COVER SHEET – AUTO ACCIDENT

WELCOME!

COMPLETE ALL PAPERWORK BEFORE YOUR APPOINTMENT!

PLEASE BRING THE FOLLOWING TO YOUR APPOINTMENT

VALID DRIVERS LICENSE
PHOTOS OF INJURY/VEHICLE
POLICE REPORT
YOUR HEALTH INSURANCE CARD
YOUR AUTO INSURANCE CARD

Please use BLUE or BLACK ink only

Need transportation?

Call the office at

912.777.3717

QUESTIONS?

Email us at

Backoffice@BrightLifeChiropractic.com

BRIGHT life CHIROPRACTIC

Bright Life Chiropractic
2 Park of Commerce Blvd –Savannah, GA 31405
www.BrightLifeChiropractic.com
912.777.3717

ACCIDENT QUESTIONNAIRE

Discover Your True Health Potential.

AUTO INSURANCE INFORMATION

**** Your car insurance will only release this information to you, the policy holder. Please call **your car insurance provider** to obtain this information****

Do you have med pay? (•) Yes ( ) No

If so, how much? **$1,000 $2,000 $5,000 $10,000**

Do you have uninsured motorists on your insurance? (•) Yes ( ) No

If so, what is the limit? _____

Patient Name _____

YOUR insurance company _____

YOUR Claim # _____

Adjuster _____

His/her telephone number _____

ATTORNEY INFORMATION

FIRM _____ **DATE OF INJURY** _____

ATTORNEY _____ **PHONE** _____

CASE MANAGER _____ **PHONE** _____

OTHER INSURANCE INFORMATION

INSURANCE COMPANY _____ **CLAIM NUMBER** _____

ADJUSTER _____ **CONTACT NUMBER** _____

COMMENTS:

_____

_____

_____

YOUR VEHICLE DAMAGE:

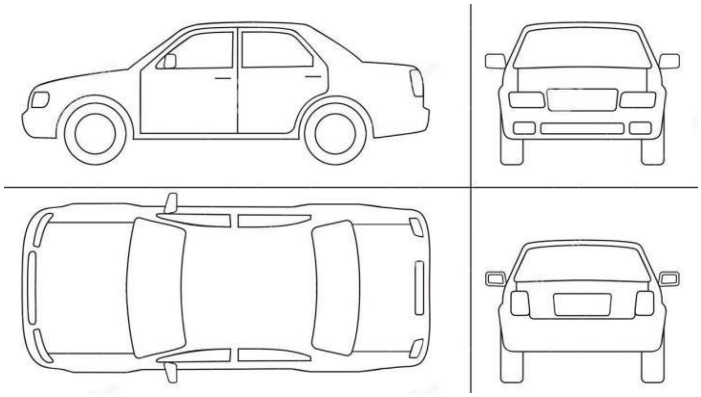
On a scale of 1-10, rate the damage to your vehicle:

(•) 1 ( ) 2 ( ) 3 ( ) 4 ( ) 5 ( ) 6 ( ) 7 ( ) 8 ( ) 9 ( ) 10

Total cost of damage: $_____

Was the vehicle drivable after the accident?

Yes (•) No ( )



AUTOMOBILE ACCIDENT FORM

Discover Your True Health Potential.

PATEINT DEMOGRAPHICS

Last:_____ First:_____ M.I._____ Male ☐ Female ☐ Date of Birth:_____

Address:_____ City:_____ ST:____ Zip:_____

Phone:_____ Email:_____ Social Security#:_____

WORK STATUS: FULL TIME ☐ PART TIME ☐ DISABLED ☐ RETIRED ☐ UNEMPLOYED ☐

Occupation: _____ Employer:_____

ACCIDENT DETAILS

Please describe the accident in detail: _____

_____

_____

Anyone else in the car with you?_____ Date of Accident:_____

Time of Accident_____ am/pm Road conditions at the time of the accident: ◯ Wet ◯ Dry Other: _____

Were you in a company vehicle? Yes ◯ No ◯ Was the accident on the job? Yes ◯ No ◯

Location of the Accident:_____

Were you aware of the approaching collision prior to impact, or did it catch you by surprise? Aware ☐ Surprise ☐

Did you hit the head rest during the accident? ◯ Yes ◯ No Did you lose consciousness upon impact? Yes ◯ No ◯

Which way was your head pointing at the time of impact? Straight ☐ Right ☐ Left ☐

Which way was your body pointing at the time of impact? Straight ☐ Right ☐ Left ☐

Were you wearing a hat or glasses at the time of impact? Yes ◯ No ◯ Which one? Glasses ☐ Hat ☐

If so, were they still on after the accident? Yes ◯ No ◯ Other: _____

AFTER ACCIDENT TREATMENT

Did you go to the hospital? Yes ☐ No ☐ Which hospital? _____

Did you go to the hospital the same day? Yes ☐ No ☐ If no, when? _____

How did you get to the hospital? Ambulance ☐ Drove ☐ Other _____

Did the hospital take imaging? X-Rays ☐ CT Scan ☐ MRI ☐ None ☐

What areas? Head ☐ Neck ☐ Mid back ☐ Low back ☐ Other _____

What did they recommend for follow-up care?_____

Please list any other doctors/treatments you have had for this injury:_____

Please list any previous injuries or trauma:_____

ACCIDENT COMPLAINTS

Rate the symptoms that have started since the accident/injury from 1-10 (1=mild, 10= extreme):

____ Neck pain	____ Arm Pain L or R	____ Numbness in arms	____ Loss of smell
____ Mid back pain	____ Shoulder Pain L or R	____ Numbness in legs	____ Loss of taste
____ Low back pain	____ Leg Pain L or R	____ Numbness in hands	____ Loss of hearing
____ Chest pain	____ Knee Pain L or R	____ Numbness in feet	____ Loss of vision
____ Abdominal pain	____ Hip Pain L or R	____ Irritability	____ Loss of smell
____ Headaches/Migraines	____ Wrist Pain L or R	____ Depression	____ Shortness of breath
____ Fainting	____ Ankle Pain L or R	____ Anxiety	____ Fatigue/Trouble Sleeping
	____ Elbow Pain L or R		

1st Complaint: DESCRIBE THIS ONE COMPLAINT ONLY

Body Part:_____ Date symptom first appeared:_____

How often do you experience this symptom? Constant ◯ Frequent ◯ Intermittent ◯ Occasional ◯

What makes the symptom feel worse?_____

What makes the symptom feel better?_____

Type of pain? Aching ☐ Throbbing ☐ Stabbing ☐ Burning ☐ Numbing ☐ Dull ☐ Sharp ☐

Please rate the intensity of this symptom from 1-10 (1=mild, 10=extreme)

Where does the pain radiate to?_____

Before the Accident:

Have you ever had this complaint before? ◯ Yes ◯ No If yes, when?_____

Please rate the intensity of your complaint from 1-10 before the accident (1=mild, 10=extreme) _____

Where did the pain radiate to? _____

What was the condition affecting you from doing? (Work, sports, home, etc.)_____

_____

2nd Complaint: DESCRIBE THIS ONE COMPLAINT ONLY

Body Part:_____ Date symptom first appeared:_____

How often do you experience this symptom? Constant ◯ Frequent ◯ Intermittent ◯ Occasional ◯

What makes the symptom feel worse?_____

What makes the symptom feel better?_____

Type of pain? Aching ☐ Throbbing ☐ Stabbing ☐ Burning ☐ Numbing ☐ Dull ☐ Sharp ☐

Please rate the intensity of this symptom from 1-10 (1=mild, 10=extreme)

Where does the pain radiate to?_____

Before the Accident:

Have you ever had this complaint before? ◯ Yes ◯ No If yes, when?_____

Please rate the intensity of your complaint from 1-10 before the accident (1=mild, 10=extreme) _____

Where did the pain radiate to? _____

What was the condition affecting you from doing? (Work, sports, home, etc.)_____

_____

Patient Signature:_____ **Date:** _____

3rd Complaint: DESCRIBE THIS ONE COMPLAINT ONLY

Body Part:_____ Date symptom first appeared:_____

How often do you experience this symptom? Constant ◯ Frequent ◯ Intermittent ◯ Occasional ◯

What makes the symptom feel worse?_____

What makes the symptom feel better?_____

Type of pain? Aching ☐ Throbbing ☐ Stabbing ☐ Burning ☐ Numbing ☐ Dull ☐ Sharp ☐

Please rate the intensity of this symptom from 1-10 (1=mild, 10=extreme)

Where does the pain radiate to?_____

Before the Accident:

Have you ever had this complaint before? ◯ Yes ◯ No If yes, when?_____

Please rate the intensity of your complaint from 1-10 before the accident (1=mild, 10=extreme) _____

Where did the pain radiate to? _____

What was the condition affecting you from doing? (Work, sports, home, etc.)_____

_____

4th Complaint: DESCRIBE THIS ONE COMPLAINT ONLY

Body Part:_____ Date symptom first appeared:_____

How often do you experience this symptom? Constant ◯ Frequent ◯ Intermittent ◯ Occasional ◯

What makes the symptom feel worse?_____

What makes the symptom feel better?_____

Type of pain? Aching ☐ Throbbing ☐ Stabbing ☐ Burning ☐ Numbing ☐ Dull ☐ Sharp ☐

Please rate the intensity of this symptom from 1-10 (1=mild, 10=extreme)

Where does the pain radiate to?_____

Before the Accident:

Have you ever had this complaint before? ◯ Yes ◯ No If yes, when?_____

Please rate the intensity of your complaint from 1-10 before the accident (1=mild, 10=extreme) _____

Where did the pain radiate to? _____

What was the condition affecting you from doing? (Work, sports, home, etc.)_____

_____

At the time of the accident, did you experience any of the following:

☐ Confusion ☐ Disorientation ☐ Lightheadedness ☐ Dizziness

☐ Nausea ☐ Blurred Vision ☐ Loss of Balance ☐ Ringing in Ears

Do you have any of those symptoms now? Yes ☐ No ☐ If yes, which ones?

_____

_____

_____

Patient Signature:_____ **Date:** _____

PATIENT NAME: _____

Please list your allergies: **O** NONE(Please check if no known allergies)

Allergy_____ Reaction_____

Allergy_____ Reaction_____

Allergy_____ Reaction_____

Allergy_____ Reaction_____

Please list any surgeries you have had: **O** NONE(Please check if no prior surgeries)

Date: _____ Type: _____

Date: _____ Type: _____

Date: _____ Type: _____

Date: _____ Type: _____

Please list any medical conditions you currently have: **O** NONE (Please check if none)

_____

_____

_____

List any medications you are currently taking: _____

SOCIAL HISTORY:

EXERCISE: ***O*** DAILY ***O*** WEEKLY ***O*** MONTHLY ***O*** RARELY ***O*** NEVER

CHILDREN: ***O*** YES ***O*** NO IF SO, HOW MANY?

DO YOU SMOKE? ***O*** YES ***O*** NO *IF YES, HOW MANY PACKS PER DAY?____FOR HOW MANY YEARS?* _____

OTHER NICOTINE PRODUCTS?*O* YES ***O*** NO IF YES, WHICH? _____

DRINK ALCOHOL? ***O*** NEVER ***O*** 1-2WEEK ***O*** 1-2 MONTH ***O*** 1-2 YEAR ***O*** DAILY

LIFESTYLE (Hobbies, recreational activities)_____

_____

FAMILY HISTORY: (IF YES, PLEASE SPECIFY WHICH FAMILY MEMBER ON THE LINE PROVIDED)

ARTHRITIS?	***O*** YES	***O*** NO_____
BLOOD CLOTS/EXCESSIVE BLEEDING?	***O*** YES	***O*** NO_____
HYPERTENSION?	***O*** YES	***O*** NO_____
DIABETES?	***O*** YES	***O*** NO_____
CANCER?	***O*** YES	***O*** NO_____
MENTAL HEALTH DISORDERS?	***O*** YES	***O*** NO_____
CARDIAC DISORDERS?	***O*** YES	***O*** NO_____

ACTIVITIES OF LIFE

Please rate how each activity affects you. Write "N/A" for any activity Not Applicable to you.

PERSONAL HYGIENE & DAILY CARE

ACTIVITY	RATING				ADDITIONAL NOTES:
	No effect	Painful (can do)	Painful (limits)	Unable to perform.	
Bathing / Showering	☐	☐	☐	☐	
Grooming Hair	☐	☐	☐	☐	
Brushing Teeth	☐	☐	☐	☐	
Using The Toilet	☐	☐	☐	☐	
Dressing The Upper Body	☐	☐	☐	☐	
Dressing The Lower Body	☐	☐	☐	☐	

DAILY PHYSICAL ACTIVITIES

ACTIVITY	RATING				ADDITIONAL NOTES:
	No effect	Painful (can do)	Painful (limits)	Unable to perform.	
Standing	☐	☐	☐	☐	
Sitting	☐	☐	☐	☐	
Squatting	☐	☐	☐	☐	
Kneeling	☐	☐	☐	☐	
Reaching Overhead	☐	☐	☐	☐	
Bending Forward	☐	☐	☐	☐	
Turning Left	☐	☐	☐	☐	
Turning Right	☐	☐	☐	☐	
Move From Lying to Sitting	☐	☐	☐	☐	
Move From Sitting to Standing	☐	☐	☐	☐	
Move From Standing to Sitting	☐	☐	☐	☐	

FUNCTIONAL ACTIVITIES

ACTIVITY	RATING				ADDITIONAL NOTES:
	No effect	Painful (can do)	Painful (limits)	Unable to perform.	
Sleeping	☐	☐	☐	☐	
Eating	☐	☐	☐	☐	
Going Up & Down Stairs	☐	☐	☐	☐	
Getting In & Out of Car	☐	☐	☐	☐	
Driving	☐	☐	☐	☐	
Focusing / Concentrating	☐	☐	☐	☐	
Preparing Food	☐	☐	☐	☐	
Household Chores	☐	☐	☐	☐	

SOCIAL, RECREATIONAL & OTHER ACTIVITIES

ACTIVITY	RATING				ADDITIONAL NOTES:
	No effect	Painful (can do)	Painful (limits)	Unable to perform.	
Competitive Sports	☐	☐	☐	☐	
Running / Jogging / Hiking	☐	☐	☐	☐	
Other Recreation Activities	☐	☐	☐	☐	
Hobbies	☐	☐	☐	☐	
Sexual Activity	☐	☐	☐	☐	

Patient Signature: _____ **Date:** _____

QUADRUPLE VISUAL ANALOGUE SCALE

Patient Name _____ Date _____

Please read carefully:

Instructions: Please check the number that best describes the question being asked.

Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

Example:

Headache Neck Low Back

No pain _____ **worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

1 – What is your pain RIGHT NOW?

No pain _____ **worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

2 – What is your TYPICAL or AVERAGE pain?

No pain _____ **worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

3 – What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)?

No pain _____ **worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

4 – What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?

No pain _____ **worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

OTHER COMMENTS:

Examiner

Reprinted from *Spine*, 18, Von Korff M, Deyo RA, Cherkin D, Barlow SF, Back pain in primary care: Outcomes at 1 year, 855-862, 1993, with permission from Elsevier Science.

INFORMED CONSENT FOR CHIROPRACTIC CARE

CHIROPRACTIC CARE, LIKE ALL FORMS OF HEALTH CARE WHILE OFFERING CONSIDERABLE BENEFITS 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 SECONDARILY TO CHIROPRACTIC CARE INCLUDE: SPRAIN/STRAIN INJURIES, IRRITATION OF A DISC CONDITION, AND RARELY, FRACTURES. ONE OF THE RAREST COMPLICATIONS ASSOCIATED WITH CHIROPRACTIC CARE OCCURING AT A RATE BETWEEN ONE INSTANCE PER ONE MILLION TO ONE PER TWO MILLION CERVICAL SPINE (NECK) ADJUSTMENTS MAY BE A VERTEBRAL INJURY THAT COULD LEAD TO A 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 CONDITIONS, 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 EXAMINATION THAT THE DOCTOR DEEMS NECESSARY AND THE CHIROPRACTIC CARE, INCLUDING SPINAL ADJUSTMENTS, AS REPORTED FOLLOWING MY ASSESSMENT.

_____

PRINT PRACTICE MEMBER NAME

_____ _____

PRACTICE MEMBER'S SIGNATURE **DATE**

IF THIS HEALTH PROFILE IS FOR A MINOR/CHILD, PLEASE FILL OUT AND SIGN BELOW

WRITTEN CONSENT FOR A CHILD

NAME OF PRACTICE MEMBER WHO IS A MINOR/CHILD_____

I AUTHORIZE DR. JARED BROWN AND/OR DR.SAMANTHA BROWN AND ANY AND ALL BRIGHT LIFE CHIRORPACTIC STAFF TO PERFORM DIAGNOSTIC PROCEDURES, RADIOGRAPHIC EVALUATION, RENDER CHIRORPACTIC CARE AND PERFORM CHIROPRACTIC ADJUSTMENTS TO MY MINOR/CHILD.

AS OF THIS DATE, I HAVE THE LEGAL RIGHT TO SELECT AND AUTHORIZE HEALTH CARE SERVICES FOR MY MINOR/CHILD. IF MY AUTHORITY TO SELECT AND AUTHORIZE CARE IS REVOKED OR ALTERED, I WILL IMMEDIATLEY NOTIFY BRIGHT LIFE CHIROPRACTIC.

_____ _____

DATE **GUARDIAN SIGNATURE AND RELATIONSHIP TO MINOR CHILD**

_____ _____

DATE **BRIGHT LIFE CHIROPRACTIC WITNESS SIGNATURE**

TERMS OF ACCEPTANCE

In order to provide the most effective healing environment, most effective application of chiropractic procedures, and the strongest possible doctor-patient relationship, it is our wish to provide each patient with a set of parameters and declarations that will facilitate the goal of optimum health through chiropractic.

To that end, we ask that you acknowledge the following point regarding chiropractic care and the services that are offered through this clinic:

A. Chiropractic is a very specific science, authorized by law to address spinal health concerns and needs. Chiropractic is a separate and distinct science, art, and practice. It is not the practice of medicine.
B. Chiropractic seeks to maximize the inherent healing power of the human body by restoring normal nerve functions through the adjustment of spinal subluxation(s). Subluxations are deviations from normal spinal structures and configurations that interfere with normal nerve processes.
C. The chiropractic adjustment process, as defined in the law of this jurisdiction, involves the application of a specific directional thrust to a region or regions of the spine with the specific intent of re-positioning misaligned spinal segments. This is a safe, effective procedure applied over one million times each day by Doctors of Chiropractic in the United States alone.
D. A thorough chiropractic examination and evaluation is part of the standard chiropractic procedure. The goal of this process is to identify any spinal health problems and chiropractic needs. If during this process, any condition or question outside the scope of chiropractic is identified, you will receive a prompt referral to an appropriate provider or specialist, according to the initial indications of the need.
E. Chiropractic does not seek to replace or compete with your medical, dental, or other types of health professionals. They retain responsibility for care and management of medical conditions. We do not offer advice regarding treatment prescribed by others.
F. Your compliance with care plans, home and self-care, etc., is essential to maximum healing and optimal health through chiropractic care.
G. We invite you to speak frankly to the doctor on any matter related to your health care at this facility, its nature, duration, or cost, in what we work to maintain as a supporting open environment.

By my signature below, I have read and fully understand the above statements.

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my satisfaction. I therefore accept chiropractic care on this basis.

_____ _____

Signature Date

Notice of Privacy Practices Acknowledgement

I understand that I have certain rights of privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA). I understand that this can and will be used to:

1. Conduct, plan and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal health care operations, such as quality assessments and physician certifications.

I acknowledge that I may request our NOTICE OF PRIVACY PRACTICES containing a more complete description of the uses and disclosures of my health information. I also understand that I may request, in writing, that you restrict how my private information is used to disclose, to carry out treatment, payment, or health care operation. I also understand you are not required to agree to my requested restrictions, but if you agree, then you are bound to abide by such restrictions.

_____ _____

Signature Date

Medical Information Release Form
(HIPAA Release Form)

Name: _____ **Date of Birth:** _____

Release of Information:
[ ] I authorize the release of information including the diagnosis, records; examination rendered to me, appointment times, and claims information. This information may be released to:

[ ] Spouse _____

[ ] Child(ren) _____

[ ] Other _____

[ ] Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing.

Messages:
Please call [ ] my home [ ] my work [ ] my mobile number: _____

If unable to reach me(please select all that apply):

[ ] you may leave a detailed message

[ ] you may leave a message asking me to return your call

[ ] you may send information regarding my treatment via text message

[ ] _____

The best time to reach me is (*day*) _____ between (*time*) _____

Signed: _____ Date: _____

Witness: _____ Date: _____

Bright Life Chiropractic

Drs. Jared & Samantha Brown

2 Park of Commerce Blvd. Suite D

Savannah, GA 31405

912.777.3717

Patient:_____ Date of Accident:_____

I do hereby authorize Dr. Jared Brown and Dr. Samantha Brown to furnish you, my attorney, with a full report of their examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I was involved.

I hereby authorize and direct you, my attorney, to pay directly to said doctor such sums as may be due and owing him/her for the medical service rendered me both by reason of this accident and by reason of any other bills that are due to his/her office and to withhold such sums from any settlement, judgment, or verdict as may be necessary to adequately protect and fully compensate said doctor. And I hereby further give a Lien on my case to said doctor against any and all proceeds of my settlement, judgement, or verdict which may be paid to you, my attorney, or myself, as the result of the injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to said doctors for all medical bills submitted by him/her for service rendered me and that this agreement is made solely for said doctor's additional protection and in consideration of his/her awaiting payment. And I further understand that such payment is not contingent on any settlement, judgement, or verdict by which I may eventually recover said fee.

I agree to promptly notify said doctor of any change or addition of attorney(s) used by me in connection with this accident, and I instruct my attorney to do the same and to promptly deliver a copy of this lien to any such substituted attorney(s).

I acknowledge that Bright Life Chiropractic is not required to permit me the option to postpone or make payments toward of services rendered, and that it is being done solely as a courtesy. As such, Bright Life Chiropractic may, at any time, seek payment for any and all amounts owed by me while this lien is in force. Additionally, if my attorney fails to acknowledge this lien in favor of Bright Life Chiropractic, the entire balance related to this personal injury treatment is my sole responsibility, and Bright Life Chiropractic may demand payment immediately.

Please acknowledge this letter by signing below and returning to the doctor's office. I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment and may declare the entire balance due and payable.

_____ _____

DATED PATIENTS SIGNATURE

The undersigned being attorney of record for the above patient does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgement, or verdict, as may be necessary to adequately protect and fully compensate said doctor above-named. Attorney further agrees that in the event this lien is litigated, that the prevailing party will be awarded attorney fees and costs.

_____ _____

DATED ATTORNEY SIGNATURE

Assignment of Benefits Form

DIRECTION TO PAY: Bright Life Chiropractic

MAIL PAYMENT TO:

BRIGHT LIFE CHIROPRACTIC
2 PARK OF COMMERCE BLVD – SUITE D
SAVANNAH, GA 31405

POWER OF ATTORNEY TO ENDORSE CHECKS AND/OR TO SIGN ANY PAPER WHICH WILL ENHANCE OR EXPEDITE PAYMENT TO PROVIDER FOR SERVICE RENDERED, INCLUDING BUT NOT LIMITED TO A RELEASE OF MEDICAL RECORDS AND ASSIGNMENT OF BENEFITS/AUTHORIZATION TO PAY.

Known by all these present that: the undersigned has made, constituted and appointed, and by these presents does hereby make, constitute and appoint BRIGHT LIFE CHIROPRACTIC and any of its duly authorized agents and employees as and to be the undersigned's true and lawful attorney for and in the undersigned's name, place and stead to endorse any and all checks, drafts or money orders which are made payable to the undersigned alone or to the undersigned and BRIGHT LIFE CHIROPRACTIC which checks, drafts or money orders are made payable for services which have been made BRIGHT LIFE CHIROPRACTIC at the request of with the knowledge and approval of the undersigned and/or maker of the check, draft or money order.

This assignment includes but is not limited to, all rights to collect benefits directly from my insurance company for services that I have received and all rights to proceed against my insurance company in any action including legal suit if for any reason my insurance company fails to make payments of benefits due to my assignee or me. This assignment also includes any rights to recover attorney's fees and costs for such action brought by the provider as my assignee.

The undersigned by these presents does give and grant BRIGHT LIFE CHIROPRACTIC as attorney the full power and authority to do and perform all and every act whatsoever requisite and necessary to be done in and about the premises as fully to all intents and purposes as the undersigned might or could do to personally present insofar as the endorsing and cashing of said check and concerned as well as any other document.

A photocopy of this document shall be as binding as an original signature page.

The undersigned does hereby ratify and confirm any and all actions taken by the said attorney in accordance with this special power and which the said attorney shall do cause to be done by virtue of these presents.

ASSIGNMENT OF BENEFITS

I,_____, hereby authorize _____
(name of insured) (name of insurance company)
to pay to and mail directly BRIGHT LIFE CHIROPRACTIC the medical benefits otherwise payable to me for their services, but not to exceed the charges of those services. I hereby irrevocably assign to BRIGHT LIFE CHIROPRACTIC and benefits under any policy of insurance, indemnity agreement, or any other collateral source as defined in Georgia Statutes for any services and charges provided by BRIGHT LIFE CHIROPRACTIC.

_____ _____ _____
PATIENT'S SIGNATURE PATIENT'S NAME DATE

DISCLOSURE LETTER

The purpose of this document is to inform all referred patients that Dr. Jared R. Brown, sole owner of Coastal Empire Chiropractic, Inc, "DBA", Bright Life Chiropractic; is also a partial owner of Medicus Spine & Joint, LLC and has ownership and financial interest in both. The undersigned patient has the opportunity to seek alternate medical care, referral or opinion before being referred to any of the aforementioned entities.

Furthermore, there are alternate choices listed below as well as others upon request, for which referrals can be made. The undersigned acknowledges that they are not limited to the referral entities listed below.

ORTHOPEDIC AND PAIN MANAGEMENT SERVICES

1. Chatham Orthopaedic Associates
2. Optim Orthopedics
3. Ortho Sport & Spine Physicians

Please acknowledge your understanding of disclosure and agreement to continue with the referral by signing below.

Patient Name: _____ DOB: _____

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Bright Life Chiropractic
Dr. Jared Brown
2 Park of Commerce Blvd. Suite D
Savannah, GA 31405
Phone:912.777.3717
Fax: 912.349.7266

To: _____ Date:_____

_____

_____

_____

From: Bright Life Chiropractic

Please forward to the address above:

☐ X-Rays and Reports

☐ Medical Records

I, _____, authorize any doctor, hospital, employer, or other person whom a signed copy or a photocopy of this authorization is delivered, to furnish any information, reports or copies of records which may be requested by Bright Life Chiropractic.

DOB:_____

Signature_____Date_____

Unless otherwise noted, this authorization expires 90 days from date signed.

_____ Date_____

Bright Life Rep.

X-RAY AUTHORIZATION

AS YOUR HEALTH CARE PROVIDER, WE ARE LEGALLY RESPONSIBLE FOR YOUR CHIROPRACTIC HEALTH RECORDS. WE MUST MAINTAIN A RECORD OF YOUR X-RAYS IN OUR FILES.

AT YOUR REQUEST, WE WILL PROVIDE A COPY OF YOUR X-RAYS IN OUR FILES.

THE FEE FOR COPYING YOUR X-RAYS ON A DISC IS $15.00. THIS FEE MUST BE PAID IN ADVANCE.

DIGITAL X-RAYS ON CD WILL BE AVAILABLE **WITHIN 72 HOURS** OF PREPAYMENT ON ANY REGULAR PRACTICE HOURS DAY. **PLEASE NOTE**: X RAYS ARE UTILIZED IN THIS OFFICE TO HELP LOCATE AND ANALYZE **VERTEBRAL SUBLUXATIONS**. THESE XRAYS ARE NOT USED TO INVESTIGATE FOR MEDICAL PATHOLOGY. THE DOCTORS OF BRIGHT LIFE CHIROPRACTIC DO NOT DIAGNOSE OR TREAT MEDICAL CONDITIONS. HOWEVER, IF ANY ABNORMALITIES ARE FOUND, WE WILL BRING IT TO YOUR ATTENTION SO THAT YOU CAN SEEK PROPER MEDICAL ADVICE.

PRINT YOUR NAME HERE _____ **DATE** _____

SIGNATURE _____ **DATE OF BIRTH** _____

FEMALE PATIENTS ONLY: TO THE BEST OF MY KNOWLEDGE, **I BELIEVE I AM NOT PREGNANT** AT THE TIME X-RAYS ARE TAKEN AT BRIGHT LIFE CHIROPRACTIC.

SIGNATURE _____ **DATE** _____

AUTO ACCIDENT VIEWS ☐

Sex: ☐ **Male** ☐ **Female**

☐ **LatCervical** **Flex/Ext**

CM	Kvp	Time	MAS
10-11	78	1/24	12.5
12-13		1/20	15
14-15		1/15	20
16-17		1/10	30
		2/15	40

MA300 Size8x10

☐ **LowerCervical**

CM	Kvp	Time	MAS
14-15	70	1/10	20
16-17		2/15	30
18-19		3/20	40
20-21		2/10	50
22-23			

MA300 Size8x10

☐ **APOM**

CM	Kvp	Time	MAS
14-15	70	1/10	20
16-17		2/15	30
18-19		3/20	40
20-21		2/10	50
22-23			

MA300 Size8x10

☐ **Other**

View_____

CM _____ Kvp _____

MAS_____ MA_____

Size _____

☐ **A-PThoracic**

CM	Kvp	Time	MAS
16-17	75	1/20	17
18-19		1/15	22
20-21		1/10	30
22-23		2/15	40
24-25		2/10	50
26-27		1/4	75
28-29		3/10	90
30-31		2/5	120
31-32			

MA300 Size14x17

☐ **LateralThoracic**

CM	Kvp	Time	MAS
22-23	80	1/15	20
24-25		1/10	30
26-27		2/15	40
28-29		2/10	50
30-31		1/4	75
32-33		3/10	90
34-35		2/5	120
36-37		1/2	150
38-39			

MA300 Size14x17

☐ **A-PLumbar**

CM	Kvp	Time	MAS
20-21	76	1/15	40
22-23	78	1/10	50
24-25	80	2/15	75
26-27		2/10	90
28-29		1/4	120
30-31		3/10	150
32-33		2/5	120
34-35		1/2	170
36-37		3/5	210
38-39		4/5	
40-41		1	
42-43		1½	
		2	

☐ **LateralLumbar** **Flex/Ext**

CM	Kvp	Time	MAS
26-27	88	2/10	30
28-29	90	1/4	40
30-31	92	3/10	50
32-33	94	2/5	75
34-35	96	1/2	90
36-37		3/5	120
38-39		4/5	160
40-41		1	200
42-43		1½	
		2	

MA300 Size14x17

Notes:

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CA Initials:

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