INFORMED CONSENT FOR CHIROPRACTIC CARE

By beginning chiropractic care at Compass Chiropractic, I acknowledge that the objective of the chiropractor is to identify and correct vertebral subluxations through the administration of a chiropractic adjustment. The adjustment is a specific manual force applied to the spine by hand or instrument, in which a quick thrust or impulse is delivered to the involved area(s). In some cases, Kevin McDade DC may need to touch otherwise sensitive areas of the body to properly deliver an adjustment or analyze my spine. I acknowledge that some techniques require the body to be placed into seemingly awkward positions to better receive the chiropractic adjustment. I hereby request and consent to the performance of chiropractic care and various other procedures and modalities, on myself (or on the patient named below for whom I am legally responsible) by the licensed doctor of chiropractic, Kevin McDade DC.

Many patients report benefits while under chiropractic care including increased range of motion, pain relief, and others. Although most people do respond positively to care, no guarantees of cure have been implied or given. As with any health care procedure, there are some associated risks which your doctor is required to bring to your attention. Though uncommon, you should note the possibility of: fracture, disc injury, muscle strain, ligament sprain, dislocation, and costovertebral separation. Strokes have been reported following chiropractic manipulation. The probability of this is exceedingly rare, estimated between one in one million and one in two million, and can be further reduced by screening procedures. Complications and injuries usually result from an underlying weakness of the bone or tissue which will be screened for during the initial exam. I understand all such risks and complications.

I understand that I am ultimately responsible for my health, and therefore may seek concurrent care from other related health care fields on my own accord. I agree to allow this office to use my confidential health information for the purposes of treatment, payment, healthcare operations and coordination of care with my medical physician(s) about my condition and treatment.

At this point in time, all of my questions have been adequately answered, but I am free to discuss any concerns with the doctor as the need arises. In the event that my conduct or cooperation become contrary to this agreement, Kevin McDade DC has the right to remove me from his care.

I have voluntarily read, understand, and agree to the aforementioned principles. By my signature below, I consent to all treatments deemed by this office to be in my best interest. I intend this document to cover the entire course of care, now and in the future, and agree to its provisions. I hereby authorize Kevin McDade DC, or whomever he designates as an assistant, to administer treatment to:

Printed Name: _____

Patient Signature: _____ Date: _____

Consent to Treatment of a Minor Child:

I hereby authorize Kevin McDade DC, and/or whomever he may designate as assistants, to administer treatment as deemed necessary to _____.

Signature of Parent/ Guardian: _____ Date: _____

Relationship to Minor: _____

HIPAA - Health Insurance Portability and Accountability Act
Notice of Privacy Policy

Compass Chiropractic
13146 Midlothian Turnpike
Midlothian, VA 23113
P: 804.499.6020
F: 804.499.6030

The following is an explanation of our Privacy Policy and your rights as a patient.

- Our office does not distribute or make available to any outside source your "protected health information," or (PHI).
- Your personal health information is secure and used only for treatment, claims submission to third party insurance carriers for the purposes of payment, and other health care operations.
- A family member may be present when taking a case history, hearing the results of exams or tests, or during normal office visits. Family or friends will only have access to your PHI with your written authorization.
- Our office may send you seasonal, birthday, or reminder cards to the address supplied on your intake forms.
- Our office may call or text you to confirm or reschedule an appointment. We may leave a message on the answering machine unless you have specifically instructed us to the contrary.
- You have the right to withdraw consent and terminate care at any time for any reason. A withdrawal of consent must be made in writing and submitted to the front desk.
- You have the right to ask questions about the status of your health at any time.
- You have the right to view and copy your own file. Copying and mailing charges may apply.

By my signature below, I acknowledge that I have read, understood, and agree with the privacy policies set forth by Compass Chiropractic. At my request, I am entitled to view and keep a copy of this abbreviated form or the corresponding full privacy statement, which is also made available on the practice's website: www.CompassChiroVA.com.

Printed Name:_____

Patient Signature: _____ Date:_____

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Personal Injury / Motor Vehicle Accident Form

We need the following information to determine how we can help you. If we do not believe your injury will respond satisfactorily, we will refer you to someone who can help. Please answer as neatly and as accurately as possible.

Patient Name: _____ Today's Date: _____

Time of Accident: _____:_____ AM/PM Date of Loss: _____

Briefly explain what happened: _____

_____

_____

Make/model of your vehicle: _____ Your speed at impact: _____mph

Make/model of other vehicle: _____ Their speed at impact: _____mph

Were you: ❑ Driver ❑ Passenger ❑ Pedestrian

Were you struck from: ❑ Behind ❑ Front ❑ Right side ❑ Left side ❑ Parked

What was your first symptom following the accident? _____

Since the injury, are your symptoms: ❑ Improving ❑ No change ❑ Getting worse

	Yes	No
Are you now (or do you expect to be) in litigation for this accident?	❑	❑
Were the police notified of the accident?	❑	❑
Were you issued a traffic citation?	❑	❑
Were you wearing a seatbelt?	❑	❑
Did you see the collision coming and brace for impact?	❑	❑
Was your head turned at all at the moment of impact?	❑	❑
Were there any secondary impacts (another vehicle, guardrail, tree, etc.)?	❑	❑
Did anything in your car hit you (i.e. something from the back seat)?	❑	❑
Did your head hit anything (dashboard, steering wheel, window, etc.)?	❑	❑
Did the airbags in your vehicle deploy?	❑	❑
Did your headrest or windshield break?	❑	❑
Were you ejected from the vehicle?	❑	❑
Did you lose consciousness at any point?	❑	❑
Did you go to the hospital, emergency, or urgent care?	❑	❑
If yes, were you transported by ambulance?	❑	❑
Was any treatment provided?	❑	❑
Have you seen any other health care professionals for this injury?	❑	❑
Did you feel any pain immediately after the accident?	❑	❑
Did you feel any pain later that night or on the next day?	❑	❑
Is your ability to work impaired or restricted as a result of this accident?	❑	❑
Before the accident, have you ever had any complaints in the involved area?	❑	❑
Before the accident, were you able to work on an equal basis with others your age?	❑	❑

[over]

Additional Symptoms and Complaints

Please check any and all symptoms that you have noticed since the time of the accident.
* Do **not** check the box for symptoms you were already experiencing before the accident *

❑ Loss of Balance	❑ Ringing in Ears	❑ Headache	❑ Pins & Needles	❑ Back Pain
❑ Dizziness	❑ Loss of Taste	❑ Light Sensitivity	❑ Weakened Grip	❑ Chest Pain
❑ Fainting	❑ Loss of Smell	❑ Neck Pain	❑ Numb Fingers	❑ Shortness of Breath
❑ Memory Loss	❑ Face Flushed	❑ Neck Stiffness	❑ Numb Feet	❑ Diarrhea/Constipation
❑ Cold Sweats	❑ Nervousness	❑ Head too Heavy	❑ Cold Hands	❑ Bowel incontinence
❑ Sleeping Problems	❑ Depression	❑ Fatigue	❑ Cold Feet	❑ Urinary incontinence

❑ Other: _____

_____

_____

Please describe how you felt:

a) Before the accident: _____

b) Immediately after the accident: _____

c) Later that night: _____

d) The next day: _____

Have you had to miss any days of work due to your injuries? ❑ Yes ❑ No

If yes, list the date(s): _____ through _____

By signing below, I certify that the above information, on this page and the previous, is complete and true to the best of my current knowledge. I understand that fabricating symptoms will result in immediate termination of my care in this office, and all bills will be immediately due and payable.

Patient Signature: _____ Date: _____

Compass Chiropractic: Health Profile

Please fill out this form to the best of your ability. All of your information is strictly confidential.

Legal Name: _____ Date: _____

Mailing Address: _____ Occupation: _____

_____ (If retired/unemployed, list former occupation)

Email: _____ Height: _____

Weight: _____lbs

How did you hear about our office? _____

Have you been to a chiropractor before? ❑ Yes ❑ No

If Yes, was it a good experience? ❑ Yes ❑ No Dr._____ Last visit: _____

Are you nervous about being adjusted? ❑ Yes ❑ No

1. Lifestyle:

Smoking: ❑ 0 Cigarettes/day (non-smoker) ❑ 1-3 Cigarettes/day
❑ 0 Cigarettes/day (former-smoker) ❑ 1-2packs/day ❑ 2+ packs/day

Alcohol: ❑ Abstainer (none at all) ❑ Heavy drinker
❑ Light/Moderate drinker ❑ Former Alcoholic (sober since: _____)

Activity Level: ❑ Sedentary (none) ❑ Moderate activity (jogging)
❑ Light activity (i.e. walking) ❑ Vigorous activity (max exertion)

Any hobbies/sports you participate in regularly? _____

_____

2. Medical History:

Hospitalizations/Surgeries: please check the boxes if you have had any of these particular surgeries.

❑ Spine ❑ Shoulder (R/L) ❑ Brain ❑ Lung ❑ Gallbladder
❑ Hip (R/L) ❑ Knee (R/L) ❑ Heart ❑ Breast ❑ Appendix

Year: _____ Area/reason: _____ Procedure: _____
Year: _____ Area/reason: _____ Procedure: _____
Year: _____ Area/reason: _____ Procedure: _____

Prior Accidents/Injuries: includes car accidents, falls, sports injuries, etc.

Year: _____ Area injured: _____ How? _____
Year: _____ Area injured: _____ How? _____
Year: _____ Area injured: _____ How? _____

Ongoing Condition(s)? ❑ No ❑ Yes, please list: _____

Allergies? ❑ No ❑ Yes, please list: _____

Prescription Medications: If you have a medication list, please give us a copy and skip this section.

Medication	Reason	Date Started

Family History: this pertains to siblings, parents, and grandparents **only**

❑ Cancer ❑ Stroke ❑ Arthritis ❑ Seizures ❑ Diabetes
❑ Thyroid ❑ Heart Attack ❑ Osteoporosis ❑ Blood clots ❑ Kidney Disease
❑ Other: _____

Were there any deaths directly related to the above conditions? ❑ No ❑ Yes (fill in below)

Who _____ Condition _____ Age _____
Who _____ Condition _____ Age _____

Review of Systems: have **you** had a problem, whether now or in the past, with any of the following?

❑ Cancer
❑ Stroke/TIA
❑ Diabetes
❑ Hot/Cold Intolerance

❑ Seizures
❑ Double vision
❑ Sleeping problems
❑ Thyroid disorders

❑ Vertigo
❑ Dizziness
❑ Ringing in ears
❑ Ear Infections

❑ Heart attack/disease
❑ Blood clots/DVT
❑ Arrhythmias/Palpitations
❑ Heartburn/Gastric reflux

❑ Jaw pain
❑ Difficulty swallowing
❑ Asthma
❑ Allergies

❑ Osteoporosis
❑ Joint pain
❑ Fatigue
❑ Muscle weakness

❑ Excessive thirst
❑ Inability to hold urine/feces
❑ Constipation/Irritable Bowel

❑ Frequent urination
❑ Weak urine flow
❑ Bloating/Indigestion

❑ Burning/painful urination
❑ Difficulty controlling urination
❑ Food Sensitivity (Gluten, Dairy, etc.)

Other Medical History:

Any steroid/epidural injections? ❑ No ❑ Yes, part of body: _____ Date: _____

Recent infections/immunizations? ❑ No ❑ Yes, please list: _____

Recent unintentional weight loss? ❑ No ❑ Yes, I've lost about _____ pounds in the last _____

FEMALES ONLY: is there any possibility that you are pregnant? ❑ No ❑ Yes ❑ Unsure

3. Primary Complaint: Please fill out this section in regards to your primary complaint only. If you have other health concerns, the doctor will discuss them with you in person.

Briefly describe the main reason you are here: _____

_____

When did this start? _____ ❑ Started suddenly ❑ Started gradually

The problem is: ❑ Right-sided ❑ Left-sided ❑ Both sides ❑ N/A

The problem is: ❑ Constant ❑ Frequent ❑ On and off ❑ Occasional

How severe is your complaint at its worst? Grade from 1-10 where 10 is very severe: _____ /10

Describe how it feels: ❑ Pain ❑ Stiffness ❑ Weakness ❑ Numbness ❑ Tingling

Check all that apply: ❑ Aching ❑ Burning ❑ Dull ❑ Sharp ❑ Stabbing

Please check off all boxes that apply to this problem

This problem is made worse by:		This problem is usually relieved by:	
❑ Activity	❑ Arising from chair	❑ Cold	❑ Stretching
❑ Bending	❑ Job	❑ Heat	❑ Support brace
❑ Lifting	❑ Lying down	❑ Activity	❑ Chiropractic
❑ Standing	❑ Morning	❑ Lying down	❑ Massage
❑ Stress	❑ Night	❑ OTC medication	❑ Morning
❑ Temp change	❑ Touch/Pressure	❑ Postural change	❑ Night
❑ Twisting	❑ Ice	❑ Rx medication	❑ Nothing
❑ Sitting	❑ Kneeling	❑ Rest	❑ Standing

When present, how long does it last? ❑ Always ❑ Days ❑ Hours ❑ Minutes ❑ Seconds ❑ No pattern

Overall, this problem has been: ❑ Improving ❑ Staying the same ❑ Worsening

Do any of these apply to your job? ❑ Prolonged standing ❑ Prolonged sitting ❑ Heavy lifting

- do you think your job contributed to this problem? ❑ Yes ❑ No

Did we miss something? Please indicate if there is anything else you would like us to know about this problem.

_____

_____

4. Other:

What are your expectations/goals? _____

Emergency Contact: Name: _____ Relationship: _____ Phone: _____

Primary Care Physician: Dr._____ Office Name: _____

Last Visit: _____ Town: _____

I have read and completed the above information and certify it to be true to the best of my knowledge. I hereby permit this office to use my responses to provide me with chiropractic care, according to the state's regulations.

Patient Name (printed): _____

Signature of Patient/Guardian: _____ Date: _____

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Coverage Options

We understand this process can be confusing. This form has been created for the sole purpose of explaining your options. You do not need to do anything with this form other than read it, so you can make an informed decision in choosing which party you would like us to bill.

Our office requires all patients to provide their own auto insurance information so we can check if you have MedPay on your policy. This does not necessarily mean they will be billed; it simply gives this office a back-up entity to whom we *can* bill, if payment for services is not properly received. The alternative, if auto insurance is not provided, is that the bill then becomes your personal responsibility. The MedPay component of your auto insurance is to protect you from getting billed.

Medical Payments

"Medical Payments" or "MedPay" is part of your auto insurance policy which will immediately cover the costs of your medical expenses, given by a licensed health care provider and those of any passengers in your car, up to a certain limit, **regardless of fault**. Senate Bill 08-011, effective January 1, 2009, made MedPay benefits mandatory on all auto insurance policies unless specifically rejected in writing or declined during the application process. Your auto insurance rates are not impacted by using your MedPay, even if another party is at-fault. We highly recommend you to use your MedPay if it is available on your policy.

Liability Insurance of Third Party

Virginia is currently an "at-fault" state regarding payment of claims resulting from an auto accident or personal injury. This means the responsible party, or his or her insurance, should cover the cost of medically necessary treatment given by a licensed health care provider. Such claims are considered for payment when all treatment is complete and a settlement is reached with the third party. We discourage patients from selecting this option because it increases the probability that they will be left with the medical bills if payments are not properly received or settlement does not occur as expect.

Attorney Representation

If you have acquired legal representation, your bills will be forwarded directly to the attorney's office. We cannot and will not bill your MedPay or the third party's insurance. When settlement is made, your attorney's office will typically disperse the funds directly to our office on your behalf.

Personal Health Insurance

Your individual health insurance plan may be used to cover your auto-related medical expenses only if you are not using an attorney AND your auto insurance does not have MedPay. We assist you in verifying your coverage, but you are still responsible for the usual co-payments or deductibles your policy requires.

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ADDITIONAL MEDPAY INFORMATION

Most people have benefits, such as MedPay, included in their automobile policies, and don't even realize it. Our office highly recommends that you use your MedPay coverage, if you have it, in the event you've been injured in an automobile accident, regardless of who is at fault.

We recommend filing with your MedPay for the following 3 reasons:

1. MedPay is similar to health insurance – using it does not cause your rates to increase. If your rates increase, it is not because you filed your MedPay, it is most likely because:

a) it was determined that you were at fault, or
b) you reported multiple auto accidents within a brief period of time and therefore are now considered to be "high risk" by your automobile insurance carrier

2. Filing your MedPay doesn't relieve the other party from having to pay for your loss. On the contrary, by filing your MedPay, when you collect from the other driver's liability insurance, a greater amount of the settlement may go directly to you because your bill in our office is already covered by your MedPay. If the other party's insurance refuses to settle or make a payment on your behalf, filing your MedPay ensures you are not stuck with all the medical bills.

3. If you have MedPay coverage and choose not to file it, then you are paying for an option but not receiving any benefit. MedPay is often included in the cost of your auto insurance premiums and specifically exists to cover you these types of cases. Since you pay for this included coverage, opting not to use it means you paid for this service needlessly.

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Personal Injury/Auto Accident Coverage Selection

Patient Name: _____ Today's Date: _____

Date of Accident/Loss: _____

NOTE: Even if the accident was not your fault, and another party's insurance will be covering your medical costs, **we still require information about your insurance policy and coverage**.

- **Medical Payments (MedPay): your automobile insurance information is required**
  Insurance Company: _____
  Phone Number: _____
  Mailing Address: _____
  Name of Insured: _____
  Policy Number: _____
  Claim Number: _____
  Claim Adjuster: _____

NOTE: we also require that you provide ***at least one*** of the following to us:

- **Personal Health Insurance: a copy of your health insurance card is required**
  Insurance Company: _____
  Phone Number: _____
  Name of Insured: _____
  Policy Number: _____

- **Liability Insurance: insurance information of the other (at-fault) party is required**
  Insurance Company: _____
  Phone Number: _____
  Mailing Address: _____
  Name of Insured: _____
  Policy Number: _____
  Claim Number: _____
  Claim Adjuster: _____

- **Representation by an Attorney: must have letter of representation by the third visit**
  Law Firm: _____ Phone: _____
  Name of Attorney/Case Manager: _____
  Mailing Address: _____

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To any insurance company with coverage applicable to my claim(s) and to any attorney representing me:

Assignment of Benefits

IN CONSIDERATION of the willingness of Compass Chiropractic to treat me on credit without demand for payment at the time services are rendered, I hereby agree and stipulate as follows:

I irrevocably assign to Compass Chiropractic any proceeds of compensation that I am or may become entitled to receive as a result of injuries that occurred on _____ to the extent of the chiropractic services rendered. I make this agreement without prejudice to any rights I may have to prosecute legal claims against any party who may be liable for my injuries, but I hereby authorize and instruct you to pay directly to Compass Chiropractic from any disability benefits, medical payment benefits, liability benefits, health and accident benefits, workers compensation benefits, judgments, settlements, or proceeds of any kind that would otherwise be payable to me, such sums as are due to Compass Chiropractic for its services rendered.

I appoint Compass Chiropractic as my attorney in fact to affix my name as an endorsement upon the reverse of any check or draft upon which I am named payee and to deposit said check or draft and apply the proceeds to any unpaid balance I may have with Compass Chiropractic.

I authorize Compass Chiropractic to release to any insurer with applicable coverage or to my attorney or successor attorney any information regarding my injuries, prior medical history, or treatment as may be necessary to facilitate collection of proceeds under this assignment.

I acknowledge that I remain personally liable for the total amount due to Compass Chiropractic for services rendered, including any balance remaining after the application of insurance payments and settlement or judgment proceeds. If Compass Chiropractic is required to take legal action against me to recover any unpaid balance on my account, I agree to reimburse Compass Chiropractic for its costs of recovery, including reasonable attorney's fees.

I further agree this assignment of benefits (AOB) cannot be revoked and the right to receive payment cannot be transferred to any other party or re-asserted by me in any way.

Patient Name: _____ DOB: _____

Patient Signature: _____ Date: _____

Witness: _____

NOTICE OF LIEN

Pursuant to Virginia Codes §8.01-66.2 and §8.01-66.9, Compass Chiropractic hereby asserts and gives notice of a lien upon any sums recovered in damages for personal injury in any civil action and also upon all funds paid to the above-named patient in compensation for or settlement of injuries sustained, whether in litigation or otherwise. Compass Chiropractic hereby requests that if its claim is not paid in full from the foregoing proceeds, a full disclosure and accounting of proceeds be provided in conformity with Codes §8.01-66.2 and §8.01-66.9. Compass Chiropractic agrees to be bound by any confidentiality agreements regarding the contents of the accounting.

Patient Signature: _____ Date: _____