

Cornerstone Chiropractic & Wellness

507 N Nokomis St. Ste. B

Alexandria, MN 56308

(320)762-2639 phone

(320)762-2650 fax

contact@cornerstonealexandria.com

Personal Injury Information

Last Name _____ First Name _____ MI _____

If child under 18 name of parent or guardian _____

Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Work Phone _____

Cell Phone _____ Driver's License # _____

SSN _____ Email _____

Date of Birth _____ Sex: M F

Marital Status: Single Married Divorced Widowed

Employer _____ Type of Work _____

Spouse's Name _____ Spouse's Employer _____

Automobile Accident: Please note that Minnesota is a No Fault state so you will need to file this claim with your auto insurance carrier and give us your auto insurance carrier information.

Workers' Compensation: If you have not done so already, please notify your employer immediately. Your employer will give you the insurance carrier information.

Insurance Company _____ Phone Number _____

Claim Mailing Address _____

City _____ State _____ Zip code _____

Date of Injury _____ Adjuster's Name _____

Policy Number _____ Claim Number _____

Attorney's Name _____ Phone Number _____

Address _____

City _____ State _____ Zip Code _____

Release and Assignment of Benefits

I authorize the release of any information necessary to process my claims
And assign and request payment be made directly to my health care provider.

Patient/Guardian Signature _____ Date _____

An accident or trauma of any kind can cause you to have spinal nerve stress, also known as vertebral subluxations. Subluxations can affect your body structure and in turn your physical and emotional health. Every accident victim needs a spinal checkup by a doctor of chiropractic.

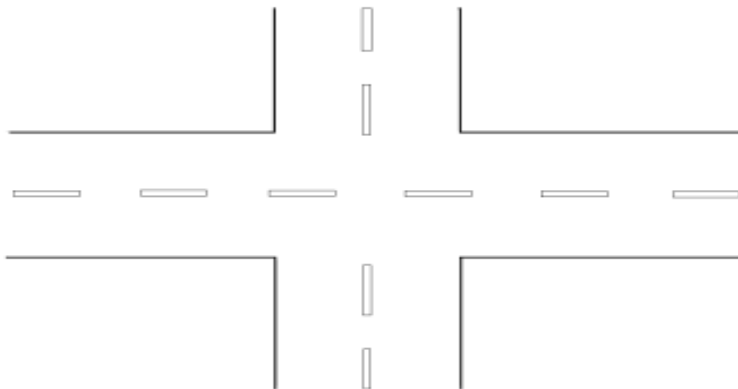
Please indicate the type of accident you were involved in

Work Sport Auto Personal Injury Other _____

Date of accident _____ Time _____ Location _____

Please explain how you were injured. Be as detailed as possible. If it was an auto accident, please mention the speed of the vehicles, where your car was hit, the damage that was done, the weather conditions and your state of mind/health at the time of the accident. Let us know if you need more paper.

Please illustrate the accident with all involved vehicles (if applicable) below.



I was: driving passenger in a _____ (type of Vehicle) on a _____ (i.e. street or hwy). The other vehicle was a _____ (type of vehicle).

I was in front, left in front, right in back, left in back, right
Wearing seat belt air bag deployed struck headrest facing front
turned

Were other people in the car? No Yes
If yes, were they hurt? No Yes
Were police notified? No Yes

Where were you taken after the accident and who cared for you?

Were X-rays, MRI or other tests done? Yes No

If yes, please list.

What treatment was given? _____

Are you receiving care from other health professionals? _____

If yes, please give name, specialty and contact information.

Injuries from the Accident

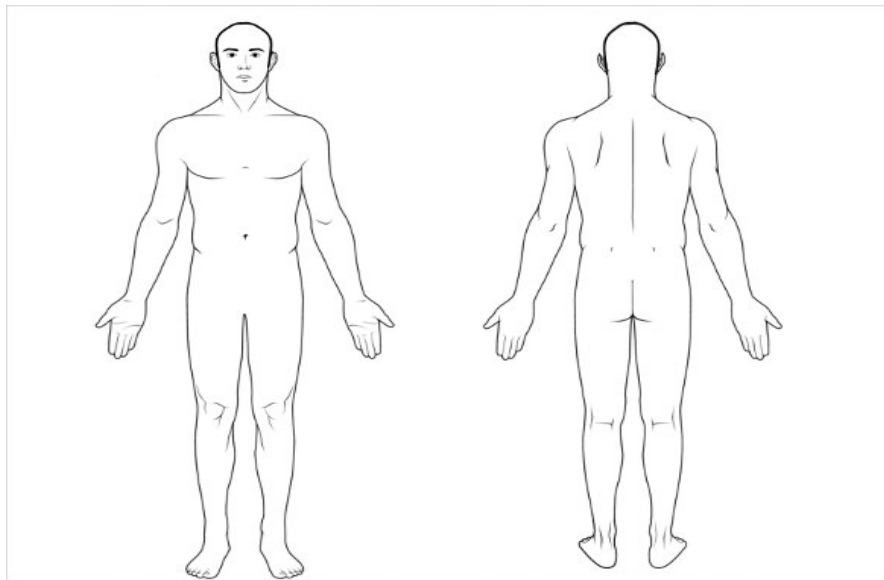
As a result of your accident, did you have any of the following: *(please check all that apply)*

Broken bones Dislocations Head Injuries Surgery Concussion

If yes to any of the above, please describe.

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

Please use the illustrations below to show where you are experiencing symptoms.



Front

Back

Patient Consent

TO OUR PATIENTS: Please read and sign the form below. Ask questions if there is something you do not understand.

Please check to indicate approval:

_____ RELEASE OF MEDICAL RECORDS FOR MY MEDICAL CARE OR AS REQUIRED BY LAW:

- To healthcare providers directly involved in my care.
- To State, Federal and accrediting bodies for required reporting data and/or surveys for compliance.
- For purposes of my care and for business operations.

Note: Records are not automatically sent to your physician. They must be requested.

_____ ASSIGNMENT OF BENEFITS/BILL MY INSURANCE:

- I authorize Cornerstone Chiropractic & Wellness to send my bills for my medical care and treatment to my insurance company and/or Medicaid for payment, to the extent my insurance company and/or Medicare or Medicaid ID required to pay the bill under terms of my insurance policy or by law.
- I request that my insurance company and/or Medicare or Medicaid pay Cornerstone Chiropractic & Wellness and the providers who are involved in my treatment.
- I consent to the release of my medical records by Cornerstone Chiropractic & Wellness to my insurance company and/or Medicare or Medicaid (and organizations working on their behalf) if necessary in order for my bills to be paid.
- I agree to pay for charges not covered by my insurance.
- **I understand that if I do not check this box Cornerstone Chiropractic & Wellness will send a bill directly to me for payment.**

_____ RELEASE OF MEDICAL RECORDS FOR MEDICAL R SCIENTIFIC RESEARCH:

- I agree that my records may be used by Cornerstone Chiropractic & Wellness for medical or scientific study.
- No information which can identify me as a patient or participant in any such study will be shared.
- I may revoke this in writing at any time.

By signing this form, I consent and authorize my medical health provider to assess and treat me. I understand that my provider is available to explain the purpose or treatment, and that I have the right to refuse recommended treatment. I understand I have the right to revoke this consent, in writing, at any time except where Cornerstone Chiropractic & Wellness had already made disclosures in reliance to the consent.

I consent to the treatment(s) provided by this clinic. I understand that my condition may necessitate medications from time to time due to the type of treatment(s) rendered and the portions of my body that may need to be examined. I understand and consent to clinic staff providing me with verbal descriptions, when there are changes to my exam(s) and treatment(s), consent to the clinic staff providing said treatment(s) and exam(s) and hereby consent to any similar subsequent treatment(s) or exam(s). If I do not consent, I will immediately inform clinic staff. There are times when individuals other than staff may see me receiving treatment at the clinic or overhear discussions of my conditions or insurance. I consent to others perceiving these interactions at the clinic. If additional privacy is required, I will inform the clinic staff.

Patient Name _____ Date _____

Guardian Signature _____ Date _____

Check only is applicable (one time acknowledgment)

_____ I acknowledge that I have been offered a copy of Cornerstone Chiropractic & Wellness's Privacy Practices Information. If I would like a copy in the future, I will ask for one.

AUTHORIZATION AND NOTICE OF DOCTOR'S LIEN

Patient's Name: _____

Patient's Attorney: _____

Insurance Company: _____

Date of Injury: _____

I authorize and direct you, my attorney, and my insurance carrier, to pay directly to Cornerstone Chiropractic & Wellness such sums as may be due and owing the clinic for medical services rendered me by reason of this accident and by reason of any other bills that are due the clinic and to withhold such sums from my portion of a settlement, judgement or verdict as may be necessary to adequately protect the clinic. I further give a lien on my case to said clinic against my portion of any and all proceeds of the first available settlement, judgement 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 Cornerstone Chiropractic & Wellness for all medical benefits, including major medical, submitted by the clinic for services rendered to me and that this agreement is made solely for this clinic's additional protection and in consideration of the clinic's awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may recover said fee.

Patient's Name _____

Address _____

Signed _____ Date _____

ACKNOWLEDGEMENT OF ATTORNEY

The undersigned, being the attorney of record for the above patient, does hereby agree to observe all terms of the above and agrees to withhold such sums from patient's portion of the first available settlement, judgement or verdict as necessary to adequately protect Cornerstone Chiropractic & Wellness.

Dated _____ Attorney's Signature _____