

CONFIDENTIAL VEHICLE ACCIDENT REPORT

Name _____ Social Security # _____ File # _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Birthdate _____ Age _____

Driver's license # _____ Marital Status: M S W D Sex M F Children _____ None _____

Occupation _____ Work Address _____

Work Phone # _____ Email: _____

Nearest Relative: Name & Telephone _____

Date of accident _____ Time of Accident _____ (AM/PM)

Were you: A) Driver ___ B) Passenger (Front)___ C)Passenger (Rear)___ (D)Pedestrian___ Number of people in vehicle___

Were you wearing a shoulder harness? ___Yes ___No Were you wearing seatbelts? ___Yes ___No

Your vehicle: A)Auto B)Truck C) Van D)Motorcycle E)Motor Home F)Bicycle Other _____

Year and model of your car _____ Who owns the vehicle _____

What was the approximate damage done to the car you were in? \$ _____ Was it driveable? ___Yes ___No

Other vehicle: A)Auto B)Truck C) Van D)Motorcycle E)Motor Home F)Bicycle Other _____

Other vehicle year of model _____ Who owns the vehicle _____

Visibility at time of accident: ___ poor ___ fair ___ good

Road conditions at time of accident: ___ dry ___ wet ___ rainy ___ snow ___ ice ___ fog ___ clear ___ dark

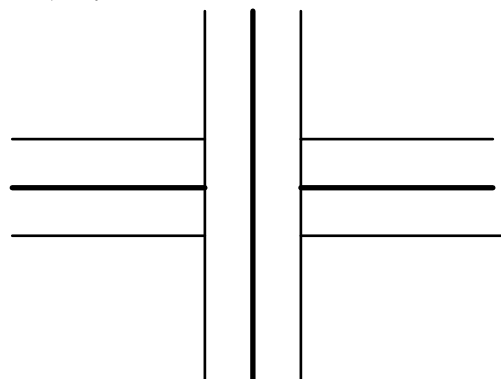
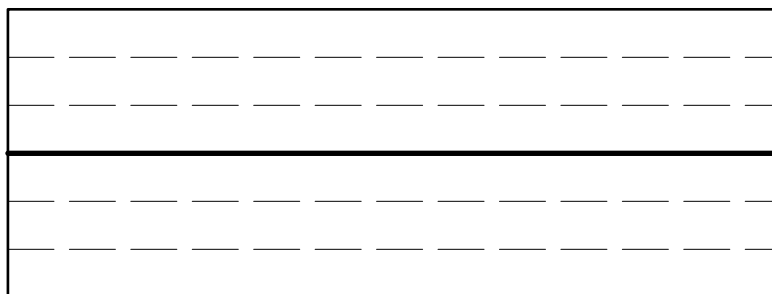
How accident occurred: A)Struck by another vehicle B)Struck another vehicle C)Struck stationary object D)Other _____

Where was your vehicle hit:A)Front B)Rear C)Rt Side D)Lt Side E)Rt Front F)Lt Front G)Rt Rear H)Lt Rear

Other vehicle contact:A)Front B)Rear C)Rt Side D)Lt Side E)Rt Front F)Lt Front G)Rt Rear H)Lt Rear

In your own words please describe the accident: _____

INDICATE ON APPROPRIATE DIAGRAM HOW THE ACCIDENT HAPPENED:



Did you see the accident coming? Yes No
Were you pre-warned that the accident was about to happen? Yes No

Did you brace for impact? Yes No

Does your car have headrests? Yes No

If yes, what was the position of those headrests compared to your head before the accident? Top of headrest even with bottom of head Top of headrest even with top of head Top of headrest even with middle of neck.

Was the car you were in braking? Yes No

Your approximate speed _____ mph **Other vehicle's approximate speed** _____ mph

What occurred at the moment of impact? (Circle as many as apply)

- A) Tensed Body for impact B) Neck whipped forward and back C) Spine torqued and twisted
- D) Thrown over seat E) Thrown from vehicle F) Pinned in vehicle
- G) Thrown from side to side H) Cut and bruised I) Other _____

What was your head position at the time of impact?

Head turned: Right Left Looking back Straight ahead
 Body rotated: Right Left

Did you strike your: (Circle as many as apply)

- A) Head** Against: Dashboard Windshield Steering Wheel Rt Door Lt Door Head Rest Unknown object
- B) Shoulder** Against: Dashboard Windshield Steering Wheel Rt Door Lt Door Seat Frame Unknown object
- C) Arm** Against: Dashboard Windshield Steering Wheel Rt Door Lt Door Seat Frame Unknown object
- D) Elbow** Against: Dashboard Windshield Steering Wheel Rt Door Lt Door Seat Frame Unknown object
- E) Wrist** Against: Dashboard Windshield Steering Wheel Rt Door Lt Door Seat Frame Unknown object
- F) Hip** Against: Dashboard Windshield Steering Wheel Rt Door Lt Door Seat Frame Unknown object
- G) Knee** Against: Dashboard Windshield Steering Wheel Rt Door Lt Door Seat Frame Unknown object
- H) Ankle** Against: Dashboard Windshield Steering Wheel Rt Door Lt Door Seat Frame Unknown object

Were you rendered unconscious? Yes No

Were you able to move all of your body parts? Yes No If no, explain _____

Were you able to get out of the car unaided? Yes No If no, explain _____

Did you bleed or get cuts and bruises? Yes No If yes, Bleeding _____ Cuts/bruises _____

Were there any flying objects in the car? _____ Were you hit? _____ Where? _____

Please describe how you felt:

A. DURING the accident: _____

B. IMMEDIATELY AFTER the accident: _____

C. LATER THAT DAY: _____

D. THE NEXT DAY: _____

CHECK SYMPTOMS YOU HAVE NOTICED SINCE ACCIDENT:

<input type="checkbox"/> Headache	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Light bothers eyes	<input type="checkbox"/> Cold sweats
<input type="checkbox"/> Neck pain	<input type="checkbox"/> Head heavy	<input type="checkbox"/> Loss of memory	<input type="checkbox"/> Feet cold
<input type="checkbox"/> Neck stiffness	<input type="checkbox"/> Pins/Needles in arms	<input type="checkbox"/> Ears ring	<input type="checkbox"/> Hands cold
<input type="checkbox"/> Sleeping problems	<input type="checkbox"/> Pins/Needles in legs	<input type="checkbox"/> Face Flush	<input type="checkbox"/> Stomach upset
<input type="checkbox"/> Numbness in Fingers	<input type="checkbox"/> Buzzing in ears	<input type="checkbox"/> Constipation	<input type="checkbox"/> Loss of taste
<input type="checkbox"/> Mid back pain	<input type="checkbox"/> Nervousness	<input type="checkbox"/> Loss of balance	<input type="checkbox"/> Diarrhea
<input type="checkbox"/> Low back pain	<input type="checkbox"/> Numbness in toes	<input type="checkbox"/> Tension	<input type="checkbox"/> Shortness of breath
<input type="checkbox"/> Fainting	<input type="checkbox"/> Fever	<input type="checkbox"/> Loss of smell	<input type="checkbox"/> Vomit
<input type="checkbox"/> Irritability	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Chest pain	<input type="checkbox"/> Depression

Symptoms other than above: _____

PAIN LEVEL: On a scale of 0 - 10, with 0 being pain free and fully functional, and 10 being constant agony and total inability to function, where would you rate yourself?

0	1	2	3	4	5	6	7	8	9	10
No pain				Moderate pain						Excruciating pain

INDICATE ABILITY TO PERFORM THE FOLLOWING ACTIVITIES:

U=Unable P=Painful D=Difficult L=Limited N=Normal

<input type="checkbox"/> Coughing or sneezing	<input type="checkbox"/> Lying on side	<input type="checkbox"/> Gripping
<input type="checkbox"/> Getting in/out of car	<input type="checkbox"/> Bending forward	<input type="checkbox"/> Pushing
<input type="checkbox"/> Bending to brush teeth	<input type="checkbox"/> Climbing stairs	<input type="checkbox"/> Pulling
<input type="checkbox"/> Turning over in bed	<input type="checkbox"/> Kneeling	<input type="checkbox"/> Reaching
<input type="checkbox"/> Walking short distances	<input type="checkbox"/> Balancing	<input type="checkbox"/> Sexual activity
<input type="checkbox"/> Standing for more than 1 hour	<input type="checkbox"/> Dressing self	<input type="checkbox"/> Stopping
<input type="checkbox"/> Lying on back	<input type="checkbox"/> Sleeping	<input type="checkbox"/> Lying on stomach
<input type="checkbox"/> Sitting at table	<input type="checkbox"/> Other _____	

Have you lost any time from work as a result of this accident? Yes No If yes, please complete below:

a. Last day worked: _____

b. Type of employment: _____

c. Are you being compensated for time from lost work? Yes No

Was a police report filed? Yes No Were you taken by ambulance to the hospital? Yes No

Did you receive medical attention at the scene of the accident? Yes No

If yes what was done? _____

Were you taken by ambulance to the hospital? ___ Yes ___ No If yes, where? _____

What was done? _____

What was the diagnosis given? _____

Where did you go immediately after the accident? A) Resumed activities B) Home C) This office

A) Medical attention: Where? _____ Were you examined? ___ Yes ___ No

Were you x-rayed? ___ Yes ___ No If yes, what area? _____ What treatment was given? _____

Date of treatment _____

Second Doctor/Clinic seen: _____ **Date of first visit:** _____

Were you examined? ___ Yes ___ No **Were X-rays taken?** ___ Yes ___ No

Were you given treatment? ___ Yes ___ No If yes, explain _____

What benefits did you receive from the treatment? _____

Date of last treatment: _____

Did you have any physical complaints before the accident? ___ Yes ___ No If yes please describe:

Have you ever been involved in an accident before? ___ Yes ___ No If yes, describe and indicate date:

List surgical operations and years _____

Drugs you now take : None ___ Nerve pills ___ Pain killers ___ Muscle relaxers ___

"Pep" pills ___ Tranquillizers ___ Insulin ___ Birth control pills ___ Others _____

Do you **smoke?**- packs per day _____ for how long? _____

drink alcohol? - drinks per day _____

use caffeine? - cups per day _____

exercise regularly? - what exercises _____

During the day (at work or at home) do you: ___ sit ___ compute ___ desk; ___ stand in one position

lift ___ > 25lbs. ___ < 25lbs Explain _____

Have you ever suffered from:

Dizziness _____ Backaches _____ Heart trouble _____ Diabetes _____
 Arthritis _____ Headaches _____ Asthma _____ Digestive Disorders _____
 Nervousness _____ Sinus Trouble _____ Neck Pain _____

FAMILY MEDICAL HISTORY: Has any family member (parents, brothers, sisters, grandparents) had any of the following disorders: **Please list family member next to disorder:**

High blood pressure _____ Heart Disease _____
 Cancer _____ Diabetes _____
 Thyroid _____ Kidney _____
 Arthritis _____ Tuberculosis _____
 Stroke _____ Lung Disease _____

ATTORNEY AND INSURANCE INFORMATION

ATTORNEY'S NAME _____

Address _____

Telephone _____

PATIENT'S INSURANCE COMPANY _____

Address _____

Telephone _____

INSURED'S INSURANCE COMPANY (If different from patient) _____

Address _____

Telephone _____

I understand and agree that health and accident policies are an arrangement between my insurance carrier and myself. Furthermore, I understand that this Chiropractic Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this Chiropractic Office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

I will be paying today by Cash Check Credit Card
Master Card Visa Card # _____ Exp. Date _____

All accounts not paid within 90 days will automatically be put through your credit card.

TODAY'S DATE _____

PATIENT'S SIGNATURE _____

GUARDIAN'S SIGNATURE _____

STEVEN M. HORWITZ, D.C.

OFFICE POLICY

Hello and welcome to my practice. It is my goal to provide you with the best chiropractic care available in the area. This includes a clear definition of my office policies stated below. Please take the time to read and sign where appropriate. If you have any questions please do not hesitate to ask. I look forward to working together to help you **regain and maintain your health!**

APPOINTMENT POLICY

24 hours notice is required should you need to cancel an appointment. You will be charged the full fee of your scheduled office visit should you fail to give 24 hours notice.

Signature _____ Date _____

PERSONAL INJURY

1. I understand that I am responsible for the entire payment of any and all services rendered.
2. I understand that all bills are to be paid at 100% of the fee charged.
3. I understand that the insured must request an **APPLICATION FOR BENEFITS** from the insured's PIP carrier so that the accident can be documented and that the insurance coverage can be verified. I understand that if the Application for Benefits is not returned to the insurance carrier, **NONE OF THE BILLS WILL BE PAID BY THE INSURANCE CARRIER.**
4. As a courtesy to the patient, the office of Dr. Horwitz will submit the bills and notes to the insurance carrier. I authorize payment of all benefits to the undersigned chiropractor for all services rendered. I authorize the release of any medical or other information necessary to process all claims.

Print Name

Signature

Date

NOTICE OF PRIVACY PRACTICE SUMMARY

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THAT INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

Steven M. Horwitz, D.C., a Maryland Chiropractic Practice (the "Practice"), in accordance with applicable federal and state law, is committed to maintaining the privacy of your protected health information ("PHI"), in other words, information about your health condition and the care and treatment you receive from the Practice. We will use and disclose elements of your PHI in the following ways:

- Treatment
- Payment
- Health Care Operations
- When release is required by law, including judicial settings and to health oversight regulatory agencies and law enforcement.
- In emergency situations or to avert serious health/safety situations.
- To medical examiners, coroners or funeral directors to aid in identifying you or to help them in their duties.
- To organ, tissue and other donations organization, upon or proximate to your death, if we have no indication on hand about your donation preferences.

Special Cases:

- Appointment reminders, treatment alternatives and other health related benefits and services
- Office newsletter
- Sponsor of your health plan

All other uses and disclosure by us will require us to obtain from you a written authorization in addition to any other permission you will provide us.

Your rights: You have the following rights concerning your PHI:

- **Restrictions:** To request restricted access to all or part of your PHI. To do this, please make this request in writing. We are not required to grant your request.
- **Confidential communications:** To receive correspondence of confidential information by alternate means or location. To do this, please make a request in writing.
- **Access:** To inspect or receive copies of your PHI. To do this, please submit a request in writing.
- **Amendments:** To request changes be made to your PHI. To do this, please submit a request in writing.
- **Accounting:** To receive an accounting of the disclosures by us of your PHI in the six years prior to your request. . To do this, please submit a request in writing.
- **This notice:** To get updates or reissue of this notice, at your request.
- **Complaints:** To complain to our office or the U.S. Department of Health & Human Services if you feel your privacy rights have been violated. To register a complaint with us, please submit this request in writing. The law forbids us from taking retaliatory action against you if you complain.

Our duties: We are required by law to maintain the privacy of your PHI. We must abide by the terms of this notice or any update of this notice.

Privacy contact: To obtain more information on, or have your questions about your rights answered; you may contact the Practice's Privacy Officer, Steven M. Horwitz, D.C., at 12200 Tech Road, Suite 104, Silver Spring, MD 20904 or via email at drsteve@youcanbenefit.com

Effective Date: This Notice is in effect as of April 14, 2003. A complete copy of the Notice of Privacy Practice is available at the reception desk.

Patient Acknowledgement: By subscribing my name below, I acknowledge receipt of a copy of this Notice, and my understanding and my agreement to its terms.

Print Patient Name

Sign Patient Name

Date

IMPORTANT INFORMATION – PLEASE READ

On your first visit, Dr. Horwitz will take a history and perform a thorough examination. Please think about your condition and be able to answer the following questions:

- When did your pain begin? Was the onset sudden or gradual?
- Where is the specific site of your pain?
- If you have more than one area of pain, which is the most painful and most important one to treat?
- What activities or movements increase your pain?
- What, if anything, diminishes your pain?
- What movements or activities are you unable to perform due to your condition?

Please bring:

- Shorts and a sleeveless T-shirt
- Any prior X-rays, MRIs, CAT Scans (films and reports), blood work reports and any other important medical records

FREQUENTLY ASKED QUESTIONS ABOUT CHIROPRACTIC CARE

What education does a chiropractor receive?

A four-year undergraduate degree is required to be accepted to chiropractic school. Chiropractic school is a four-year program consisting of 4800 hours of classroom, laboratory, and clinical study, including anatomy, physiology, chiropractic technique, radiology, biochemistry, toxicology, biomechanics, nutrition, diagnosis and physical examination, and a one-year clinical internship. Upon completion, a Doctor of Chiropractic (D.C.) degree is granted.

Can a chiropractor really make a diagnosis?

YES! One case I will never forget illustrates the importance of proper diagnosis in chiropractic practice. A 45-year-old woman came in complaining of severe lower back pain. As I was examining her, I noticed that the end of each finger was deformed, like fluid had accumulated in the pad of each finger. The woman was a smoker and had been examined three months prior, but the changes to her fingers were never noticed by the other doctors. Lumbar (low back) X-rays showed destruction of a portion of two vertebrae and chest films showed a large metastasis (tumor) to the lung. She was immediately referred to an oncologist.

Do chiropractors treat muscles as well as bones?

YES! When muscles (tendons and ligaments also) are “pulled” or “strained” it means they have torn. Think of each muscle fiber as a single strand of rope. Did one strand of rope tear or did the entire rope tear? When this tear heals, it forms a tight knot called an adhesion (like the lumps when you knead bread dough). To break up this knot, we use two advanced techniques: Active Release Technique® (ART) and Graston Technique (GT). Medications like ibuprofen (Advil, Motrin, Nuprin), naproxen (Aleve), Celebrex or Vioxx can help with the initial inflammation and pain, but they may disrupt and prevent proper healing of the muscle tissue and have significant side effects, especially gastro-intestinal bleeding.

How long to I have to come for treatment?

No patient is treated longer than they want or need. Our motto is “We don’t keep you coming, we get you going!”

How do our patients find us?

Our patients are typically referred by family, friends and local physicians. We are happy work with your primary care physician or other health care professional on your case.