:

❒Blurred Vision	❒Double Vision	❒Reduced Vision	❒Impaired Hearing	❒Ringing In Ears
❒Chest Pain	❒Difficulty Breathing	❒Palpitations	❒Constipation	❒Diarrhea
❒Nausea	❒Vomiting	❒Frequent Urination	❒Inability to Hold Urine	❒Painful Urination

Please complete the attached 4-page MUSCULO-SKELETAL form as thoroughly as possible, checking all appropriate boxes to document your CURRENT complaints and symptoms.

10 MUSCULO-SKELETAL - fill out a different numbered section for each injury area (for example, neck - section #1, back - section #2, leg - section #3, etc.)

{please fill out each section with only information related to that body part }

#1 PAIN COMPLAINT: ____________________

1. When did your symptoms appear?
Date of onset:_______________ Was it: ❑ Sudden ❑ Gradual

2. Is this condition getting progressively worse? ❑Yes ❑No ❑Unknown

3. Describe your pain/complaint:
❑ Dull ❑ Sharp ❑ Ache ❑ Stabbing
❑ Deep ❑ Superficial ❑ Spasm/tension ❑ Numbness
❑ Tingling ❑ Burning ❑ Stiffness ❑ Pulling

4.Radiation: Does the pain go to other parts of the body?
❑ Yes ❑ No Where?_____________________________

5. Degree: What is the degree of your pain?
❑ Mild ❑ Moderate ❑ Severe

6. Frequency: How often do you have this pain?
❑ Occasional ❑ Intermittent ❑ Frequent ❑ Constant

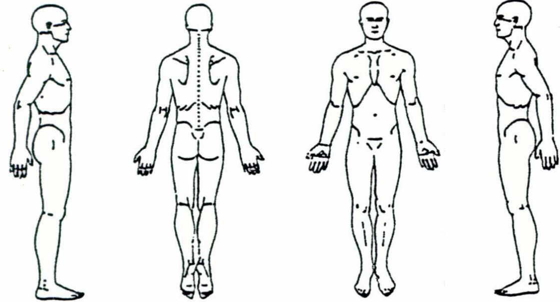
7. Duration: How long does the pain last? ___Min. ___ Hrs.____ Days

8. What makes the pain worse?
❑ Standing ❑ Sitting ❑ Bending ❑ Twisting
❑ Walking ❑ Lifting ❑ Sleeping ❑ Heat
❑ Cold ❑ Stooping ❑ Sex ❑ Other

9. What makes the pain better?
❑ Sitting ❑ Standing ❑ Rest ❑ Heat ❑ Cold
❑ Aspirin/medication ❑ Other______________________

10. Does it interfere with your :
❑ Work ❑ Sleep ❑ Daily routine ❑ Recreation

11. What treatment have you already received for this condition?
❑ Medications ❑ Surgery ❑ Physical therapy ❑ Chiropractic services ❑ None ❑ Other___________________________________



Draw/Shade the affected areas on the image(s) above to indicate your pain locations. Please use arrows to show the direction that the pain flows to or from these areas.

Please RATE YOUR PAIN!
Please circle the accurate pain level below (1-low; 10-high)
1 2 3 4 5 6 7 8 9 10

#2 PAIN COMPLAINT: ____________________

1. When did your symptoms appear?
Date of onset:_______________ Was it: ❑ Sudden ❑ Gradual

2. Is this condition getting progressively worse? ❑Yes ❑No ❑Unknown

3. Describe your pain/complaint:
❑ Dull ❑ Sharp ❑ Ache ❑ Stabbing
❑ Deep ❑ Superficial ❑ Spasm/tension ❑ Numbness
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4.Radiation: Does the pain go to other parts of the body?
❑ Yes ❑ No Where?_____________________________

5. Degree: What is the degree of your pain?
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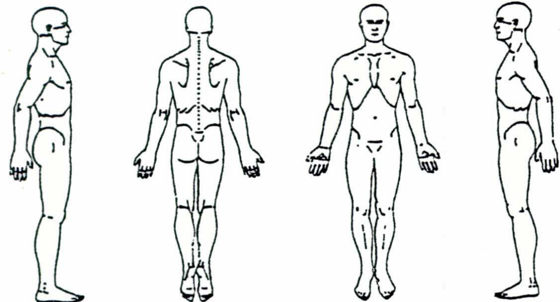

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1 2 3 4 5 6 7 8 9 10

 Name: ______________________________ Date: _____________ Signature: ______________________

10

MUSCULO-SKELETAL - fill out a different numbered section for each injury area (for example, neck - section #1, back - section #2, leg - section #3, etc.)

{please fill out each section with only information related to that body part }

#3 PAIN COMPLAINT: ____________

1. When did your symptoms appear?
Date of onset:_______________ Was it: ❑ Sudden ❑ Gradual

2. Is this condition getting progressively worse?❑Yes ❑No ❑Unknown

3. Describe your pain/complaint:
❑ Dull ❑ Sharp ❑ Ache ❑ Stabbing
❑ Deep ❑ Superficial ❑ Spasm/tension ❑ Numbness
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4.Radiation: Does the pain go to other parts of the body?
❑ Yes ❑ No Where?____________________________

5. Degree: What is the degree of your pain?
❑ Mild ❑ Moderate ❑ Severe

6. Frequency: How often do you have this pain?
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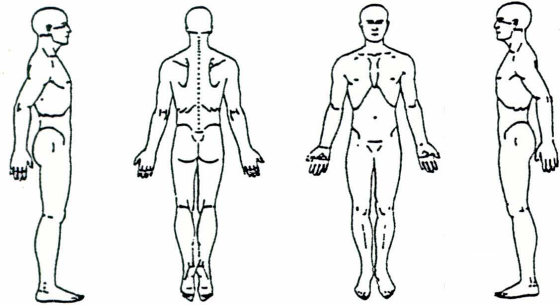

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1 2 3 4 5 6 7 8 9 10

#4 PAIN COMPLAINT: ____________

1. When did your symptoms appear?
Date of onset:_______________ Was it: ❑ Sudden ❑ Gradual

2. Is this condition getting progressively worse?❑Yes ❑No ❑Unknown

3. Describe your pain/complaint:
❑ Dull ❑ Sharp ❑ Ache ❑ Stabbing
❑ Deep ❑ Superficial ❑ Spasm/tension ❑ Numbness
❑ Tingling ❑ Burning ❑ Stiffness ❑ Pulling

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❑ Yes ❑ No Where?____________________________

5. Degree: What is the degree of your pain?
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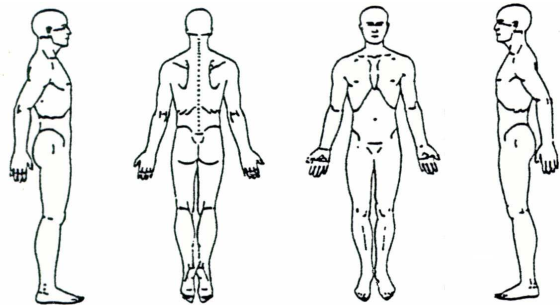

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MUSCULO-SKELETAL - fill out a different numbered section for each injury area (for example, neck - section #1, back - section #2, leg - section #3, etc.)

{please fill out each section with only information related to that body part }

#5 PAIN COMPLAINT: ____________

1. When did your symptoms appear?
Date of onset:_______________ Was it: ❑ Sudden ❑ Gradual

2. Is this condition getting progressively worse? ❑Yes ❑No ❑Unknown

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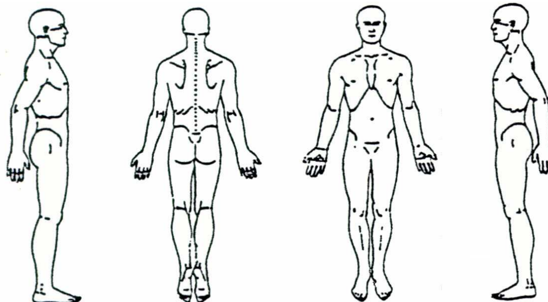

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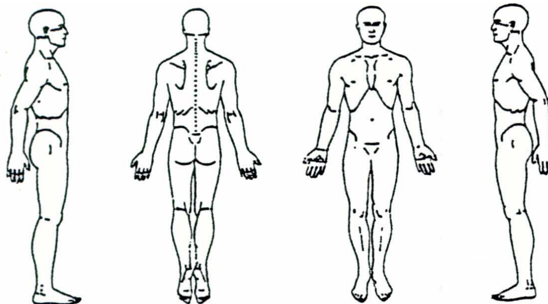

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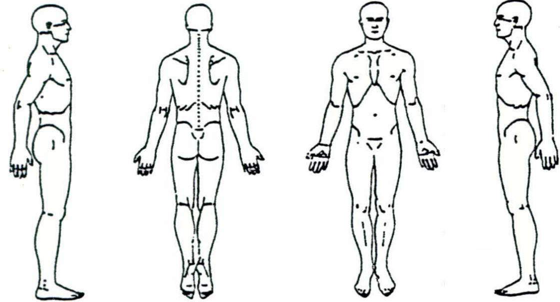
#7 **PAIN COMPLAINT:** ____________



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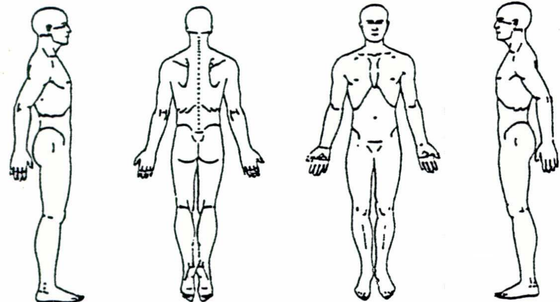
10. Does it interfere with your :
❑ Work ❑ Sleep ❑ Daily routine ❑ Recreation
11. What treatment have you already received for this condition?
❑ Medications ❑ Surgery ❑ Physical therapy ❑ Chiropractic services ❑ None ❑ Other_________________________________

Draw/Shade the affected areas on the image(s) above to indicate your pain locations. Please use arrows to show the direction that the pain flows to or from these areas.

Please RATE YOUR PAIN!
Please circle the accurate pain level below (1-low; 10-high)
1 2 3 4 5 6 7 8 9 10

#8 **PAIN COMPLAINT:** ____________



1. When did your symptoms appear?
Date of onset:_______________ Was it: ❑ Sudden ❑ Gradual
2. Is this condition getting progressively worse?❑Yes ❑No ❑Unknown
3. Describe your pain/complaint:
❑ Dull ❑ Sharp ❑ Ache ❑ Stabbing
❑ Deep ❑ Superficial ❑ Spasm/tension ❑ Numbness
❑ Tingling ❑ Burning ❑ Stiffness ❑ Pulling

4.Radiation: Does the pain go to other parts of the body?
❑ Yes ❑ No Where?___________________________
5. Degree: What is the degree of your pain?
❑ Mild ❑ Moderate ❑ Severe
6. Frequency: How often do you have this pain?
❑ Occasional ❑ Intermittent ❑ Frequent ❑ Constant
7. Duration: How long does the pain last? ___Min. ___ Hrs.____ Days
8. What makes the pain worse?
❑ Standing ❑ Sitting ❑ Bending ❑ Twisting
❑ Walking ❑ Lifting ❑ Sleeping ❑ Heat
❑ Cold ❑ Stooping ❑ Sex ❑ Other

9. What makes the pain better?
❑ Sitting ❑ Standing ❑ Rest ❑ Heat ❑ Cold
❑ Aspirin/medication ❑ Other_____________________
10. Does it interfere with your :
❑ Work ❑ Sleep ❑ Daily routine ❑ Recreation
11. What treatment have you already received for this condition?
❑ Medications ❑ Surgery ❑ Physical therapy ❑ Chiropractic services ❑ None ❑ Other_________________________________

Draw/Shade the affected areas on the image(s) above to indicate your pain locations. Please use arrows to show the direction that the pain flows to or from these areas.

Please RATE YOUR PAIN!
Please circle the accurate pain level below (1-low; 10-high)
1 2 3 4 5 6 7 8 9 10

 Name: _____________________________ Date: ____________ Signature: _____________________

11 Loss of Enjoyment of Sports, Hobbies, Travel, Daily Activities, & School (p. 1 of 2)

Patient ______________________________ Date __________________ Date of Injury ___________

❒ Initial ❒ Update

Please check all that apply to your EXERCISE & SPORTS Activity *because of the accident*

❒ My exercise was affected by this crash
❒ I go to the gym & work out in pain
❒ I no longer go to the gym to work out
❒ I run but in pain
❒ I no longer run
❒ I take walks & have pain while walking
❒ I no longer take walks
❒ I used to make income at sports
❒ I have lost sports income since crash
❒ I am an amateur athlete
❒ I am a professional athlete
❒ ____________________________
❒ ____________________________

❒ I have gained ____ pounds since the accident
❒ I had to quit my _______________ team after the accident
❒ I had to quit my _______________ team after the accident
❒ I had to quit my _______________ team after the accident
❒ I had to quit my _______________ team after the accident
❒ I don't enjoy the sport of ______________ anymore
❒ I didn't enjoy the sport of ______________for ___weeks
❒ I don't enjoy the sport of ______________ anymore
❒ I didn't enjoy the sport of ______________for ___weeks
❒ I don't enjoy the sport of ______________ anymore
❒ I didn't enjoy the sport of ______________for ___weeks
❒ I don't enjoy the sport of ______________ anymore
❒ I didn't enjoy the sport of ______________for ___weeks

Please check all that apply to your HOBBY Activities *because of the accident*

❒ My hobbies were affected by accident
❒ Hobby #1 ____________________
❒ I can't do hobby #1 anymore
❒ I do hobby #1 but in pain
❒ I have lost money from not doing #1
❒ I didn't do hobby #1 for ___weeks
❒ Hobby #2 ____________________
❒ I can't do hobby #2 anymore
❒ I do hobby #2 but in pain
❒ I have lost money from not doing #2
❒ I didn't do hobby #2 for ___ weeks

❒ Hobby #3 ____________________
❒ I can't do hobby #3 anymore
❒ I do hobby #3 but in pain
❒ I have lost money from not doing #3
❒ I didn't do hobby #3 for ___weeks
❒ Hobby #4 ____________________
❒ I can't do hobby #4 anymore
❒ I do hobby #4 but in pain
❒ I have lost money from not doing #4
❒ I didn't do hobby #4 for ___ weeks
❒ ____________________________

Please check alt that apply to your TRAVEL Activities *because of the accident*

❒ Business travel was affected by crash
❒ Pleasure travel was affected by crash
❒ I hurt driving in my own car
❒ I am in too much pain to drive
❒ I hurt when a passenger in a car
❒ I am in too much pain to sit in a car
❒ I have anxiety when I'm in a car
❒ I hurt when I'm on an airplane
❒ I am in too much pain to travel by plane

❒ Travel Plan #1 ____________________________
❒ I did not go on travel plan #1
❒ I went, but did not enjoy #1 as much
❒ I went and the accident had no effect on #1
❒ Travel Plan #2 ____________________________
❒ I did not go on travel plan #2
❒ I went, but did not enjoy #2 as much
❒ I went and the accident had no effect on #2
❒ I missed time with my family/friends b/c can't travel

11 Loss of Enjoyment of Sports, Hobbies, Travel, Daily Activities, & School (p. 2 of 2)

Patient ______________________________ Date __________________ Date of Injury ___________

❒ Initial ❒ Update

Please check all the DAILY LIVING Activities that cause you pain *because of the accident.*

❒ Dressing
❒ Putting on pants
❒ Putting on shoes
❒ Tying my shoes
❒ Putting on shirt
❒ Drying my hair
❒ Combing my hair
❒ Washing my hair
❒ Taking a shower
❒ Taking a bath
❒ Leaning forward
❒ Laying in bed
❒ Sitting in my favorite chair
❒ Sleeping
❒ Going out with my friends
❒ Sitting in a restaurant
❒ Shopping
❒ Driving to/from work
❒ Sitting in Church
❒ Playing with my children
❒ Caring for my children
❒ Bending at the waist
❒ Sitting in a movie theater
❒ Exercise
❒ Eating
❒ Stooping
❒ Squatting down
❒ Kneeling
❒ Brushing my teeth
❒ Riding in a car
❒ Opening a jar
❒ Lifting a pan when cooking
❒ Closing the trunk on my car
❒ Opening the garage door
❒ Using my home computer
❒ Climbing stairs
❒ Going down stairs
❒ Sexual activity
❒ Turning my head to left or right
❒ Holding my head up all day
❒ Watching TV
❒ I have pain sitting & doing nothing
❒ Talking on the phone
❒ Reading
❒ Writing
❒ Opening doors
❒ Drying with a towel after a bath or shower
❒ Life has become a chore just to do normal things
❒ It is depressing to live like this
❒ ________________________________
❒ ________________________________
❒ ________________________________
❒ ________________________________
❒ ________________________________
❒ ________________________________
❒ ________________________________
❒ ________________________________
❒ ________________________________

Please check all that apply to your SCHOOL & EDUCATION Activities *because of the accident.*

School was affected by the accident
❒ I am a student at _____________
❒ I am in the ____________year/grade
❒ I was ❒ full time ❒ part time
❒ I am now ❒ full time ❒ part time
❒ I had to take fewer classes b/c of crash
❒ I missed ________ days of school
❒ I had to drop out of school b/c of crash
❒ My grades are lower since the crash
❒ I have pain carrying my school books
❒ I hurt sitting in class more than ___ minutes
❒ My neck hurts when I look down to read
❒ I don't learn as quickly as before the crash
❒ I don't learn things as well as before the crash
❒ I have difficulty concentrating in class
❒ It takes much longer to study/do my homework
❒ ________________________________
❒ ________________________________

______________________________ ______________________________
Signature of Patient Date

PERSONAL INJURY QUESTIONNAIRE

12

RESPONSIBILITY FOR PAYMENT

As a courtesy to you, ***Comprehensive Health and Chiropractic Centre*** will gladly submit your medical bills to your insurance company(ies) and/or your attorney; however, all services rendered by this office will be charged directly to you, and, ultimately, you will be personally responsible for payment of these bills regardless of any settlement you may or may not receive.

______________________________ ____/____/____

Patient Signature Date

13

AUTHORIZATION TO RELEASE INFORMATION

You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred by me as a result of professional services rendered by you, and hereby release you of any consequence thereof.

I understand that in the case of default on my part, that necessitates ***Comprehensive Health and Chiropractic Centre*** or its agents to employ legal and/or collection counsel, I am responsible for collection charges incurred. These charges will be added to my bill.

Should I be unable to meet the terms of this agreement at anytime, I agree to notify the office immediately.

______________________________ ____/____/____

Patient Signature Date

______________________________ ____/____/____

Staff Signature Date

14

CHCC AGREEMENT

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

I agree to notify this doctor immediately whenever I have changes in my health condition(s) in the future.

I also understand that if I suspend or terminate my care at this office, any outstanding charges for professional services rendered to me will be immediately due and payable.

I understand that in the case of default on my part, that necessitates Comprehensive Health and Chiropractic Centre or its agents to employ legal and/or collections counsel, I am responsible for collection charges incurred. These charges will be added to my bill.

Should I be unable to meet the terms of this agreement at any time, I agree to notify the office immediately.

______________________________ ____/____/____

Patient Signature Date

______________________________ ____/____/____

Parent or Guardian Signature (if patient is minor) Date