CYNERGY
HEALTH & WELLNESS

Motor Vehicle Accident History

Patient Information:

Last Name_____ First Name_____ Middle Initial___
Address_____ City_____
State_____ Zip Code_____
Marital status (circle one) M S W D
Main phone#_____ Other Phone#_____
Email address_____
Date of Birth _____
Gender: Male Female Non-Binary Trans Pronouns: _____
Occupation_____ Employer _____
Work Address_____
Person to contact in an emergency _____
Phone#_____ Relationship to Patient_____

Responsible Party
Name of person responsible for payment of this account_____
Relation to patient_____ Phone#_____
_____
Address City State Zip Code

Insurance Information
If you have any insurance information, please give to our front desk staff.

Accident/Injury History

1. Date of Accident: _____ Time of Day: _____ Road Condition: ( ) Dry ( ) Wet
2. Were you: ( ) Driver ( ) Passenger ( ) Front Seat ( ) Back Seat
3. Number of people in your vehicle? _____
4. Were you wearing a seat belt? ( ) Y ( ) N If no, go to question #6
5. If yes, were you wearing a lap belt? ( ) Y ( ) N shoulder harness? ( ) Y ( ) N

6. What direction were you headed? ( ) North ( ) South ( ) East ( ) West
(Name of street and city):_____

7. What direction was the other vehicle headed? ( ) North ( ) South
( ) East ( ) West
(Name of street and city):_____
8. Were you struck from: ( ) Behind ( ) Front ( ) Left Side ( ) Right Side
Other combination, please describe: _____
9. What was the position of your head during the accident? ( ) Straight ( ) Turned Right ( ) Turned Left ( ) Other_____
10. Did any part of your body strike/hit anything inside of your vehicle (steering wheel, dashboard, etc.)? ( ) Y ( ) N If yes, please explain:
_____
11. Did any items become displaced in the vehicle (rearview mirror, ashtray, packages, etc.)? ( ) Y ( ) N If yes, please describe:
_____
12. Approximate speed of your car: _____ mph
Estimated speed of the other car: _____ mph
13. Make/model of your car: _____
Make/model of the other vehicle: _____
14. Were the police notified? ( ) Y ( ) N Please provide this office with a copy of the police report.
15. In your own words, please describe the accident:
_____
_____
_____
16. Did you have any physical complaints BEFORE the accident? ( ) Y ( ) N
If yes, please describe in detail: _____
17. Please describe how you felt:
a. DURING the accident: _____
b. IMMEDIATELY AFTER the accident: _____
c. LATER THAT DAY: _____
d. THE NEXT DAY: _____
18. Were you knocked unconscious? ( ) Y ( ) N If yes, for how long? _____
19. Where were you taken after the accident? _____
20. Have you been treated by another doctor since this accident? ( ) Y ( ) N
If yes, please list the doctor's name and address: _____
_____
What type of treatment did you receive? _____
_____
21. Did this accident occur while you were performing your regular job duties?
( ) Y ( ) N
22. How do you feel now, what is your number one problem or the one area of greatest pain? _____
_____

23. Please rate the level of this pain on the following scale: 0 is no pain, 10 is severe pain or the worst pain you have ever felt. If your pain varies from day to day, please circle two numbers to indicate a range of your pain.

0 1 2 3 4 5 6 7 8 9 10

24. Since this injury occurred, is your pain: ( ) Improving ( ) Getting Worse
( ) Staying the Same

25. How often do you experience the pain?

___ 1-2 hours per day ___ About half of the day
___ Most of the day ___ The pain never goes away

26. How does the pain affect your daily activities?

___ It does not affect my daily activities
___ I have had to change how I do things
___ I have had to stop doing some of my daily activities
___ I am unable to perform daily activities

27. What increases your pain? _____

28. What decreases your pain? _____

29. Have you ever experienced this problem before? [ ] Y [ ] N When? _____

30. Do you have a previous illness/disease which affects your present condition? ( ) Y ( ) N

If yes, please describe: _____

31. List any other complaints currently bothering you and rate your pain level for each.

a._____ 0 1 2 3 4 5 6 7 8 9 10
b._____ 0 1 2 3 4 5 6 7 8 910
c._____ 0 1 2 3 4 5 6 7 8 9 10
d. _____0 1 2 3 4 5 6 7 8 9 10

32. Have you lost time from work as a result of this accident? ( ) Y ( ) N

a. Type of employment: _____
b. Last day worked: _____

33. Have you ever been involved in an accident before? ( ) Y ( ) N

a. If yes, when? _____
b. Describe the accident(s):_____
_____
c. Were you injured? [ ] Y [ ] N Explain:
_____

34. List all medication you are currently taking (prescribed and over counter)
_____

35. List all surgeries you have had (with date)
_____

If you have experienced any of the following conditions in the past mark a "P" on the line provided. If you are currently experiencing any of the following conditions please mark a "C" on the line provided. (Check all that apply)

___ heart attack ___ stroke ___ arthritis ___ gall bladder trouble
___ diabetes ___ glaucoma ___ fainting spells ___ kidney stones
___ difficulty with urination ___ bloody stools ___ difficulty with bowel movements
___ prostate trouble ___ anemia ___ cancer ___ asthma
___ HIV ___ ulcers ___ diverticulosis ___ menstrual cramping
___ dizziness ___ loss of memory ___ chest pain ___ shortness of breath
___ constipation ___ diarrhea ___ general fatigue ___ sudden weight loss

___ nausea ___ muscle cramping ___ soreness in joints ___ loss of hearing
___ ears ringing ___ headache ___ migraine ___ epilepsy
___ gout ___ tuberculosis ___ syphilis ___ sprained ankle [ ] R [ ] L
___ knee/hip replacement ___ broken bones (specify)

General Activities (check all that apply)

___ read in bed ___ fall asleep in recliner/on couch
___ sleep on stomach ___ sleep with 2 or more pillows
___ needlepoint/knitting ___ sewing ___ lift weights
___ swim ___ jog/run ___ other form of exercise
___ play video games (__ hrs/day) ___ computer use (__ hrs/day)
___ watch television (__ hrs/day)

Neurodivergences: (Check all that apply)

___ ADHD ___Autism Spectrum Disorder ___ Intellectual Disability ___ OCD
___ Sensitivities: _____
___ Other: (please list how we can support) _____
_____
_____

Mental Health Considerations: (Check all that apply)

___Anxiety ___ Depression
___Other:_____

Please add anything else you would like the doctor to know:

_____
_____
_____

Authorization

I certify that I have read, and I understand the above information to the best of my knowledge. The questions above have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize this office to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such chiropractic care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to this office benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Patient Name: _____

Patient Signature: _____

Today's Date: _____

Doctor's Notes/Comments:

_____

_____

_____

INFORMED CONSENT

A patient coming to the doctor gives him/her permission and authority to care for him/her in accordance with appropriate testing, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare cases, underlying physical defects, deformities, or pathologies may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare, if he/she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health care procedures from whatever he/she is suffering from: latent pathological defects, illnesses, or deformities, which would otherwise not come to the attention of the physician. This office does not perform breast, pelvic, prostate, rectal, or full skin evaluations. These examinations should be performed by your family physician, GYN, and dermatologist to exclude cancers, abnormal skin lesions that should undergo biopsy/removal, or other treatments. This clinic does not provide care for any condition (such as high blood pressure, diabetes, high cholesterol) other than those addressed in your physical medicine care plan. We also do not prescribe or refill ANY controlled substances. All prescriptions should be refilled by your original prescriber and any new prescriptions should be issued by your primary care provider.

The patient assumes all responsibility/liability if the patient does not report on health forms any past medical history, illnesses, medicines, or allergies.

I, the undersigned patient, agree to settle any claim or dispute I may make against or with any of these persons or entities, whether related to the prescribed care or otherwise. I understand that any claim or dispute will be resolved by binding arbitration under the current malpractice terms, which can be obtained by written request.

Patient's Signature: _____ **Date:** _____

Chiropractic care, like all forms of health care, while offering considerable benefit, may also provide some level of risk. This level of risk is most often very minimal; yet, in rare cases, injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include sprain/strain injuries, irritation of a disc condition, and rarely, fractures. One of the rarest complications associated with chiropractic care, occurring at a rate between one instance per one million to one instance per two million cervical spine (neck) adjustments may be a vertebral artery injury that could lead to stroke.

Prior to receiving chiropractic care in this office, a health history and physical examination will be completed. These procedures are performed to assess your specific condition, your overall health, and, in particular, your spinal health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies are needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan prior to beginning care. I understand and accept that there are risks associated with chiropractic care and give consent to the examinations that the doctor deems necessary, and to chiropractic care, including spinal adjustments, as reported following my assessment.

Patient's Signature: _____ **Date:** _____

Spinal Decompression Consent:

Spinal Decompression is a non-surgical and drug-free answer for disc related syndromes of the lumbar or cervical spine. Many people across the country have found relief from the pain associated with herniated discs, bulging discs, facet syndrome, degenerative joint disease, pinched nerves, and other spinal afflictions. This FDA-cleared technology relieves pain by enlarging the space between the discs. Spinal Disc Decompression uses computer-aided technology to apply gentle, non-surgical, decompression to your spine, increasing circulation into the spinal discs and joints, thus helping to relieve the symptoms that cause pain and dysfunction.

Patient's Signature:_____**Date**_____

ASSIGNMENT OF BENEFITS FORM

YOUR AUTO INSURANCE INFO:
Auto Insurance Company Name:_____
Claim Number:_____
Adjuster's Name:_____
Adjuster's Phone Number:_____

OTHER PARTY AUTO INSURANCE INFO:
Auto Insurance Company Name:_____
Claim Number:_____
Adjuster's Name:_____
Adjuster's Phone Number:_____

I hereby assign all medical benefits to which I am entitled to Cynergy Chiropractic Center, Inc. This applies for all insurance carriers, including Medicare, private insurance, and any other health/ medical plan. This form will be kept on file.

I understand that it is my responsibility to report any changes in insurance coverage to Cynergy Chiropractic Center, Inc.

I authorize the release of any medical or pertinent information necessary to obtain these benefits to my insurance carrier, or any other medical entity for continued medical care.

I understand that I am financially responsible for any amount not covered by insurance.

_____
Signature of Patient or Personal Representative

_____
Printed Name of Patient or Personal Representative

_____
Date

CYNERGY
HEALTH & WELLNESS

DOCTOR'S LIEN

TO: Insurance Company_____
_____
_____
_____
_____
_____

CYNERGY CHIROPRACTIC
Dr. Peter Eisenhauer, D.C.

980 Grant Street, Suite 100
Denver, Colorado 80203
Phone (303) 832-3668
Fax (303) 861-1403

PATIENT NAME:_____
CLAIM #:_____
DATE OF ACCIDENT:_____
NAME OF INSURED:_____

RE: Medical Reports and Doctor's Lien

I do hereby authorize the above doctor(s) to furnish you, Insurance Company, with a full report of the examination, diagnoses, prognosis, treatment notes, etc. for the above stated automobile accident in which I was involved.

I hereby authorize and direct you, Insurance Company, to pay directly to said doctor such sums as may be due and owing for medical service rendered me both by reason of this accident and by reason of any other bills that are due to Cynergy Chiropractic Center, Inc. and to withhold such sums from any settlement, judgment, or verdict as any be necessary to adequately protect said doctor(s). And I hereby further give a lien on my case to said doctor(s) against any and all proceeds of any settlement, judgment, or verdict which may be paid to you, Insurance Company, or me as the result of the injuries for which I have been treated in connection therewith.

I fully understand that I am directly and fully responsible to said doctor(s) for all medical bills submitted by Cynergy Chiropractic Center, Inc. for services rendered me and that this agreement is made solely for said doctors' additional protection and in consideration of them awaiting payment.

Dated: _____ Patient's Signature: _____

The undersigned, being attorney of record for the above patient, does hereby agree to observe all the terms above to withhold such sums from any settlement, judgment, or verdict as may be necessary to adequately protect the above named doctor(s).

Insurance Company
Dated: _____ Claim Rep. Signature: _____

REP.PRINT NAME: _____

Insurance Company: Please date, sign and return one copy to doctor's office at once.
Reply via fax at the number above
Keep one copy for your records.

HIPAA: Consent for Purposes of Treatment, Payment, and Health Care Operations

I, _____, hereby consent to the use or disclosure of my protected health information by Cynergy Chiropractic Center, Inc. for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills, or to conduct health care operations of Cynergy Chiropractic Center, Inc.

I understand that diagnosis or treatment of me by Cynergy Chiropractic Center, Inc. may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or health care operations of the practice. Cynergy Chiropractic Center, Inc. is not required to agree to the restrictions that I may request. However, if Cynergy Chiropractic Center, Inc. agrees to a restriction that I request, the restriction is binding on Cynergy Chiropractic Center, Inc.

I have the right to revoke this consent, in writing, at any time, except to the extent Cynergy Chiropractic Center, Inc. has taken action in reliance on this consent.

My "Protected Health Information" means health information, including my demographic information, collected from me and created and received by my physician, another health care provider, a health plan, my employer, or a health care clearinghouse. This protected health information relates to my past, present, or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review Cynergy Chiropractic Center, Inc.'s Notice of Privacy Practices prior to signing this document.

Cynergy Chiropractic Center, Inc.'s Notice of Privacy Practices has been provided to me.

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 Cynergy Chiropractic Center, Inc.

The Notice of Privacy Practices also describes my rights and the duties of Cynergy Chiropractic Center, Inc. with respect to my protected health information.

Cynergy Chiropractic Center, Inc. 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.

_____

Signature of Patient or Personal Representative

_____

Printed Name of Patient or Personal Representative

_____

Date

_____

Description of Personal Representative's Authority

CYNERGY
HEALTH & WELLNESS

MASSAGE THERAPY CONSENT

I understand that the massage I receive is provided for the basic purpose of relieving muscular tension, relieving pain, and facilitating range of motion and relaxation. If I experience any pain or discomfort during the session, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage should not be construed as a substitute for medical examination, diagnosis, or treatment. I understand that massage therapists are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such.

Massage should not be performed under certain medical conditions. As such, I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the massage therapist updated as to any changes in my medical profile during the session and understand that there shall be no liability on the massage therapist's part should I fail to do so. I understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session. I also understand that the massage therapist reserves the right to refuse to perform massage on anyone whom he/she deems to have a condition for which massage is contraindicated.

I have read the above noted consent and I have had the opportunity to question the contents herein. By signing this form, I confirm my consent to treatment. I understand that at any time I may rescind my consent and massage therapy services will cease.

_____

Date

_____

Print Patient's Name

_____

Signature of Patient or Representative

CYNERGY
HEALTH & WELLNESS

Cancellation/Reschedule & Missed Appointment Policy for Massage & Acupuncture

Cancellation/Reschedule/Missed Appointment Policy:

Please be aware that we require 24 hours notice when cancelling, rescheduling or missing a Massage Therapy or Acupuncture appointment. For cancellations or rescheduling with less than the required 24 hour notice, regardless of the reason behind the need to move your appointment, an $94 full hour fee will be charged. We have implemented this policy as a courtesy to our acupuncturist and massage therapists. In the event that less than 24 hours notice was given, and we are able to fill the acupuncture or massage slot, the $94 fee will be waived; however, if we are *unable* to fill your vacated appointment time, we will charge the $94 fee for the cancelled appointment.

We will be retaining a Credit Card number stored in our secure system which will be used to charge the same day as the missed appointment. If you prefer to use a different card, please let our Front Desk know.

By signing below, I state that I understand and agree to the cancellation, reschedule / missed appointment policy upheld by Cynergy Chiropractic Center, Inc. for Massage and Acupuncture services.

Print Name: _____

Signature _____

Date _____

Credit Card # (Required) _____

EXP_____