CONFIDENTIAL
HEALTH INFORMATION

Columbia Pike Chiropractic
Jaime A. Chica D.C

Today's Date: __________________ Chart Number:_________________________

Personal Information

First Name: ____________________________________ Middle:________________Last:__________________________________

Address:____ Apt: ____________________

City:_____________________________________ State_________ Zip:________________ Date of Birth:_______________________

Home Phone: ( )_________-_____________ Social Security Number :_______________________________________

Cell Phone: ( )_________-_____________ Gender: ❑ Male ❑ Female

Fax Number: ( )_________-_____________ Marital Status: ❑ Married ❑ Single ❑ Divorced

Email Address: ____ ❑ Separated ❑ Widowed

Spouse's name if married: _____________________________________ Ages of children: _______________________________

How did you hear about us? ❑ Outdoor Sign ❑ Yellow Pages ❑ Medical Physician ❑ Insurance ❑ Lawyer ❑ Online ❑ Family/Friend ❑ Other:________________________

Employer

Business name: ____ Occupation:___________________________________

Business Address: ____City____________________ State:______Zip:______________

Phone: ( )________-____________ Fax Number: ( )________-____________ Type of work: _______________________

Emergency Contact:

Name: ______________________________________ Relationship:___________________ Phone Number: ( )______-___________

Who is responsible for your bill? ❑ Self (Paying Cash) ❑ Self (Health Insurance) ❑ Medicare ❑ Auto Ins ❑ Worker's Comp ❑ Other:________________

Insurance Carrier: ____

Health ID Card No: ____

Group No:____

Insured Person's Name: ____

Primary Care Physician: ____

Who carries this policy?

❑ Self ❑ Spouse ❑ Parent

Insured Person's Birth date: _____________________

Phone Number: ( )________-________________

Car Accident Insurance Information:

Date of Accident: ______________________ Where did accident occur? ____

Which Best Describes You: ❑ Driver ❑ Front Passenger ❑ Rear Passenger

Name of your Car Insurance: ____ Claim #____________________________________

Name of Other Party's Car Insurance: __________________________________Claim #____

Do you have a Lawyer? ❑ Yes ❑ No Name of Lawyer: ____

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Columbia Pike Chiropractic or insurance company to release any information required to process my claims.

X ____ ______________________

Patient/Guardian Signature Date

CLINICAL HISTORY

Name: ____ Date: ______________

☐ Automobile Accident ☐ Work Accident D.O.A: ________

CHIEF COMPLAINT

Pain Location: ☐ Head ☐ Neck ☐ Middle back ☐ Low back ☐ Chest ☐ Ribs ☐ R. Shoulder ☐ L. Shoulder ☐ R. Hand / Wrist. ☐ L. Hand / Wrist ☐ R. Knee. ☐ L. Knee ☐ R. Ankle / Foot. ☐ L. Ankle / Foot. ☐ Abdomen. ☐ Jaw

Explain:____

____

____

Frequency: ☐ Constant. ☐ Occasional. ☐ Intermittent ☐ Frequent.

Pain Description: ☐ Achy ☐ Sharp ☐ Burning ☐ Dull ☐ Pounding. ☐ Stabbing ☐ Stiffness ☐ Radiating Leg / Arm L/R

Pain Progression: ☐ Same ☐ Getting Worst ☐ Improving ☐ Fluctuating

Severity: Rate the severity of your pain by checking a box on the following scale.

No Pain	0	1	2	3	4	5	6	7	8	9	10	Excruciating Pain

-------Mild ------ -------Moderate------- -------Severe-------

Additional Symptoms: ☐ Dizziness ☐ Nausea ☐ Anxiety ☐ Loss of smell ☐ Irritability ☐ Depression ☐ Confusion ☐ Arm numbness / tingling R or L? ☐ Pain behind eyes ☐ Breathing difficulties ☐ Sleeping difficulties ☐ Loss of taste ☐ Blurred vision ☐ Concentration difficulties ☐ Ringing ears ☐ Leg numbness / tingling R or L?

FAMILY HISTORY

Mark with an X if anybody on your family (parents, relatives) suffer of any of the following illness:

Cancer	☐	Epilepsy	☐	Arthritis	☐	Kidney disease	☐
Tuberculosis	☐	Dementhia	☐	Hemophilia	☐	High Blood Pressure	☐
Diabetes	☐	Gout	☐	Asthma	☐	Heart Disease	☐

PERSONAL HISTORY

Surgeries :☐ (Describe) ____

Hospitalization: ☐ (Describe)____

Medications that you are currently taking :____

____

Auto Accident : Yes ☐ No ☐ When?: ____

Allergies: Yes ☐ No ☐ Smoke?: Yes ☐ No ☐ Ocasionally ☐ Frequently ☐

Drink alcoholic beverages? Yes ☐ No ☐ Ocasionally ☐ Frequently ☐

GENERAL

Mark the most appropriate:

	Past	Present		Past	Present
Headaches	☐	☐	Work Injury	☐	☐
Hemophilia	☐	☐	Venereal disease	☐	☐
Psychiatric problems	☐	☐	Eating disorders	☐	☐
Thyroid Disease	☐	☐	Drug dependency	☐	☐
Depression	☐	☐	Dizziness	☐	☐

	Past	Present		Past	Present		Past	Present		Past	Present
Asthma	☐	☐	Cancer	☐	☐	Arthritis	☐	☐	Anemia	☐	☐
Epilepsy	☐	☐	Diabetes	☐	☐	Tuberculosis	☐	☐	Hepatitis	☐	☐
Fever	☐	☐	Gout	☐	☐	Aids	☐	☐	Vitamins	☐	☐

SKIN

Psoriasis	☐	☐	Eczema	☐	☐	Dermatitis	☐	☐	Herpes	☐	☐

CLINICAL HISTORY

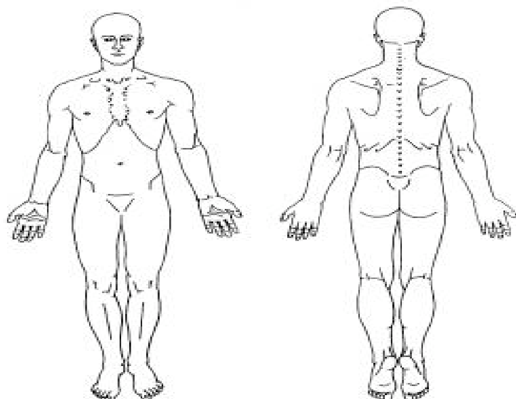
EENT	Past	Present		Past	Present		Past	Present
Glaucoma	☐	☐	Visual impairment	☐	☐	Otitis	☐	☐
Cataracts	☐	☐	Tinitus	☐	☐	Sinusitis	☐	☐
Conjuntivitis	☐	☐	Loss of Hearing	☐	☐	Nose Bleeding	☐	☐
Rhinitis	☐	☐	Persistent Cough	☐	☐	Hoarseness	☐	☐

	Past	Present
CARDIOVASCULAR - RESPIRATORY	☐	☐
High Blood Pressure	☐	☐
Chest Pain	☐	☐
Myocardial Infarction	☐	☐
Heart Disease	☐	☐
Rheumatic Fever	☐	☐
Heart Murmur	☐	☐
Ankle Swelling	☐	☐
Difficulty breathing, walking, sleeping	☐	☐
Chronic Cough	☐	☐
Spitting Phlegm	☐	☐
Spitting blood	☐	☐
Pneumonia	☐	☐
Bronchitis	☐	☐
___________________________________		

	Past	Present
GASTROINTESTINAL - G / U	☐	☐
Liver Disease	☐	☐
Ulcer	☐	☐
Loss of Apetite	☐	☐
Flatulence (gas)	☐	☐
Vomit, Nausea	☐	☐
Abdominal Pain	☐	☐
Gall Bladder Stones	☐	☐
Hemorrhoids	☐	☐
Constipation	☐	☐
Hernia	☐	☐
Jaundice	☐	☐
Kidney Stone	☐	☐
Urinary Tract Infection	☐	☐
Blood in Urine	☐	☐
Difficulty Urinating	☐	☐

REPRODUCTIVE	Past	Present
Pregnant	☐	☐
Irregular Menses	☐	☐
Abnormal Pap	☐	☐
Prostate Problem	☐	☐
Testicular Pain	☐	☐

Mark with an X the places of pain



MUSCULOSKELETAL AND NERVOUS SYSTEM	Past	Present
Low Back Pain	☐	☐
Neck Pain	☐	☐
Pain between Shoulder Blades	☐	☐
Pain in Arms	☐	☐
Pain in Legs - Sciatica	☐	☐
Muscle Cramps	☐	☐
Loss of strength in arms or legs	☐	☐
Numbness arms or legs	☐	☐
Loss of sensation arm or leg	☐	☐
Herniated Disc-Spine	☐	☐
Scoliosis	☐	☐
Fractures - Sprains	☐	☐
Osteoporosis	☐	☐
Short Leg	☐	☐

Prior Similar Symptoms

☐ I have not had any symptoms similar to my actual condition
☐ I had my actual symptoms before, but they didn't bother me
☐ My actual symptoms already existed but they got worse after the accident

My most recent symptoms (if applicable) occurred: _____ ☐ months ago ________ ☐ years ago or on Date: _____/_____/_____

Signature: ____________________________________ Date: ___________________________

Automobile Accident Description

Date of Accident: ______________ **Time of accident:** __________ **City of Accident:** _____________________

1. Your Vehicle Type
□ Car □ Station Wagon
□ Van □ Pickup truck
□ Large Truck □ Bus
Model and year of your car: _________________________

2. Your position in vehicle
□ Driver □ Front Passenger
□ Left Rear Passenger
□ Right Rear Passenger

3. What was your car doing at the time of the accident?
□ Stopped at intersection □ Stopped in traffic □ Stooped at light
□ Making a right turn □ Making a left turn □ Parking
□ Proceeding along □ Slowing down □ Accelerating
Model and year of another car: ___________________________

4. Speed / Damage
Your vehicle's speed: ___mph
Other vehicle's speed :___mph

5. Details of Accident
Visibility at time of accident
□ Poor □ Fair □ Good

6. Road Conditions
Road conditions at time of accident
□ Icy □ Wet □ Sandy □ Dark □ Clean and Dry

Damage to your vehicle
□ Mild □ Moderate □ Total
Damage to other vehicle
□ Mild □ Moderate □ Total

Who hit? Who what?
□ You hit other vehicle
□ Other vehicle hit you
□ You hit___________

Point of impact
□ Head-On □ Left front □ Right front
□ Rear-End □ Left rear □ Right rear
□ Left side □ Right side Other __________________

7. Body position, etc.
Did you see the accident coming? **Yes** □ **No** □
Were you braced for the impact? **Yes** □ **No** □
Did you have a seat belt on? **Yes** □ **No** □
Did you have a shoulder harness on ¿ **Yes** □ **No** □

Does your vehicle have headrests?? Yes □ **No** □
What was the position of your headrest at the time of the impact?
□ Even with top of head □ Even with bottom of head □ Middle of neck
What was the direction of your head at the time of impact??
□ Facing straight forward □ Turned to the right
□ Turned to the left □ Down

8. Additional Accident Information /Additional vehicles involved in the crash
____
____
____

9. During the accident:
Did your body strike the inside of your car?? **Yes** □ **No** □
If yes, describe: ___________________________________
Did you lose consciousness? **Yes** □ **No** □ Min:_____
Did airbags deploy? **Yes** □ **No** □
□ Driver □ Passenger □ R. Door □ L. Door
Were any objects thrown around the interior of the car?
□ Eye Glasses □ Cell phone □ Food □ Nothing
Did your seat break? **Yes** □ **No** □
Did police show up at the scene? **Yes** □ **No** □
Was an accident report filled out? **Yes** □ **No** □
To whom the police issue a ticket? **You** □ **Other** □

10. After the accident:
Check off your symptoms right after and a few days following:
1-Pain on: □ Head □ Neck □ Middle back □ Low back□ Chest
□ Ribs □ R. Shoulder. □ L. Shoulder □ R. Hand. □ L. Hand
□ R. Knee. □ L. Knee □ R. Ankle / Foot. □ L. Ankle / Foot.
□ Abdomen. □ Jaw Other: _________________
2- Additional Symptoms: □ Dizziness □ Nausea □ Anxiety
□ Loss of smell □ Irritability □ Depression □ Arm Numbness R or L?
□ Pain behind eyes □ Breathing difficulties □ Sleeping difficulties
□ Loss of taste □ Blurred vision □ Concentration difficulties
□ Ringing ears □ Confusion □ Leg numbness and tingling R or L?

11. Emergency Room??
Where did you go after the accident?
□ Home □ Work □ Hospital ER. □ Private Doctor
How did you get there?
□ Drove self □ Somebody else □ Ambulance □ Police
Were x-rays done? Yes □ **No** □ **Blood Work? Yes** □ **No**□
Body parts x-rayed? ________________________________
What lab work? ____________________________________
The x-rays revealed: ________________________________
Treatments: □ Cervical Collar □ Ice □ Other ________
Medications: ______________________________________
Follow-up instructions: _____________________________
____

12. Treatment History
Doctors seen prior to your first visit to this office
1. Dr. ___________________ First visit date: ___/___/___
Specialty: ______________X-rays done? **Yes** □ **No** □
Type of Treatment received: _________________________________
How many treatments received? ____ Currently treating? **Yes** □ **No** □
Did treatments Benefit you?? **Yes** □ **No** □
Date of last visit: ___/___/___
2. Dr. ___________________ date of first visit: ___/___/___
Type of treatment received: _________________________________
How many treatments received? _____ Currently treating? **Yes** □ **No** □
Did treatments benefit you? **Yes** □ **No** □
Date of last visit: ___/___/___

Signature: _________________________________ Date _________________

Columbia Pike Chiropractic

Jaime A. Chica D.C.

5555 Columbia Pike, Suite #201, Arlington, VA 22204
Phone: (703) 379-6300 Fax: (703) 379-4440

FINANCIAL AGREEMENT

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is NOT A SUBSTITUTE FOR PAYMENT. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid by your insurance.

IN ORDER TO CONTROL YOUR OUTSTANFING BALANCE, IT IS OUR POLICY TO COLLECT CO-PAYS, CO-INSURANCE AND DEDUCTIBLE AT TIME SERVICE IS REQUIRED.

If this account is assigned to an attorney/or outside agency for collection and/or suit, Columbia Pike Chiropractic shall be entitled to reasonable attorney's fees and for cost collection.

I authorize the release of any information necessary to determine the liability for payment and to obtain reimbursement on any claim.

____________________________ ____________________________
PATIENT SIGNATURE INSURED'S SIGNATURE

____
DATE

INSURANCE ASSIGNMENT OF BENEFITS

AUTHORIZATION TO RELEASE INFORMATION:
I hereby authorize Columbia Pike Chiropractic to release any information acquired in the course of my medical examination and treatment, including drug use, alcoholism, and HIV positive test results, to my insurance carrier(s) as necessary to process my insurance.

AUTHORIZATION TO PAY BENEFITS:
I hereby authorize my insurance carrier(s) to make payment directly to Columbia Pike Chiropractic for the Chiropractic and/or medical benefits payable for the services rendered.

____________________________ ____________________________
PATIENT SIGNATURE INSURED'S SIGNATURE

____
DATE

Columbia Pike Chiropractic

Jaime A. Chica D.C.

5555 Columbia Pike, Suite #201, Arlington, VA 22204
Phone: (703) 379-6300 Fax: (703) 379-4440

PRACTICE'S REQUIREMENTS

The Practice:

(a) Is required by federal law to maintain the privacy of you PHI and to provide you with this Privacy Notice detailing the Practice's legal duties and privacy practices with respect to your PHI
(b) Under the Privacy Rule, may be required by State law to grant greater access or maintain greater restrictions on the use or release of your PHI than that which is provided for under federal law
(c) Is required to abide by the terms of the Privacy Notice
(d) Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for all of your PHI that it maintains
(e) Will distribute any revised Privacy Notice to you prior to implementation
(f) Will not retaliate against you for filing a complaint

EFFECTIVE DATE

This Notice is in effect as of 9/23/2013

PATIENT ACKNOWLEDGEMENT

By subscribing my name below, I acknowledge receipt of a copy of the Notice, and my understanding and my agreement to its terms

____
PATIENT

____
DATE

FOR PRACTICE USE ONLY

Practice Documentation of Good Faith Effort to Obtain Acknowledgement

Patient's acknowledgement of the Notice could not be obtained because:

__Patient refused to sign
__Communication barrier prohibited obtaining acknowledgment
__Emergency circumstances
__Other

Details:

___________________________ ___________________________
Signature of Practice Date

IRREVOCABLE ASSIGNMENT OF BENEFITS, AUTHORIZATION AND LIEN

To Whom It May Concern:

This Irrevocable Assignment of Benefits, Authorization and Lien (this "Assignment") is made by and between ______________________________ ("Patient") and COLUMBIA PIKE CHIROPRACTIC ("Health Care Provider"). With this Assignment, and in consideration of treatment without having to render concurrent payment, Patient, hereby irrevocably transfers sets over and assigns to Health Care Provider all insurance and/or litigation proceeds to which Patient is now or may hereafter become entitled, including those listed below, up to the total amount due and owing the Health Care Provider for services rendered to the Patient by reason of accident or illness, including interest thereon, as well as any other charges that are due or may become due the Health Care Provider, including, without limitation, requested reports, collection costs and expenses and attorney's fees, and Patient further hereby irrevocably authorizes and directs any insurance company and/or attorney to whom an original or copy of this Assignment is provided to withhold from Patient and pay directly to such Health Care Provider such amount(s) from (1) any insurance benefits payable to Patient or on Patients behalf, including, but not limited to, medical payments benefits, No Fault benefits, health and accident benefits, personal injury protection benefits, third-party liability coverage, foundation grants, governmental or agency benefits, worker's compensation benefits or any other insurance proceeds or benefits of any kind which are payable to or on behalf of the Patient, and (2) any litigation proceeds (which may include insurance proceeds) from any settlement, judgment or verdict in Patients favor as may be necessary to fully pay any and all financial obligations owed to the Health Care Provider by the Patient. This Assignment is to be a complete and current transfer of Patients right, title, and interest, separate from any statutory or contractual lien or claim to which the Health care Provider may also be entitled. Patient acknowledges that Health Care Provider has a substantial pecuniary interest in the enforcement of this Assignment.

The Patient further agrees that, in the event the insurance company and/or attorney obligated hereunder to make payments to the Health Care Provider fails or refuses to make payment for the full amount due as set forth above, this Assignment is a full, immediate and complete assignment of all the Patient's rights, title, interest, remedies and benefits in and to the assigned property to the extent of the Health Care Providers total claim amount; therefore, Patient hereby irrevocably and fully assigns and transfers to the Health Care Provider any and all causes of action that Patient might have or that might exist in Patients favor against such insurance company and/or attorney with respect to the assigned property. In addition to the foregoing assignment, Patient hereby authorizes, nominates and appoints as Patients attorney-in-fact any officer of Health Care Provider, to prosecute said causes(s) of action either in Patients name or in the Health Care Providers name and Patient further authorizes the Health Care Provider to compromise, settle or otherwise resolve said claim(s) or cause(s) of action as it sees fit.

In further consideration of the services provided by the Health Care Provider, Patient hereby grants a lien to said Health Care Provider against any and all insurance benefits and litigation proceeds outlined in the first paragraph above which may be payable to or on behalf of the Patient as a result of the injuries or illness for which Patient has been treated by said Health Care Provider. The Patient further agrees that the statute of limitations applicable to Health care Providers right to demand payment from the patient shall be tolled for all reasonable times that negotiations or litigation between third parties and the Patient are ongoing.

Patient hereby acknowledges that Virginia law imposes a lien in the amount of $750.00 upon Patients claim against the individual or entity whose negligence is alleged to have caused Patients injuries.

Notwithstanding the foregoing, the Patient agrees that until the Health Care Provider is paid in full, the Patient shall remain personally and fully responsible for and promises to pay the total amount due the Health Care Provider (including principal, interest, collection costs and attorney's fees of 35%) until fully paid. The Patient further understands and agrees that this Assignment does not constitute any agreement of or consideration for the Health Care Provider to await payments from any source, and in the event the Health Care Provider deems itself in its sole discretion insecure as to the prospect payment, it may demand payments from Patient immediately upon rendering services at its option and proceed to collect same through legal means if necessary.

Patient authorizes the Health Care Provider to release this Assignment and any information pertinent to Patients case to any insurance company, adjuster or attorney to facilitate collection under this Assignment. Patient hereby nominates and appoints any officer of the Health Care Provider as Patient's attorney-in-fact to endorse/sign Patient's name on any and all checks for payment of the services provided to Patient by said Health Care Provider.

In the event that any part or provision of this Assignment shall be determined to be invalid or unenforceable, the remaining parts and provisions of this Assignment which can be separated from the invalid, unenforceable provision shall continue in full force and effect.

Notice regarding the assignment of medical expense benefits is provided in a separate document. I have been presented with and had an opportunity to read the notice. Acknowledged:_________(patient initials)

Witness the following signatures and seal as of the indicated date:

PATIENT	HEALTH CARE PROVIDER
Patients Signature________________________________	Columbia Pike Chiropractic 5555 Columbia Pike, Ste 201, Arlington ,VA 22204
Printed Name____________________________________	
Date_____________ SS#______________________	By:
Witness____________________________	It's President
	Date______________

Columbia Pike Chiropractic
Jaime A. Chica D.C.

5555 Columbia Pike, Suite 201
Arlington, VA 22204

Phone: (703) 379-6300
Fax: (703) 379-4440

NOTICE: AUTOMOBILE ACCIDENT PATIENTS
(Addendum to Assignment of Benefits Form)

If you have been in an automobile accident, you may be entitled to payment from your automobile insurance if you have medical expense benefits coverage. By signing this assignment of benefits form, you are giving to your health care provider the right to receive some or all of the payment directly from your automobile insurance company.

If you have health insurance and your healthcare provider is in-network: As long as you provide information necessary to verify your health insurance coverage, the healthcare provider may only bill the amount you owe for any copayment, coinsurance, or deductibles to your automobile insurance and you may be entitled to any remainder of your automobile insurance benefit.

If you do not provide information necessary to verify your health insurance coverage, do not have health insurance, or your healthcare provider is not in your health insurer's provider network, your healthcare provider may bill its full charges to your automobile insurance.

You may want to consult your insurance agent or attorney before signing or initialing this form. **You are not required to sign/initial this form to receive care. However, if you do not sign this form, you will be required to (i) pay any applicable co-pays and deductibles at the time the services are provided and allow us to bill your health insurance company or (ii) pay for all care at the time of service.**

By signing below, I acknowledge that I have read or had the opportunity to read this notice.

Patient Signature:____

Patient Printed Name: ____

Date: ___________________________

INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

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 the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or 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.

I have had the opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures.

I understand and I 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 complications, 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 known, is my best interest.

I have read, and 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.

To be completed by patient:

____
Print Patient's Name

____
Signature of Patient

____
Date Signed

To be completed by doctor or staff:

Name and address of clinic/office:

Linea Chiropractic Center
7730 Herschel Ave #AA
La Jolla, CA 92037

Print name (s) doctor (s) treating this patient:

Patricia Lotufo, D.C.