WELCOME TO

BRIGHT life
CHIROPRACTIC

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

NEED TRANSPORTATION?

CALL THE OFFICE AT

912.777.3717

QUESTIONS?

EMAIL US AT

BACKOFFICE@BRIGHTLIFECHIROPRACTIC.COM

LOCATION:

2 PARK OF COMMERCE BLVD. SUITE D

SAVANNAH, GA 31405

AUTO ACCIDENT PAPERWORK

BRIGHT life CHIROPRACTIC

AUTO INSURANCE 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_____

Attorney/ Case Manager Email_____

OTHER INSURANCE INFORMATION

Insurance Company_____ Claim Number_____

Adjuster_____ Contact Number_____

Comments_____

_____

_____

YOUR VEHICLE DAMAGE:

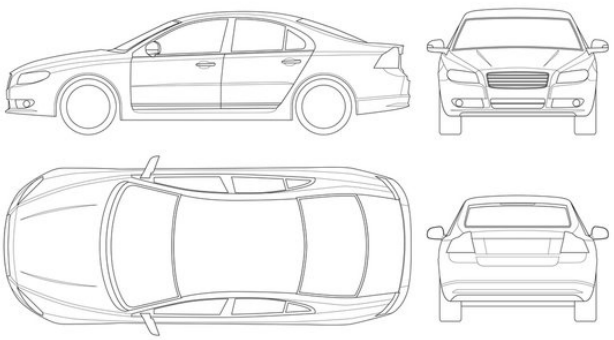
On a scale of 1-10, rate the damage of your vehicle:

◯1 ◯2 ◯3 ◯4 ◯5 ◯6 ◯7 ◯8 ◯9 ◯10

Total cost of damages: $_____

Was the vehicle drivable after the accident? ◯YES ◯NO

Circle where the damage is at on your vehicle:



AUTO ACCIDENT PAPERWORK

BRIGHT life CHIROPRACTIC

PATIENT DEMOGRAPHICS

NAME:_____ MALE FEMALE DATE OF BIRTH:_____

ADDRESS:_____CITY:_____STATE:_____ZIP:_____

PHONE:_____EMAIL:_____SOCIAL SECURITY #_____

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

OCCUPATION:_____EMPLOYER:_____

ACCIDENT DETAILS

Please describe the accident in detail:_____

_____

_____

Were you the driver or a passenger?_____Did you have a seat belt on? ◯YES ◯NO

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_____

Speed you were going at the time of the accident:_____mph Location of accident:_____

Were you in a company vehicle? ◯YES ◯NO Was the accident on the job? ◯YES ◯NO

Were you aware of the approaching collision prior to the 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

AFTER ACCIDENT TREATMENT

Did you go to the hospital? ◯YES ◯NO If so, Which hospital?_____

Did you go to the hospital the same day?◯YES ◯NO If no, when?_____

How did you get hospital? ◯Ambulance ◯Drove ◯Other_____

Did the hospital take imaging? ◯X-ray ◯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:_____

AUTO ACCIDENT PAPERWORK

BRIGHT life CHIROPRACTIC

Patient Name:_____

ACCIDENT COMPLAINTS

Rate the symptoms that have started since the accident/injury from 1-10 (0=no pain, 10=extreme):

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

1ST COMPLAINT

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

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_____

Where did the pain radiate to?_____

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

_____

2ND COMPLAINT

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

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_____

Where did the pain radiate to?_____

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

_____

Patient Signature:_____ Date:_____

AUTO ACCIDENT PAPERWORK

BRIGHT life CHIROPRACTIC

Patient Name:_____

3RD COMPLAINT

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

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_____

Where did the pain radiate to?_____

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

_____

4TH COMPLAINT

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

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_____

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:_____

AUTO ACCIDENT PAPERWORK

BRIGHT life CHIROPRACTIC

Patient Name:_____

PATIENT HISTORY

Please list any allergies: ◯ NONE (please check if no known allergies)

Allergy_____ Reaction_____

Allergy_____ Reaction_____

Allergy_____ Reaction_____

Allergy_____ Reaction_____

Pease list any surgeries you have had: ◯ NONE (please check if no prior surgeries)

Date_____ Type _____

Date_____ Type _____

Date_____ Type _____

Date_____ Type _____

Please list any medications you are currently taking: ◯ NONE (please check if none)

_____

_____

Please list any medical conditions you currently have: ◯ NONE (please check if none)

_____

_____

SOCIAL HISTORY

EXERCISE: ◯ DAILY ◯ WEEKLY ◯ MONTHLY ◯ RARELY ◯ NEVER

CHILDREN: ◯ YES ◯ NO IF SO, HOW MANY?_____

DO YOU SMOKE? ◯ YES ◯ NO IF YES, HOW MANY PACKS PER DAY?___ FOR HOW MANY YEARS?___

OTHER NICOTINE PRODUCTS? ◯ YES ◯ NO IF YES, WHICH?_____

DRINK ALCOHOL? ◯ NEVER ◯ 1-2WEEK ◯ 1-2 A MONTH ◯ 1-2 A YEAR ◯ DAILY

LIFESTYLE (HOBBIES, RECREATIONAL ACTIVITIES)_____

_____

FAMILY HISTORY

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

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

AUTO ACCIDENT PAPERWORK

BRIGHT life CHIROPRACTIC

NAME:_____

ACTIVITIES OF LIFE

Place a check mark in the box to mark your rating. Use "N/A" for any activity Not Applicable to you (or your child).

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	☐	☐	☐	☐	

FUCTIONAL ACTIVITIES

ACTIVITY	RATING				ADDITIONAL NOTES:
	NO EFFECT	PAINFUL (CAN DO)	PAINFUL (LIMITS)	UNABLE TO PERFORM	
SLEEPING	☐	☐	☐	☐	
EATING	☐	☐	☐	☐	
GOING UP & DOWN STAIRS	☐	☐	☐	☐	
GETTING IN & OUT CAR	☐	☐	☐	☐	
DRIVING	☐	☐	☐	☐	
USING A COMPUTER	☐	☐	☐	☐	
FOCUSING/ CONCENTRATING	☐	☐	☐	☐	
PREPARING FOOD	☐	☐	☐	☐	
HOUSEHOLD CHORES	☐	☐	☐	☐	
LIFTING CHILDREN	☐	☐	☐	☐	
CARRYING BAG/ PURSE	☐	☐	☐	☐	

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 ACTIVITES	☐	☐	☐	☐	
HOBBIES	☐	☐	☐	☐	

AUTO ACCIDENT PAPERWORK

BRIGHT life CHIROPRACTIC

QUADRUPLE VISUAL ANALOGUE SCALE

Patient Name: _____ Date: _____

Please read carefully:

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

Note: If you have more that 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 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?**

No pain _____ Worst possible pain

0 1 2 3 4 5 6 7 8 9 10

Other Comments:

AUTO ACCIDENT PAPERWORK

BRIGHT life CHIROPRACTIC

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**

AUTO ACCIDENT PAPERWORK

BRIGHT life CHIROPRACTIC

Name: _____

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: _____

AUTO ACCIDENT PAPERWORK

BRIGHT life CHIROPRACTIC

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 Brain Injury Solutions, and Coastal Healthcare Solutions 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.

Concussion/TBI treatment Services:

1. Savannah Neurology
2. Rosinfeld Neurology and Sleep
3. Neurological and Spine Insitute

Orthopedic Services:

1. Ortho Sport and Spine
2. Chatham Orthopedics
3. Memorial Health Orthopedics

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.

AUTO ACCIDENT PAPERWORK

BRIGHT life CHIROPRACTIC

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

☐ **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	

☐ **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

☐ **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:

_____

_____

_____

_____

Start Time:_____ End Time:_____

ADJ AFTER? YES NO

CA Initials:

_____

ACUTE CONCUSSION EVALUATION (ACE)

PHYSICIAN/CLINICIAN OFFICE VERSION

Gerard Gioia, PhD[1] & Micky Collins, PhD[2]
[1]Children's National Medical Center
[2]University of Pittsburgh Medical Center

Patient Name:_____
DOB: _____ Age:_____
Date:_____ ID/MR#_____

A. Injury Characteristics **Date/Time of Injury**_____ **Reporter: __Patient __Parent __Spouse __Other**_____

1. Injury Description _____

1a. Is there evidence of a forcible blow to the head (direct or indirect)? __Yes __No __Unknown
1b. Is there evidence of intracranial injury or skull fracture? __Yes __No __Unknown
1c. Location of Impact: __Frontal __Lft Temporal __Rt Temporal __Lft Parietal __Rt Parietal __Occipital __Neck __Indirect Force

2. Cause: __MVC __Pedestrian-MVC __Fall __Assault __Sports (*specify)*_____Other_____

3. Amnesia Before (Retrograde) Are there any events just BEFORE the injury that you/ person has no memory of (even brief)? __ Yes __No Duration

4. Amnesia After (Anterograde) Are there any events just AFTER the injury that you/ person has no memory of (even brief)? __ Yes __No Duration

5. Loss of Consciousness: Did you/ person lose consciousness? __ Yes __No Duration

6. EARLY SIGNS: __Appears dazed or stunned __Is confused about events __Answers questions slowly __Repeats Questions __Forgetful (recent info)

7. Seizures: Were seizures observed? No__ Yes___ Detail_____

B. Symptom Check List* Since the injury, has the person experienced any of these symptoms any more than usual today or in the past day?

Indicate presence of each symptom (0=No, 1=Yes). ***Lovell & Collins, 1998 JHTR***

PHYSICAL (10)		COGNITIVE (4)		SLEEP (4)	
Headache	0 1	Feeling mentally foggy	0 1	Drowsiness	0 1
Nausea	0 1	Feeling slowed down	0 1	Sleeping less than usual	0 1 N/A
Vomiting	0 1	Difficulty concentrating	0 1	Sleeping more than usual	0 1 N/A
Balance problems	0 1	Difficulty remembering	0 1	Trouble falling asleep	0 1 N/A
Dizziness	0 1	**COGNITIVE Total (0-4)** _____		**SLEEP Total (0-4)** _____	
Visual problems	0 1	**EMOTIONAL (4)**			
Fatigue	0 1	Irritability	0 1		
Sensitivity to light	0 1	Sadness	0 1		
Sensitivity to noise	0 1	More emotional	0 1		
Numbness/Tingling	0 1	Nervousness	0 1		
PHYSICAL Total (0-10) _____		**EMOTIONAL Total (0-4)** _____			
(Add Physical, Cognitive, Emotion, Sleep totals) Total Symptom Score (0-22)		_____			

Exertion: Do these symptoms worsen with:
Physical Activity __Yes __No __N/A
Cognitive Activity __Yes __No __N/A

Overall Rating: How different is the person acting compared to his/her usual self? (circle)

Normal 0 1 2 3 4 5 6 Very Different

C. Risk Factors for Protracted Recovery *(check all that apply)*

Concussion History? Y ___ N___	√	Headache History? Y ___ N___	√	Developmental History	√	Psychiatric History
Previous # 1 2 3 4 5 6+		Prior treatment for headache		Learning disabilities		Anxiety
Longest symptom duration Days__ Weeks__ Months__ Years__		History of migraine headache __ Personal __ Family_____		Attention-Deficit/ Hyperactivity Disorder		Depression
						Sleep disorder
If multiple concussions, less force caused reinjury? Yes__ No__		_____		Other developmental disorder_____		Other psychiatric disorder _____

List other comorbid medical disorders or medication usage (e.g., hypothyroid, seizures)_____

D. RED FLAGS for acute emergency management: Refer to the emergency department with sudden onset of any of the following:

* Headaches that worsen	* Looks very drowsy/ can't be awakened	* Can't recognize people or places	* Neck pain
* Seizures	* Repeated vomiting	* Increasing confusion or irritability	* Unusual behavioral change
* Focal neurologic signs	* Slurred speech	* Weakness or numbness in arms/legs	* Change in state of consciousness

E. Diagnosis (ICD): __Concussion w/o LOC 850.0 __Concussion w/ LOC 850.1 __Concussion (Unspecified) 850.9 ___Other (854) _____
__No diagnosis

F. Follow-Up Action Plan **Complete *ACE Care Plan* and provide copy to patient/family.**

___ **No Follow-Up Needed**
___ **Physician/Clinician Office Monitoring**: Date of next follow-up _____
___ **Referral:**
___ Neuropsychological Testing
___ Physician: Neurosurgery____ Neurology____ Sports Medicine____ Physiatrist____ Psychiatrist____ Other_____
___ Emergency Department

ACE Completed by:_____

This form is part of the "Heads Up: Brain Injury in Your Practice" tool kit developed by the Centers for Disease Control and Prevention (CDC).