HANSON
CHIROPRACTIC CENTER
Dr. Ryan Hanson, D.C.

Automobile/PI Accident or Work Comp Questionnaire

_____ _____ _____

Patient's Name **DOB** **Today's Date**

Address: _____ City: _____ State: _____ Zip: _____

E-mail Address: _____ Home Phone: _____

Mobile Phone: _____ Carrier: ATT Sprint Verizon T-Mobile Other: _____

Marital Status: Single Married Do you have Insurance: Yes No Work Phone: _____

Social Security #: _____ Driver's License #: _____

Employer: _____ Occupation: _____

Spouse's Name: _____ Spouse's Employer: _____

Number of Children and Age: _____

Name and Number of Emergency Contact: _____

Please answer all questions completely

Dear Patient: This information is considered confidential. We need this information because we care enough to want to know and your answers will help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. In order for us to understand your condition properly, please be as neat an accurate as possible while completing this form.

What were the time and date of present injury? _____

Please explain in detail how your accident happened. _____

_____

_____

_____

What side were you struck from? (circle one) Behind Front Left Side Right Side

What direction was your vehicle moving and what speed? _____

Describe your vehicle's visual damage after the accident: _____

What direction was the other vehicle moving and what speed? _____

Was the vehicle towed? (circle one) Yes No

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List the extent of your injuries as you know them: _____

_____

_____

Where did you feel pain immediately after the accident? _____

Circle the type of pain you felt at the time of your injury:

Radiating Burning Dull Aching Numbness Sharp/Stabbing Tingling

Check symptoms you have noticed since the accident:

__ Headache
__ Light bothers the eyes
__ Head seems too heavy
__ Pins and needles in arms
__ Sleeping problems
__ Pins and needles in legs
__ Numbness in fingers
__ Numbness in toes
__ Shortness of breath
__ Dizziness
__ Buzzing in ears
__ Memory loss
__ Ears ring
__ Back pain
__ Constipation
__ Loss of smell
__ Loss of taste
__ Stomach upset
__ Depression
__ Diarrhea
__ Feet cold
__ Hands cold
__ Face flushed
__ Tension
__ Fever
__ Chest pain
__ Fatigue
__ Neck pain
__ Neck stiff
__ Fainting
__ Loss of balance
__ Nervousness
__ Irritability
__ Cold sweats

List symptoms other than above: _____

_____

Were you (circle one) Driver Passenger

Were you in (circle one) Front seat Back seat

Using seat belts? (circle one) Yes No

Did the air bag deploy? (circle one) Yes No

What direction were you looking at the time of the accident? (circle one) Forward Backward Left Right

Did you strike any part of your body to the interior of the car? If yes, please explain: _____

_____

Were the police notified? (circle one) Yes No

Was a police report filed? (circle one) Yes No

Was EMS at the scene? (circle one) Yes No

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Where did you go after the accident? _____

Did you require post-accident hospitalization? (circle one) Yes No

If yes, were you admitted (how long)? _____

Name of hospital? _____ Name of doctor(s)? _____

What treatment was given? _____

Was any other doctor consulted after your accident? (circle one) Yes No

If yes, what was the doctor's name? _____ (circle one) DC MD DO DDS

What was the diagnosis? _____

What treatment was given? _____

How often did you see the doctor? _____

Have you ever had any complaints in the involved area before? (circle one) Yes No

If yes, what were the complaints? _____

_____

Since this injury are your symptoms: (circle one) Improving Worsening Staying the same

Before the injury were you capable of working on an equal basis with others your age? (circle one) Yes No

Are your work activities restricted as a result of this accident? (circle one) Yes No

Driver of other vehicle (if applicable):

Name _____ Insurance Company _____ Policy Number _____

Driver of vehicle in which you were injured (if applicable):

Name _____ Insurance Company _____ Policy Number _____

Name of your insurance adjuster _____ Phone Number_____

Have you retained an attorney? (circle one) Yes No

If yes, please list the following information about your attorney: Name _____

Address _____ Phone Number_____
Street City, State Zip

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Which direction were you heading (if applicable)? (circle one) North South East West

What street/highway were you driving on? _____

Which direction was the other vehicle heading (if applicable)? (circle one) North South East West

What street/highway was the other driver driving on? _____

Were you knocked unconscious? (circle one) Yes No If yes, how long? _____

How fast was the other vehicle moving? _____

Were any of the vehicles totaled? _____

What was the movement of your vehicle? _____

_____

If your vehicle was moving, what was the approximate MPH? _____

What part of your vehicle was impacted? _____

How bad was the visual damage of your vehicle? (Circle one)

No Visual Damage Slight Visual Damage Moderate Visual Damage

Heavy Visual Damage Totaled

Did your vehicle have to be towed from the scene? (Circle one) YES NO

Were other automobiles involved? (Circle one) YES NO

If YES, how many? _____

If YES, where was the impact on the other vehicles? _____

If YES, what was the movement of the other vehicle? _____

Additional info: _____

_____

_____ _____

Patient's Name (printed) **DOB**

_____ _____

Patient's Signature **Today's Date**

_____ _____

Witness **Today's Date**

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Past History

Have you ever suffered with any of this or a similar problem in the past? Yes No

If yes, how many times? _____ When was the last episode? _____

How did the injury happen? _____

Other forms of treatment tried: (circle one) Yes No
If yes, please state what type of treatment: _____

Who provided the treatment: _____ **How Long Ago**: _____
What were the results: _____

Please identify any and all types of jobs you have had in the past that may have imposed any physical stress on you or your body: _____

If you have ever been diagnosed with any of the following conditions, please indicate with a **P** for **past**, **C** for **currently have** and **N** for **never have had**:

___ Broken Bone ___ Dislocations ___Tumors ___ Rheumatoid Arthritis ___ Fracture ___Disability

___ Cancer ___Heart Attack ___Osteoarthritis ___Diabetes ___ Cerebral Vascular

___ Other Serious Problems: _____

PLEASE identify ALL PAST and any **CURRENT** conditions you feel may be contributing to your present problem:

How long ago?	Type Of Care Received?	By Whom?
INJURIES →		
SURGERIES →		
CHILDHOOD DISEASES →		
ADULT DISEASES →		

Social History:

1. **Smoking: Cigars Pipes Cigarettes How Often?** Daily Weekends Occasionally Never
2. **Alcoholic Beverages:** Daily Weekends Occasionally
3. **Recreational Drug Use:** Daily Weekends Occasionally

Family History:

1. **Does anyone in your family suffer with the same condition(s)?** No Yes
   If yes, whom: Grandparent Parent Sibling Daughter Son

   Have they ever been treated for this condition? _____
2. **Any** other hereditary conditions the doctor should be aware of? Yes No

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I hereby authorize payment to be made directly to Hanson Chiropractic Center for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to Hanson Chiropractic Center for any and all services I receive at this office.

_____ _____

Patient's Name (printed) **DOB**

_____ _____

Patient's Signature **Today's Date**

_____ _____

Witness **Today's Date**

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Please identify the condition(s) you are feeling today:

Primarily _____

Secondarily: _____ Third: _____ Fourth: _____

On a scale of **1** to **10** with **10** being the worst pain and **zero** being no pain, rate your above complaints by **circling the number:**

Primary or chief complaint is - - -	0	1	2	3	4	5	6	7	8	9	10
Secondary complaint is - - - - - - -	0	1	2	3	4	5	6	7	8	9	10
Third complaint is - - - - - - - - - - -	0	1	2	3	4	5	6	7	8	9	10
Fourth complaint is - - - - - - - - - -	0	1	2	3	4	5	6	7	8	9	10

When did the problem(s) begin? _____

When is the problem at its worst? ☐ AM ☐ PM ☐ mid-day ☐ late PM

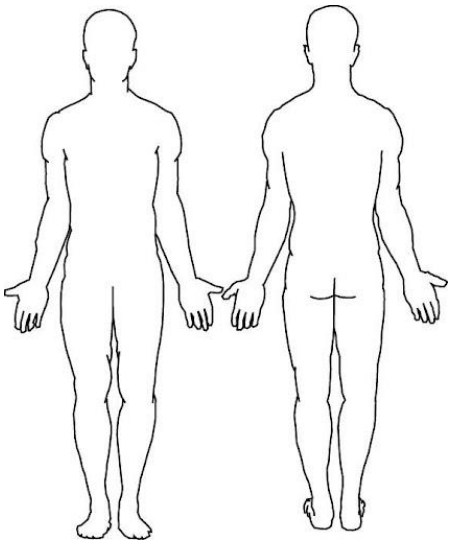
How long does it last? _____

What relieves your symptoms? _____

What makes them feel worse? _____

PLEASE MARK the areas on the diagram with the following **letters** to describe your symptoms:

R = Radiating **B = B**urning **D = D**ull **A = A**ching **N = N**umbness **S = S**harp/**S**tabbing **T = T**ingling



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Patient Name: _____ **Patient Signature**: _____ **Date**: _____

Daily Activities: Effects or Current Conditions of Performance

Please Identify how your current condition is affecting your ability to carry out activities that are routinely apart of your life.

Bending	☐ No Effect	☐ Painful (Can Do)	☐ Painful (Limits)	☐ Unable to Perform
Concentrating	☐ No Effect	☐ Painful (Can Do)	☐ Painful (Limits)	☐ Unable to Perform
Computer work	☐ No Effect	☐ Painful (Can Do)	☐ Painful (Limits)	☐ Unable to Perform
Gardening	☐ No Effect	☐ Painful (Can Do)	☐ Painful (Limits)	☐ Unable to Perform
Playing Sports	☐ No Effect	☐ Painful (Can Do)	☐ Painful (Limits)	☐ Unable to Perform
Recreation Act.	☐ No Effect	☐ Painful (Can Do)	☐ Painful (Limits)	☐ Unable to Perform
Shoveling	☐ No Effect	☐ Painful (Can Do)	☐ Painful (Limits)	☐ Unable to Perform
Sleeping	☐ No Effect	☐ Painful (Can Do)	☐ Painful (Limits)	☐ Unable to Perform
Watching TV	☐ No Effect	☐ Painful (Can Do)	☐ Painful (Limits)	☐ Unable to Perform
Carrying	☐ No Effect	☐ Painful (Can Do)	☐ Painful (Limits)	☐ Unable to Perform
Dancing	☐ No Effect	☐ Painful (Can Do)	☐ Painful (Limits)	☐ Unable to Perform
Dressing	☐ No Effect	☐ Painful (Can Do)	☐ Painful (Limits)	☐ Unable to Perform
Lifting	☐ No Effect	☐ Painful (Can Do)	☐ Painful (Limits)	☐ Unable to Perform
Pushing	☐ No Effect	☐ Painful (Can Do)	☐ Painful (Limits)	☐ Unable to Perform
Rolling Over	☐ No Effect	☐ Painful (Can Do)	☐ Painful (Limits)	☐ Unable to Perform
Sitting	☐ No Effect	☐ Painful (Can Do)	☐ Painful (Limits)	☐ Unable to Perform
Standing	☐ No Effect	☐ Painful (Can Do)	☐ Painful (Limits)	☐ Unable to Perform
Working	☐ No Effect	☐ Painful (Can Do)	☐ Painful (Limits)	☐ Unable to Perform
Climbing	☐ No Effect	☐ Painful (Can Do)	☐ Painful (Limits)	☐ Unable to Perform
Doing Chores	☐ No Effect	☐ Painful (Can Do)	☐ Painful (Limits)	☐ Unable to Perform
Driving	☐ No Effect	☐ Painful (Can Do)	☐ Painful (Limits)	☐ Unable to Perform
Sexual Activities	☐ No Effect	☐ Painful (Can Do)	☐ Painful (Limits)	☐ Unable to Perform
Reading	☐ No Effect	☐ Painful (Can Do)	☐ Painful (Limits)	☐ Unable to Perform
Running	☐ No Effect	☐ Painful (Can Do)	☐ Painful (Limits)	☐ Unable to Perform
Sitting to Standing	☐ No Effect	☐ Painful (Can Do)	☐ Painful (Limits)	☐ Unable to Perform
Walking	☐ No Effect	☐ Painful (Can Do)	☐ Painful (Limits)	☐ Unable to Perform

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Informed Consent

Regarding: Chiropractic Adjustments, Modalities, and Therapeutic Procedures:

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risks are often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one per one million to one per two million, have been associated with chiropractic adjustments.

Treatment objectives as well as the risks associated with chiropractic adjustments and, all other procedures provided at the Hanson Chiropractic Center have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method and/or techniques that the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

_____ ___/___/_____ ☐ Witness Initials

Patient or Authorized Person's Signature Date

Regarding: X-Rays/Imaging Studies

Females Only: Please read carefully and check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise, see our receptionist for further explanation.

☐ The first day of my last menstrual cycle was on ____/____/____

☐ I have been provided a full explanation of when I am most likely to become pregnant, and the best of my knowledge, I am not pregnant.

By my signature below I am acknowledging that the doctor and/or a member of the staff has discussed the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposer to x-rays. After careful consideration I therefore, hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

_____ ___/___/_____ ☐ Witness Initials

Patient or Authorized Person's Signature Date

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Dr. Ryan Hanson, D.C.

Our Office Policies

ADMINISTRATIVE- NOTICE OF- OFFICE POLICIES

Dr. Ryan Hanson

As a potential new patient, we feel it is important that you understand our office policies regarding, how patients of this practice are cared for, and the various methods we offer to facilitate payment for that care. **Please read each policy carefully so there is no misunderstanding as to what you can expect as a patient of this practice, and what we expect in return**.

☐ **YOUR CARE** - When a patient seeks chiropractic health care and we agree to provide that care, it is essential for the patient and the doctor to be working toward the same objective. Chiropractic care at Hanson Chiropractic Center is rendered primarily to minimize and reduce subluxations. The doctor uses Pettibon Spinal Correction and activator adjustments through a myriad of techniques to accomplish this goal. It is important that you understand both the objective and the method(s) so there is no confusion or disappointment. Tremendous progress has been made in the rehabilitating and correction of spinal problems. Where in the past, chronic spinal structural problems could not be reversed or corrected, today they can. **Your doctor will outline a course of treatment that will take you beyond simple pain relief, through two distinct phases of care to make a structural correction to your spine that will enable your central nervous system to function optimally, thereby improving your overall health.**

☐ **FIRST DAY GOALS**- Prior to receiving chiropractic care at this office, a health history and examination will be completed. Imaging studies as well as any other necessary diagnostics may also be ordered, to confirm the true nature of your condition and exact location of subluxations. The results of these procedures will aid in assessing your presenting problem, your overall health and, in particular, the condition of your spine. They will also assist the doctor in determining the type and amount of care you will need. All relevant findings will be reported to you along with care plan recommendations so t**h**at you can make the best possible decision regarding your health care needs. Our gold standard for care is to ensure the reduction of subluxations while teaching patients what they need to do to maintain their health for a lifetime, in additional to being adjusted.

☐ **PATIENT'S REPORT OF FINDINGS** – To enhance your understanding of the chiropractic approach that will be used to manage your health, immediately following your first adjustment, you will be scheduled for a 'Doctors Report of Findings'. **The information you receive at this appointment will be both informative and clinically relevant to your case, therefore attendance is required for individuals who wish to become new patients of this practice. Because the results of your x-rays and all examinations as well as the doctors' recommendations for care, will be discussed at that time, we strongly urge new patients to invite their spouse or significant other to attend.** We know from experience that when a patient's family understands the goals and objectives of chiropractic care and how restoring and maintaining good health can affect their lives as well, they become infinitely supportive and helpful in making important decisions concerning treatment options.

☐ **PATIENT PRIVACY –I**t is important to understand that any conversations you have with the doctor could potentially be overheard by other patients. In order to maintain patient privacy, it is the policy of this practice to refrain from discussing any confidential matters with patients during treating hours while patients are being adjusted. If you have a confidential matter you wish to discuss, please let us know and we will schedule time for you to speak to the doctor in a private consultation room. **These consultations must be scheduled in advance.**

☐ **INSURANCE COVERAGE-** All services that are billable to insurance will be submitted, as outlined according to the care plan recommended by the doctor. Not all chiropractic services are billable/covered by insurance companies. Any insurance coverage will be verified within 48 hours of the patient's first appointment. Payments for all charges are due in full until the verification is complete. **All verifications are an estimate of coverage based on the information provided by the policy and not a guarantee of payment. Any balance remaining after payment is the responsibility of the patient.**

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☐ **PAYMENTS-** Based on the care prescribed by the doctor, payment options will be presented on your 3rd visit during the Patient's Report of Findings. We accept Cash, Check, VISA, Mastercard, AMEX or Discover. Additionally, please let us know if you have a Health Savings Account or Health Reimbursement Account. Some payment arrangements do require that we maintain a valid credit card on file through our secure online processing service. **Non-refundable items include:** Supplements, Head weights, Traction, Wobble Cushion, and opened packages of Spinal Moldings or Wedges. If you choose to discontinue care at any time, payment/refund for services rendered will be collected upon close of account. Account will not be closed until all outstanding insurance claims are processed by the patient's insurance company. If patient balance remains unpaid after two notices of payment due are sent, a fee of $10 will be charged for certified mail and collection services acquired to seek payment. Hanson Chiropractic Center utilizes Action Collections to acquire unpaid balances after 3 months of non-payment.

Over time it is our goal that you gain a greater understanding as to the purpose of chiropractic. Patients who are accepted for care have a unique opportunity to observe firsthand the positive results and benefits derived from being under chiropractic care. This knowledge and awareness reap a positive environment that promotes healing and encourages families to maintain good health. We want your experience with us to be an exceptional one, so help us to help you. Together, we can make affirmative changes in your life and the lives of those you care about.

If you have any questions regarding these policies, before submitting your ***Application for Care,*** please ask and we will be happy to discuss them with you further. We want you to make an informed decision about your applying for care at this office. Therefore, it is important for you to understand these policies, how Dr. Ryan practices chiropractic, and how we can help you receive the best care to achieve your goals for health.

Note: Patient and Office retains a copy of this policy agreement.

I hereby acknowledge receiving a copy of the practices 'Office Policies' a two page document. I assign to Hanson Chiropractic Center the rights under all insurance and benefit plan documents, and authorize direct payment to each healthcare provider of all insurance and plan benefits payments for services provided to me (or the patient) by this provider. By paying my provider directly, my insurance company or employer is fulfilling its obligation to me (or the patient) under the health insurance policy, or the employer is fulfilling its obligations as required by law. I also agree that I (or the patient) am financially responsible for charges not paid according to this assignment.

My signature acknowledges that I have received a copy of these policies and understand this 'Notice'. I further acknowledge that any concerns regarding these 'Policies 'as well as all my questions have been answered by a qualified member of the staff to my complete satisfaction.

_____ _____
Patient's Name (printed) DOB

_____ _____
Patient signature Date

_____ _____
Witness Date

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CHIROPRACTIC CENTER
Dr. Ryan Hanson, D.C.

Hanson Chiropractic Center's NOTICE OF PRIVACY PRACTICE

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your **P**ersonal **H**ealth **I**nformation. In addition, we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as dictated by our office policy, we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstance. If you would like a more detailed explanation, one will be provided to you. In addition, you will find we have placed several copies in report folders labeled 'HIPAA' on tables in the reception. Once you have read this notice, please sign the last page, return only the signature page (page 2) to our front desk receptionist. Keep this page for your records.

Permitted Disclosures:

1. Treatment purposes- discussion with other health care providers involved in your care.
2. Inadvertent disclosers- open treating area meaning open discussion. If you need to speak privately to the doctor, please let our staff know so we can place you in a private consultation room.
3. For payment purposes- to obtain payment from your insurance company or any other collateral source.
4. For workers compensation purposes- to process a claim or aid in investigation.
5. Emergency- in the event of a medical emergency we may notify a family member.
6. For public health and safety- in order to prevent or lessen a serious or eminent threat to the health or safety of a person or general public.
7. To government agencies or law enforcement- to identify or locate a suspect, fugitive, material witness or missing person.
8. For military, national security, prisoner and government benefits purposes.
9. Deceased persons- discussion with coroners and medical examiners in the event of a patient's death.
10. Telephone calls or emails and appointments reminders- we may call your home leave messages regarding a missed appointment or apprize you of changes in practice hours or upcoming events.
11. Change of ownership- in the event this practice is sold, the new owners would have access to your PHI.

Your Rights:

1. To receive an accounting of disclosures.
2. To receive a paper copy of the comprehensive "Detail" Privacy Notice.
3. To request mailings to an address different than residence.
4. To request restrictions on certain uses and disclosures and with whom we release information to, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction.
5. To inspect your records and receive one copy of your records at no charge, with notice in advance.
6. To request amendments to information. However, like restrictions, we are not required to agree to them.
7. To obtain one copy of your records at no charge, when timely notice is provided (72 hours). X-Rays are original records and you are therefore not entitled to them. If you would like us to outsource them to an imaging center, to have copies made, we will be happy to accommodate you. However, you will be responsible for this cost.

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Dr. Ryan Hanson, D.C.

Hanson Chiropractic's NOTICE REGARDING YOUR RIGHT TO PRIVACY continued….

I have received a copy of Hanson Chiropractic's Patient Privacy Notice. I understand my rights as well as the practices duty to protect my health information, and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this 'Notice of Privacy Practice' at a time in the future and will make the new provisions effective for all information that it maintains past and present.

I am aware that a more comprehensive version of this "Notice" is available to me and several copies kept in the reception area. At this time, I do not have any questions regarding my rights or any of the information I have received.

_____ _____
Patient's Name (printed) DOB

_____ _____
Patient's Signature Date

_____ _____
Witness Date

Please list below anyone whom you give legal access to you Medical Records/ Accounting Information:

_____ _____ _____
Name Phone Number Relationship to Patient

_____ _____ _____
Name Phone Number Relationship to Patient

Complaints:
If you wish to make a formal complaint about how we handle your health information, please call Dr. Ryan Hanson at (405) 341-0494. If he is unavailable, you may make an appointment with our receptionist to see him within 72 hours or 3 business days. If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Ave. SW
Room 509F HHH Building
Washington DC 20201

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Dr. Ryan Hanson, D.C.

Terms Of Acceptance

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has one primary goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment:

- **Problem: Vertebral Subluxation:** A misalignment of one or more of the 24 vertebra in the spinal column, which cause alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

- **Solution: Adjustment:** An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is be specific adjustments on the spine.

- **Goal: Health:** A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the service of a health care provider who specializes in that area. Regardless of what the disease is called, we do not treat it. Nor do we offer advice regarding treatment prescribed by others.

OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, _____ have read and fully understand the above statements.
(Print Name)

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on the basis.

_____ _____ _____
Signature **DOB** **Date**

_____ _____
Witness Signature **Date**

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Auto Insurance Information

Please complete both insurances as much as possible.

Responsible Driver (Other Party): _____

Insurance Company: _____

Adjuster's Name: _____

Telephone Number: _____

Insurance Address: _____

Patient's Name: _____

Insurance Name: _____

Adjuster's Name: _____

Telephone Number: _____

Claim Number: _____

Insurance Address: _____