**PERSONAL INJURY INTAKE**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Consent to receive text messages: ☐ Yes ☐ No Height: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Consent to receive emails: ☐ Yes ☐ No Weight: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Spouse’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ # of Children: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_ Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear about us? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Full description of accident, injury, or onset:

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Enter the details of your condition during and after the accident/onset:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Your vehicle type: Other vehicle type:**☐ car ☐ van ☐ car ☐ van

☐ bus ☐ station wagon ☐ bus ☐ station wagon  
☐ pick-up truck ☐ large truck ☐ pick-up truck ☐ large truck  
☐ other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ☐ other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Location of accident: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Weather at time of accident: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Your position in the vehicle:**

☐ driver ☐ front passenger  
☐ left rear passenger ☐ right rear passenger

**Your vehicle was:**

☐ stopped at a light ☐ stopped in traffic

☐ making a left turn ☐ making a right turn

☐ slowing down ☐ stopped at an intersection  
☐ parking ☐ accelerating  
☐ other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Object you hit** (if applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Visibility at time of accident:**

☐ poor ☐ fair ☐ good

**Point of impact:**

☐ head-on ☐ rear-end ☐ left front ☐ left rear  
☐ right front ☐ right rear

☐ I hit the other vehicle  
☐ The other vehicle hit me

**Road Conditions:**

☐ icy ☐ wet  
☐ loose gravel ☐ dark  
☐ clean & dry

Date of accident: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Time of accident: \_\_\_\_\_:\_\_\_\_\_ AM // PM

Your vehicle's speed: \_\_\_\_\_\_\_mph

Other vehicle's speed: \_\_\_\_\_\_\_mph

**Damage to your vehicle:**

☐ mild  
☐ moderate

☐ totaled

**At the time of impact, the position of the headrest was:**

☐ even with top of my head ☐ even with the bottom of my head  
☐ in the middle of my neck

☐ I don’t remember ☐ not applicable

**At the time of impact, my head was:**

☐ facing straight forward ☐ turned to the right  
☐ turned to the left

☐ I don’t remember ☐ not applicable

I saw the accident coming: ☐ Yes ☐ No  
I was braced for the impact: ☐ Yes ☐ No  
I was wearing my seatbelt: ☐ Yes ☐ No  
My shoulder harness was on: ☐ Yes ☐ No  
The driver-side airbag deployed: ☐ Yes ☐ No  
The passenger-side airbag deployed: ☐ Yes ☐ No

The side airbags deployed: ☐ Yes ☐ No

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**During the accident:**My body hit the inside of my vehicle: ☐ Yes ☐ No

If yes, describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I lost consciousness: ☐Yes ☐No If yes, for how long? \_\_\_\_\_\_\_

**After the accident, I had/have the following symptoms:**

Check all of the boxes that apply to you.

☐ headache ☐ dizziness  
☐ mid-back pain ☐ cold hands  
☐ neck stiffness ☐ nervousness

☐ fainting ☐ neck pain  
☐ nausea ☐ low back pain

☐ cold feet ☐ confusion  
☐ diarrhea ☐ fatigue

☐ tension ☐ toe numbness

☐ anxiety ☐ loss of taste  
☐ loss of smell ☐ irritability  
☐ constipation

**When I left the scene, I went to:**

☐ my home ☐ work  
☐ my primary care doctor ☐ the emergency room

Did the police come to the scene? ☐ Yes ☐ No

Do you have an accident report? ☐ Yes ☐ No

**How I left the scene:**

☐ I drove myself ☐ someone else drove me

☐ in an ambulance ☐ with the police

**If you went to the ER, name of the facility:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Did you have x-rays or lab work done at the ER?** ☐ Yes ☐ No

If yes, may we contact the facility for a copy of your reports? ☐ Yes ☐ No

\*\*If you have the report(s) with you, please give a copy to the front desk when you return this document.

Body part(s) x-rayed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other important information related to your ER visit:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Description of Symptoms:**

**Symptom 1** (describe your primary symptom): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Type of pain:**

☐ dull ☐ sharp

☐ aching ☐ cutting  
☐ throbbing ☐ numbing

☐ tingling ☐ burning

☐ cramping ☐ spasm  
☐ stinging ☐ shooting

☐ pounding ☐ constricting

☐ stabbing

**Frequency of pain** (during the time you are awake)**:**

☐ sometimes (25%)  
☐ half of the time (50%)  
☐ most of the time (75%)

☐ all of the time (100%)

**Intensity of pain:**

☐ it does NOT affect my daily activities  
☐ it limits my ability to perform my daily activities

☐ it prevents me from performing daily activities

**Radiation of pain** (to other parts of your body)**:** Left Right Both

**Factors that influence pain:**

☐ bending forward ☐ bending backward

☐ bending left ☐ bending right  
☐ twisting left ☐ twisting right

☐coughing ☐ sneezing  
☐ straining ☐ standing  
☐ sitting ☐ lifting  
☐ morning ☐ evening  
☐ laying down

**Symptom 2** (describe your secondary symptom): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Type of pain:**

☐ dull ☐ sharp

☐ aching ☐ cutting  
☐ throbbing ☐ numbing

☐ tingling ☐ burning

☐ cramping ☐ spasm  
☐ stinging ☐ shooting

☐ pounding ☐ constricting

☐ stabbing

**Frequency of pain** (during the time you are awake)**:**

☐ sometimes (25%)  
☐ half of the time (50%)  
☐ most of the time (75%)

☐ all of the time (100%)

**Intensity of pain:**

☐ it does NOT affect my daily activities  
☐ it limits my ability to perform my daily activities

☐ it prevents me from performing daily activities

**Radiation of pain** (to other parts of your body)**:** Left Right Both

**Factors that influence pain:**

☐ bending forward ☐ bending backward

☐ bending left ☐ bending right  
☐ twisting left ☐ twisting right

☐coughing ☐ sneezing  
☐ straining ☐ standing  
☐ sitting ☐ lifting  
☐ morning ☐ evening  
☐ laying down

**Activities of Daily Living Assessment**

Please check the box next to each activity you currently have difficulty doing as a result of your accident/illness:

**Personal Hygiene**

☐ bathing ☐ drying hair  
☐ brushing teeth ☐ cleaning dishes

☐ putting on shoes ☐ preparing meals

☐ taking out trash ☐ combing hair

☐ going to the toilet ☐ putting on shirt  
☐ putting on pants ☐ tying shoes

☐ washing face

**Physical Activities**

☐ walking ☐ standing  
☐ sitting ☐ squatting  
☐ bending forward ☐ bending back

☐ bending left ☐ bending right

☐ twisting left ☐ twisting right

**Functional Activities**

☐ carrying small objects ☐ carrying large objects

☐ carrying a briefcase ☐ carrying a purse

**Social & Recreational Activities**

☐ bowling ☐ swimming

☐ roller skating ☐ dancing  
☐ hobbies

**Everyday Activities**

☐ showering ☐ doing laundry

☐ eating ☐ washing hair  
☐ making the bed ☐ kneeling  
☐ reclining ☐ reaching  
☐ putting on shirt ☐ leaning forward

☐ leaning back ☐ leaning left  
☐ leaning right ☐ twisting right

☐ lifting weights off floor ☐ lifting weights off table  
☐ pushing things while standing ☐ pushing things while seated  
☐ pulling things while standing ☐ pulling things while seated

☐ jogging ☐ competitive sports

☐ golfing ☐ dating  
☐ dining out ☐ standing for long periods of time

☐ sitting for long periods of time ☐ walking for long periods of time

☐ kneeling for long periods of time ☐ exercising upper body

☐ exercising lower body ☐ exercising arms  
☐ exercising legs ☐ climbing stairs

☐ climbing incline ☐ driving a motor vehicle  
☐ driving for long periods of time ☐ riding as a passenger in a motor vehicle  
☐ riding as a passenger for long periods of time

Write in below any additional information regarding your Activities of Daily Living (that wasn't covered above):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Please list any current medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Treatment for your symptoms prior to your first appointment at LIV Integrative Health:**

Did you receive any treatment for symptoms that resulted from your accident/illness? ☐ Yes ☐ No

If yes, please provide the following information:

First visit date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Doctor’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Doctor’s specialty: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Treatment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

­­­­­­­­­­­­­Currently receiving treatment? ☐ Yes ☐ No # of visits to date: \_\_\_\_\_\_\_\_\_  
Did treatments benefit you? ☐ Yes ☐ No Last visit date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Did you have similar symptoms **prior** to your accident?☐ I did NOT have symptoms similar to my current complaint(s)  
☐ my current complaint(s) DID exist but had not been bothering me  
☐ my current complaint(s) DID exist and were worsened by the accident/injury

If applicable - My most recent prior symptom occurred: ☐ months ago ☐ years ago

Has your history contributed to your current symptoms?  
☐ my history HAS contributed to my current symptoms

☐ my history HAS NOT contributed to my current symptoms  
☐ I am NOT SURE if my history has contributed to my current symptoms

☐ not applicable

**Please check any recent or chronic medical conditions:**

☐ Alcoholism ☐ Cramps ☐ HIV ☐ Pacemaker

☐ Allergies ☐ Depression ☐ Hot flashes ☐ Polio

☐ Anemia ☐ Diabetes ☐ Irregular heartbeat ☐ Poor posture

☐ Arteriosclerosis ☐ Digestion problems ☐ Irregular cycle ☐ Sleep problems/insomnia

☐ Arthritis ☐ Dizziness ☐ Kidney infection ☐ Spinal curvatures

☐ Asthma ☐ Ears ringing ☐ Kidney stones ☐ Stroke

☐ Back pain ☐ Excessive menstruation ☐ Loss of memory ☐ Swelling of ankles

☐ Breast lump ☐ Eye pain/difficulties ☐ Loss of balance ☐ Swollen joints

☐ Bruise easily ☐ Fatigue ☐ Loss of smell ☐ Thyroid condition

☐ Cancer ☐ Frequent urination ☐ Loss of taste ☐ Vertigo

☐ Chest pain/conditions ☐ Headaches ☐ Neck pain/stiffness ☐ Ulcers

☐ Cold extremities ☐ Hepatitis C ☐ Nervousness ☐ Other:

☐ Constipation ☐ High blood pressure ☐ Nosebleeds

**Have you ever:** Yes No Briefly explain

Broken bones? ☐ ☐ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Been hospitalized? ☐ ☐ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Been in an auto accident? ☐ ☐ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Had sprains and/or strains? ☐ ☐ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Been struck unconscious? ☐ ☐ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Had surgery? ☐ ☐ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Informed Consent**

I hereby consent to the performance of examination and treatment by the licensed Doctor of Chiropractic, medical doctors, physician’s assistants, physical therapists, Pilates instructors, acupuncturists and/or licensed therapists who may be employed by or engaged in practice in this clinic.

Additionally, as is the case with most health care interventions, there is a certain inherent risk of complication associated with physical examination, physiotherapeutic, spinal manipulation procedures, home and in office exercises, use of medical equipment (in office and home use), Chinese herbal medicine and medications. These complications include but are not limited to muscle strains, dislocations, skin irritation, costovertebral sprains, bruising, electrical shock, fractures, disc trauma, minor burns, stroke and nerve injury. I understand my doctor will not be able to anticipate all potential complications, but elect to rely on his/her clinical expertise and judgment to determine reasonable courses of clinical action, based upon known facts, which are considered to be in my best interest. I understand that results are not guaranteed and that I have the opportunity to discuss the purposes and risks associated with all recommended evaluation and treatment procedures at any time. I also hold LIV Integrative Health and its staff harmless for injuries caused by the use of durable medical equipment due to improper use or manufacture defects. No guarantee for results can be made or expected but rather I wish to rely on the doctor to choose and recommend the best course of treatment based upon facts known that is in my best interests.

I have read and understand the preceding statements and hereby consent to voluntarily participate in treatment at LIV Integrative Health deemed appropriate by my doctor. If at any time I decide that I am unwilling to engage in these procedures, I reserve the right to inform my doctor of such and not participate in these forms of evaluation or treatment.

Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Notice of Information Practices**

Protecting the privacy of your personal health information is important to us. By signing below you understand how information about you may be used and disclosed and how you can get access to this information.

Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research and law enforcement activities. Any other disclosures for the purposes of treatment, payment or practice operations will be made only after obtaining your consent.

Disclosures of protected health information are limited to the minimum necessary for the purpose of the disclosure. The provision does not apply to the transfer of medical records for treatment.

You may inspect and receive copies of your records within 30 days a request to do so. There may be a reasonable fee for photocopying, postage and preparation.

You may request changes to your records. Our practice has the right to accept or deny your request.

In the future, we may contact you for appointment reminders, announcements, and to inform you about our practice and its staff.

Our practice is required to abide by this notice. We have the right to change this notice in the future. Any revisions will be prominently displayed in a clearly visible location in our office.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Financial Responsibility**

I understand and agree that health insurances policies are an arrangement between an insurance carrier and myself.

As a courtesy to you, LIV Integrative Health will call your insurance company to verify your benefits. We assume no liability for errors made by your insurance company in this quote. We will review the coverage with you. It is then your responsibility to pay any balance remaining after your insurance carrier has paid its portion of the bill. If you have a deductible that is not yet met, we will collect payment from you directly. Once your deductible has been met, we will collect your co-pay or co-insuranceat the time of services.

**Your insurance company may send insurance checks for your treatment directly to you, the patient, rather than to us, the provider. The amount of these checks is due to us in addition to any co-pay or co-insurance. Please ensure that this amount is promptly paid to us for services rendered.**

If you do not pay the amount of the insurance checks issued within 6 months of the date of service, we will require payment in full whether or not you have received the insurance payments. If you refuse to pay your bill, we may initiate collections proceedings.

Whether or not my insurance company is billed for services rendered, I understand and agree that all services rendered to me and charged are my personal responsibility for timely payment. I understand that if I suspend or terminate my treatment, any fees for professional services rendered to me will be immediately due and payable.

By signing below, I acknowledge that I understand and agree to the terms of the Financial Responsibility.

Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Assignment of Insurance Benefits / Authorization of Information**

I instruct and direct my insurance company to pay LIV Integrative Health the professional and medical expense benefits allowable under my current insurance policy for services rendered. This is a direct assignment of my rights and benefits under this policy. I understand and agree that I am ultimately responsible for the balance on my account for any services rendered.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient – Physician Arbitration Agreement**

**Article 1: Agreement to Arbitrate:** It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

**Article 2: All Claims Must Be Arbitrated:** It is the intention of the parties that this agreement shall cover all claims or controversies whether in tort, contract or otherwise, and shall bind all parties whose claims may arise out of or in any way relate to treatment or services provided or not provided by the below identified physician, medical group or association, their partners, associates, associations, corporations, partnerships, employees, agents, clinics, and/or providers (hereinafter collectively referred to as "Physician") to a patient, including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" shall mean both the mother and the mother's expected child or children.

Filing by Physician of any action in any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim. However, the assertion of any claim against Physician, any fee dispute, whether or not the subject of any existing court action, shall also be resolved by arbitration.

**Article 3: Procedures and Applicable Law:** A demand for arbitration must be communicated in writing by U.S. mail, postage prepaid, to all parties, describing the claim against Physician, the amount of damages sought, and the names, addresses and telephone numbers of the patient, and (if applicable) his/her attorney. The parties shall thereafter select a neutral arbitrator who was previously a California superior court judge, to preside over the matter. Both parties shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the arbitrator. Patient shall pursue his/her claims with reasonable diligence, and the arbitration shall be governed pursuant to Code of Civil Procedure §§ 1280-1295 and the Federal Arbitration Act (9 U.S.C. §§ 1-4). The parties shall bear their own costs, fees and expenses, along with a pro rata share of the neutral arbitrator’s fees and expenses.

**Article 4: Retroactive Effect:** The patient intends this agreement to cover all services rendered by Physician not only after the date it is signed (including, but not limited to, emergency treatment), but also before it was signed as well.

**Article 5: Revocation:** This agreement may be revoked by written notice delivered to Physician within 30 days of signature and if not revoked will govern all medical services received by the patient.

**Article 6: Severability Provision:** In the event any provision(s) of this Agreement is declared void and/or unenforceable, such provision(s) shall be deemed severed therefrom and the remainder of the Agreement enforced in accordance with California law.

**Conclusion**

I understand that I have the right to receive a copy of this agreement. By my signature, I also acknowledge that a copy which will be added to my medical record for review at any time.

**NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.**

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Doctor’s/Doctor’s Representative Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_