Dr.William Bucur --16995 W Greenway Rd. Suite 102/ Surprise, Az. 85388/ 623-433-8895

Auto Intake Form

HOW DID YOU HEAR ABOUT OUR OFFICE? Please Circle One.

Walk In, Community Event, Mailing, Postcard, Internet/Facebook, Banner, Patient Referral - Name: _____

Other: _____

Patient Information

Last Name: _____ First Name: _____ M: _____ Male / Female

Address: _____Apt# _____ City: _____ State: _____ Zip:_____

Home : (_ __)_____-_____Cell: (_ __)_____-_____ Work: (__ _)____-_____DOB: _____/_____/_____

E-Mail: _____SSN:_____-_____-_____

Marital Status: Married Single Divorced Widowed

Occupation: _____ Medical Practitioner: _____

Employer_____ Address: _____ City: _____

State: _____ Spouse Name: _____ DOB: _____/_____/_____ Age: _____

Patient Medical Insurance Information:

Subscriber Name: _____Relationship: _____

Primary Private Insurance: _____ Phone: _____

Address: _____Phone: _____

Policy #_____ Group #_____

Patient Auto Insurance Information:

Subscriber Name: _____ Relationship: _____

Primary Private Insurance:_____Phone:_____

Address: _____Phone: _____

Claim #_____ Policy #_____

Are you the "**At Fault Party**": Yes / No If no, please insert "At Fault Party" Insurance information below:

Date of Accident: _____ Was an Accident report made: Yes / No

City of _____ County of: _____ State: _____

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At Fault Auto Insurance Information

Name of **"At Fault"** Party: _____ DOB: _____/____/____

Insurance Carrier: _____ Phone: _____ Address: _____

City: _____State: _____ Zip: _____ Policy _____

Claim #_____Representative Name: _____Ext: _____

Accident Questionnaire:

In the car, were you: (circle one)

Driver Front Passenger Right Rear Passenger Left Rear Passenger

What type of accident were you in?

Front-End Collision Rear-End Collision Side-Impact Collision Other: _____

Did your vehicle strike another vehicle? Yes / No **Were you struck?** Yes / No

Were you wearing your seatbelt? Yes / No

At the time of impact were you: Looking ahead Looking to the right Looking to the Left

Did you strike anything in the vehicle? Yes / No Please specify: _____

Describe how you felt immediately following impact? _____

Were you unconscious? Y / N **In a daze?** Y / N

Did you go to the hospital? Y / N **If yes, When?** At time of Accident? **Or** Later in the day?

Were you taken in an ambulance? Y / N Other: _____

Did the EMT place you in: Neck Collar? Splints? Brace?

Which Hospital were you taken to? _____

Were X-rays taken? Y / N **If yes, what was the diagnosis?** _____

Have you seen any other doctor in regards to this incident? Y / N Dr.'s Name: _____

If no Immediate symptoms, how long until you felt symptoms? _____ Days _____Hours _____Weeks

Check One: Immediately Bad? _____ Gradually Bad? _____

I VERIFY AND ACKNOWLEDGE THAT ALL INFORMATION IS CURRENT AND CORRECT: (Please sign below)

Signature of Patient: _____ Date: _____

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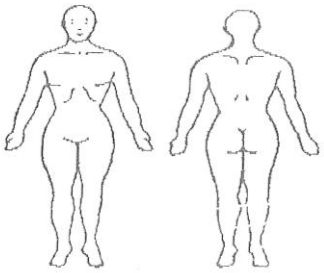
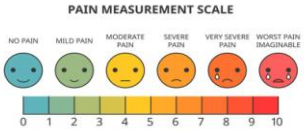
Please circle most affected areas below:



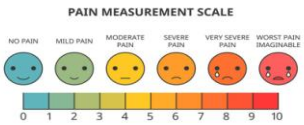
DESCRIBE AREA OF COMPLAINT - Begin with the area causing the most distress. (circle the words that appy)

Area #1 _____ **Tone - (Circle) - Dull Sharp Achy/Soreness Stiff/Tightness Numbness/Tingling**



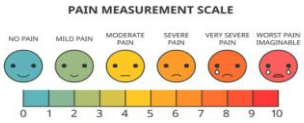
Rate - _____ **Frequency – (Circle) - Constant Intermittent Occasional**

Area #2 _____ **Tone - (Circle) - Dull Sharp Achy/Soreness Stiff/Tightness Numbness/Tingling**



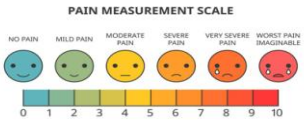
Rate - _____ **Frequency – (Circle) - Constant Intermittent Occasional**

Area #3 _____ **Tone - (Circle) - Dull Sharp Achy/Soreness Stiff/Tightness Numbness/Tingling**



Rate - _____ **Frequency – (Circle) - Constant Intermittent Occasional**

Area #4 _____ **Tone - (Circle) - Dull Sharp Achy/Soreness Stiff/Tightness Numbness/Tingling**



Rate - _____ **Frequency – (Circle) - Constant Intermittent Occasional**

1. Have you tried anything to relieve the pain? If so, what? _____ Results: **Yes No**

2. Have you seen any other doctors for this condition? If yes, who? _____ Results: **Yes No**

3. Are you currently under drug/medical care? **Yes No** Condition _____ Results: **Yes No**

4. Previous Chiropractic Care: _____ Approx. date of last visit: _____/_____/_____

5. Previous Spinal Injuries? **YES NO** _____ Automobile Accidents? **YES NO**

6. How many & when _____ Exercise Problems or Injuries? **YES NO**

7. Exercise**:** **Often Occasionally** 8. Difficulty Sleeping? **YES NO** 9. Position that Relieves Tension? **Side Stomach Back**

10. Previous Injuries or Broken Bones: _____

11. Surgeries: When:_____Area:_____

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Please circle all that apply to you:

Allergies	Arthritis	Asthma	Blood Clots
Blood Pressure	Cholesterol	Chronic Pain	Depression
Diabetes	Digestion Issues	Eczema	Epilepsy
Hearing & Ear	Heart Disease	Heart Attack	HIV/AIDS
Hepatitis (A,B,C)	Infectious Disease	Joint Replacements	Lung Conditions
Menopause	Mental Health	Migraine	Neurological Issues
Shingles	Sleep Disorder	Thyroid	Other:_____

Pregnancy: Due Date:_____# of weeks: _____

I VERIFY AND ACKNOWLEDGE THAT ALL INFORMATION IS CURRENT AND CORRECT: (Please sign below)

Signature of Patient: _____ Date: _____

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Financial Agreement

I will pay in full for services at the time of my appointment unless I have insurance coverage that requires another arrangement, or I make a different agreement with my provider.

My initials indicate that I have read and agree with each item below.

Professional Fees

Any co-payment or co-insurance will be due in full at the time of service.

All initial appointment fees are due upon first day of service. Special financial arrangements must be discussed by the second appointment.

A $25 processing fee will be charged for any NSF fees on any return of payment.

Same day cancellations will be charged **50%** of the scheduled service price. **No show**: if you do not show for your scheduled appointment you will be charged the **FULL AMOUNT** of the service. Call **24 hours prior** to your scheduled appointment. **NO CHARGE**

Authorization of Release of Records

I authorize the release of any medical information necessary to process my claim and/or for better treatment in this office including x-rays, MRIs, Lab tests, etc.

Payment and Assignments of Services

It is my responsibility to know what services are covered by my insurance plan. I have reviewed carefully the section in my insurance coverage booklet that describes the coverage of benefits for the services that will be provided at this office. I will call my plan administrator with any questions. I will pay for any services I receive that are not covered or denied by my insurance plan.

I will provide full and accurate insurance information in advance of my appointment, or will pay for the appointment on a self-pay basis. I will present my insurance card at the time of my appointment. I will provide updated insurance information promptly in the case of any changes.

I understand that I, not my insurance company, am responsible for full payment of my fees. I understand that insurance billing is provided by my healthcare provider as a courtesy, but I remain the responsible party.

I understand that, if after 90 days my insurance company has not responded I will receive a statement. I agree to pay my balance in full at that time. I understand that I will be reimbursed promptly if and when the insurance payment arrives.

I understand that, if my account is referred to a collection specialist due to nonpayment, I will pay any applicable collection fees.

I understand that, "Authorization to Pay the Doctor" I hereby authorize payment directly to Greenway/Cotton Chiropractic of the insurance benefits otherwise payable to me.

I understand that, Personal Injury/Auto Claim_____ Non Personal Injury/Auto Claim _____ in the case that I choose Non Personal Injury/Auto Claim, I state that I was not involved in any auto accident or personal injury caused by any other party. I further state that my diagnostic test or treatment is not the result of an injury while on the job or by any other person related to my employment.

I understand that, In the case of auto carrier or workman's compensation claims, whether settled or unsettled, I understand that I am responsible for all costs of chiropractic care which become payable within 30 days after the end of treatment and am held to the same rules as mentioned in the balance held policy noted above.

I understand that I am solely responsible for any and all missed, canceled or reschedule appointment fees whether the charges are in relation to an auto case or otherwise. I understand that my credit card will be charged at the time of the occurrence, if I am unable to give proper notice of more than 24 hours prior to my schedule appointmen

Dispute Procedure

In the event of a dispute between myself and Greenway/Cotton Chiropractic whether for charges, procedures or balances I owe, I hereby waive the statute of limitations on collections and/or recovery. I also understand that litigation is certain once balances owed reaches 120 days past due, and I agree to pay all litigation costs incurred by Greenway/Cotton Chiropractic as a result of inaction to timely payment of my account. I understand and agree to pay a 50% collection fee on any outstanding balances due that are turned over to a collection agency.

By signing this document, I hereby agree to abide by all mentioned policies, authorizations, assignments, and procedures.

Signature of Patient: _____ **Date:** _____

Witness/ Personnel: _____ **Date:** _____

HIPPA Privacy Rule: Consent for Purposes of Treatment, Payment and Healthcare Operations

I acknowledge that Greenway/Cotton Chiropractic "Notice of Privacy Practices Abridged Edition" has been provided to me.

I understand I have a right to review the entire Greenway/Cotton Chiropractic Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Greenway/Cotton Chiropractic. The Notice of Privacy Practices for Greenway/Cotton Chiropractic also provided on request at the main administration desk of this practice. This Notice of Privacy Practices also describes my rights and Greenway/Cotton Chiropractic duties with respect to my protected health information.

Greenway/Cotton Chiropractic reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

PATIENT ACKNOWLEDGEMENT

By signing my name below, I acknowledge receipt of the above stated notice and my understanding and agreement to its terms.

_____ _____

Signature of Patient or Personal Representative **Date**

_____

Print Name of Patient or Personal Representative

_____

Description of Personal Representative's Authority

Informed Consent to Chiropractic Services

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 on the patient named below, for whom I am legally responsible) by the licensed doctor of chiropractic who now or in the future work at the clinic or office listed below or any other office or clinic.

I consent to the opportunity to discuss with the doctor of chiropractic or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and 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 upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

I have read, or have had read to me, the above consent. I consent to the 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.

Patient Signature_____ **Date** _____

Release of Information

MUST BE FILLED OUT COMPLETELY

AUTHORIZATION FOR RELEASE OF RECORDS & PHYSICIAN'S LIEN

TO: Attorney/Insurance Carrier

_____

_____

_____

_____

From: Greenway/Cotton Chiropractic P.C.

William M. Bucur D.C.

16995 W. Greenway Rd., Ste 102

Surprise, AZ, 85388

Patient Name: _____

RELEASE OF RECORDS: I do hereby authorize the above doctor to furnish you, my attorney/insurance carrier, with a full report of this case history, examination, diagnosis, treatment, and prognosis of myself in regard to my accident on record.

LIEN ON SETTLEMENT: I hereby give a Lien to the above doctor on any settlement, claim, judgment, or verdict as a result of said accident. I authorize and direct you, my attorney/Insurance Carrier, to pay directly to said doctor all sums that are due and owing, for services rendered me, by withholding such sums from any settlement, claim, judgment, or verdict as may be necessary to protect said doctor adequately. Prior to dispersing any such fees, it is the responsibility of the payer to verify with this office all outstanding balances.

ASSIGNMENT OF BENEFITS: I further assign my claim or right to compensation for treatment expenses incurred with the doctor/clinic named above arising from a tort or liability claim in connection with this accident or injury.

IRREVOCABLE LIEN: I understand that this Lien shall be irrevocable either by myself or any other agent that represents me; that in the event another attorney is substituted in this matter, the new attorney shall honor this lien as inherent to the settlement and enforceable upon the case as if it was executed by him.

RESPONSIBILITY FOR PAYMENT: I understand that I am directly and fully responsible to said doctor/clinic for chiropractic bills submitted for services rendered me, and that this agreement is made solely for said doctor's additional protection and in consideration of his awaiting payment. I further understand that such payment is not contingent on any settlement, claim, judgment, or verdict by which I may eventually recover said fee. In the event that there is a deductible or co-pay to be satisfied, I understand and agree to pay any deductible or co-pay required by any insurance company that is billed for me. I also understand and agree that I am responsible for any reasonable collection fees required to secure the doctor's payment.

Patient Signature: _____ Dated: _____

NOTICE OF PRIVACY PRACTICES

Abridged Edition

Effective April 14, 2003, the Department of Health & Human Services has implemented protection for patient health care information. It outlines who we may disclose information to without your authorization and how we can disclose your protected health information with your authorization as well as how you can gain access to your personal health information or to make a complaint to the Department of Health & Human Services if you feel your protected health information was used in an improper way. This notice will give you a brief description of our entire privacy practices.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

So that this office can treat you, receive payment for that treatment and run our health care operation, we may use your protected health information without your authorization to send to third party payers, administrators, etc.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION THAT MAY BE MADE WITH YOUR WRITTEN AUTHORIZATION

With your signed authorization we may make communications with you to promote products and services that may not be for a specific purpose of providing treatment advice. You have the right to revoke this authorization. Other permitted and required uses and disclosures that may be made without your authorization or opportunity to object – we may disclose to a member of your family, a relative, a close friend or other person you identify, your protected health information that directly relates to that person's involvement in your health care. We may also disclose your protected health information to an authorized public or private entity as required by law.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES THAT MAY BE MADE WITHOUT YOUR CONSENT, AUTHORIZATION OR OPPORTUNITY TO OBJECT

We may use or disclose your protected health information in the following situations:

- Required by law
- Health Oversight
- Legal Proceedings
- Research

Your rights – You may inspect or obtain a copy of your protected health information for as long as we maintain that information unless protected by federal law.

RIGHT TO REQUEST A RESTRICTION OF YOUR PROTECTED HEALTH INFORMATION

You may ask us not to use or disclose any part of your protected health information for the purpose of treatment, payment or health care operation. Also, you may request that any part of your protected health information not be disclosed to your family members or friends who may be involved in your care. Your request must be in writing and state specific restrictions requested and to whom it applies.

RIGHT TO REQUEST TO RECEIVE CONFIDENTIAL COMMUNICATION FROM US BY ALTERNATIVE MEANS OR AT AN ALTERNATIVE LOCATION

You may request that you receive these communications from us at an alternative location or by alternative means than is normally provided to other patients.

RIGHT TO AMEND YOUR PROTECTED HEALTH INFORMATION

You may request an amendment to your protected health information for as long as we maintain your protected health information. In certain cases we may deny your request for an amendment.

RIGHT TO RECEIVE AN ACCOUNTING OF CERTAIN DISCLOSRUES WE HAVE MADE

You have the right to receive an accounting if we receive a request for disclosure of information for purposes other than treatment, payment and health care operations

RIGHT TO OBTAIN A PAPER COPY OF THIS NOTICE

You have the right to receive a complete copy of our privacy practices by paper or electronically.

COMPLAINTS

If you believe your privacy rights have been violated, you may complain to us or to the Secretary of Health & Human Services. This notice was published and becomes effective (updated) January 1st, 2018.