

*Welcome to*

# Chiropractic Works Health Center

**Dr. Kenneth R. Weil,**  
1715 Howell Mill Road, C-12  
Atlanta, Georgia 30318  
[www.AtlantaChiro.com](http://www.AtlantaChiro.com)  
**(404) 350-8000**



*“We specialize in automobile accident injuries”*

We have two very important goals in regards to your automobile accident:

1. To help you recover from your injuries in as short a time as possible so that you can resume your life as before the accident, by providing you with exceptional chiropractic care.
2. To provide proper documentation and care that is specific to your individual needs.

To help us serve you better, it is necessary for you to answer all of the following questions to the best of your ability. If you have any questions, please ask a staff member for help before proceeding to the next question. We recognize that the questionnaire is long, however every question is important for us to provide you with outstanding care as well as to properly document all information for insurance purposes. Thank you for the opportunity to serve your chiropractic needs.

Chiropractic Works Health Center  
**AUTO INJURY PATIENT QUESTIONNAIRE**

TODAY'S DATE \_\_\_\_\_  
FIRST NAME \_\_\_\_\_ M.I. \_\_\_\_\_ LAST NAME \_\_\_\_\_  
SEX (M/F) \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ SOCIAL SECURITY # \_\_\_\_\_  
MARITAL STATUS - S M W D  
ADDRESS \_\_\_\_\_  
CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_  
HOME PHONE \_\_\_\_\_ CELL PHONE \_\_\_\_\_ PHONE CARRIER \_\_\_\_\_  
WORK NAME \_\_\_\_\_ WORK ADDRESS \_\_\_\_\_  
WORK PHONE # \_\_\_\_\_ IMMEDIATE SUPERVISOR \_\_\_\_\_  
WHAT TYPE OF WORK DO YOU DO? \_\_\_\_\_  
EMAIL ADDRESS: \_\_\_\_\_  
NAME OF SPOUSE \_\_\_\_\_ SPOUSE BIRTHDATE \_\_\_\_\_  
REFERRED BY: \_\_\_\_\_

**DATE OF INJURY/ACCIDENT (required)** \_\_\_\_\_

IN YOUR OWN WORDS, DESCRIBE THE ACCIDENT

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

What was your position in the vehicle?  driver  front passenger  rear left passenger  rear right passenger  
Other \_\_\_\_\_

What type of vehicle were you driving? \_\_\_\_\_

What speed were you traveling at time of the accident? \_\_\_\_\_ mph

Who hit you?  I was struck by another vehicle  I hit another vehicle  I hit a stationary object

Where was your vehicle hit? \_\_\_\_\_ What type of vehicle hit you? \_\_\_\_\_

What speed was the other vehicle traveling? \_\_\_\_\_ mph What part of the other vehicle hit you? \_\_\_\_\_

Were you wearing seatbelts? Y/N  Full shoulder and lap belt?  Lap belt only?  Shoulder strap only?

Position of headrest  behind head  behind neck  behind shoulders  No headrest

Position of head  straight forward  turned right  turned left; Looking  up  down

Position of hands  on steering wheel  other, please describe \_\_\_\_\_

Position of body  sitting upright  turned  other; please describe \_\_\_\_\_

How many people were in your vehicle? \_\_\_\_\_ Please give the names of any others in your vehicle \_\_\_\_\_

Were there any others injured in your vehicle?  Y/N Who? \_\_\_\_\_

Were there any casualties in this accident?  Y/N Who? \_\_\_\_\_

How much damage was done to your vehicle?  0 - 500\$  500 - 1000\$  More than 1000\$

Did your airbag deploy? \_\_\_\_ Y/N

Were you prepared for the impact? \_\_\_\_ Y/N

\_\_\_\_ I was completely surprised \_\_\_\_ I saw the collision coming \_\_\_\_ I saw the collision coming and braced appropriately

What position was your body in just prior to the accident? \_\_\_\_\_

What happened to your body at the moment of impact? \_\_\_\_\_

Please describe how you felt physically - during the accident: \_\_\_\_\_

Immediately after the accident: \_\_\_\_\_ The next day: \_\_\_\_\_

Presently: \_\_\_\_\_

What was your mental/emotional state immediately after the accident? \_\_\_\_\_

Did you receive medical attention at the scene of the accident? \_\_\_\_ Y/N Where did you go after the accident? \_\_\_\_\_

Did you go to the hospital after the accident? \_\_\_\_ Y/N

How did you get there? \_\_\_\_ ambulance \_\_\_\_ drove yourself \_\_\_\_ driven by someone else

When did you go to the hospital? \_\_\_\_ immediately after \_\_\_\_ the next day \_\_\_\_ within a week \_\_\_\_ within a month

If you waited longer than a month what was your reason for waiting? \_\_\_\_\_

Name of the hospital \_\_\_\_\_ Doctor's Name \_\_\_\_\_

What type of treatment did you receive? \_\_\_\_ bandages \_\_\_\_ cast \_\_\_\_ neck brace \_\_\_\_ splints \_\_\_\_ collar \_\_\_\_ shot

\_\_\_\_ medication \_\_\_\_ X-rays \_\_\_\_ antibiotics \_\_\_\_ ice pack \_\_\_\_ hot pack \_\_\_\_ surgery \_\_\_\_ crutches

Please give the name and the reason for the medication or shots: \_\_\_\_\_

Have you seen any other doctors since the accident? \_\_\_\_ Y/N , If so who? \_\_\_\_\_

Did any part of your body hit any of the following (write in what part of your body hit the car)?

Dashboard \_\_\_\_\_

Left door \_\_\_\_\_

Windshield \_\_\_\_\_

Seat headrest \_\_\_\_\_

Steering wheel \_\_\_\_\_

Unknown object \_\_\_\_\_

Right door \_\_\_\_\_

Airbag \_\_\_\_\_

Since the accident, have your symptoms: \_\_\_\_ improved \_\_\_\_ worsened \_\_\_\_ stayed the same.

PATIENT NAME: \_\_\_\_\_

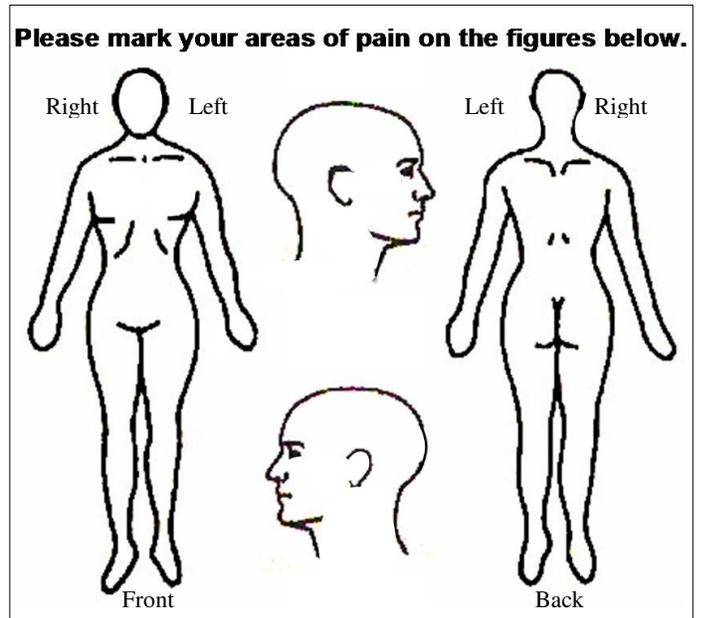
Date of Birth: \_\_\_\_\_

TODAY'S DATE \_\_\_\_\_

**CHECK-OFF ANY SYMPTOMS YOU ARE CURRENTLY EXPERIENCING**

1. Rate your condition from 1 to 10 with 10 being terrible.
2. Did the...accident "Cause" or "Aggravate" your condition?

		<u>Rating</u>
<input type="checkbox"/>	Headaches	Caused / Aggravated _____
<input type="checkbox"/>	Neck pain	Caused / Aggravated _____
<input type="checkbox"/>	Upper/Mid back pain	Caused / Aggravated _____
<input type="checkbox"/>	Lower back pain	Caused / Aggravated _____
<input type="checkbox"/>	Chest pain	Caused / Aggravated _____
<input type="checkbox"/>	Shoulder issues <b>R L</b>	Caused / Aggravated _____
<input type="checkbox"/>	Arm issues <b>R L</b>	Caused / Aggravated _____
<input type="checkbox"/>	Hand issues <b>R L</b>	Caused / Aggravated _____
<input type="checkbox"/>	Leg issues <b>R L</b>	Caused / Aggravated _____
<input type="checkbox"/>	Foot issues <b>R L</b>	Caused / Aggravated _____
<input type="checkbox"/>	Head heaviness	Caused / Aggravated _____
<input type="checkbox"/>	Neck stiffness	Caused / Aggravated _____
<input type="checkbox"/>	Back stiffness	Caused / Aggravated _____
<input type="checkbox"/>	Pins/needles in arms	Caused / Aggravated _____
<input type="checkbox"/>	Pins/needles in hands	Caused / Aggravated _____
<input type="checkbox"/>	Pins/needles in legs	Caused / Aggravated _____
<input type="checkbox"/>	Pins/needles in feet	Caused / Aggravated _____
<input type="checkbox"/>	Upset stomach	Caused / Aggravated _____
<input type="checkbox"/>	Diarrhea	Caused / Aggravated _____
<input type="checkbox"/>	Constipation	Caused / Aggravated _____
<input type="checkbox"/>	Fainting	Caused / Aggravated _____
<input type="checkbox"/>	Blurred vision	Caused / Aggravated _____
<input type="checkbox"/>	Buzzing/ringing in ears	Caused / Aggravated _____
<input type="checkbox"/>	Loss of balance	Caused / Aggravated _____



<input type="checkbox"/>	Loss of taste	Caused / Aggravated _____
<input type="checkbox"/>	Loss of smell	Caused / Aggravated _____
<input type="checkbox"/>	Anxiety	Caused / Aggravated _____
<input type="checkbox"/>	Sleeping problems	Caused / Aggravated _____
<input type="checkbox"/>	Tension	Caused / Aggravated _____
<input type="checkbox"/>	Other _____	Caused / Aggravated _____

How would you describe your primary symptoms (check all that apply) ?

- |                                |                                   |                                    |                                   |                                   |                                    |
|--------------------------------|-----------------------------------|------------------------------------|-----------------------------------|-----------------------------------|------------------------------------|
| <input type="checkbox"/> Sharp | <input type="checkbox"/> Soreness | <input type="checkbox"/> Throbbing | <input type="checkbox"/> Tingling | <input type="checkbox"/> Dull     | <input type="checkbox"/> Stiffness |
| <input type="checkbox"/> Spasm | <input type="checkbox"/> Burning  | <input type="checkbox"/> Ache      | <input type="checkbox"/> Weakness | <input type="checkbox"/> Numbness | <input type="checkbox"/> Shooting  |

Does pain radiate or travel? Yes No Describe \_\_\_\_\_

How often is the pain present?

- Constant (81-100%)     Frequent (51-80%)     Occasional (26-50%)     Intermittent (25% or Less)

What makes your problem worse (aggravates)?

- Nothing     Walking     Standing     Sitting     Moving around/exercise     Lying Down  
 Inactivity     Other \_\_\_\_\_

Areas of your everyday activities that are (or have been) affected (please check)

- |   |  |  |  |
|---|--|--|--|
| <input type="checkbox"/> Sleeping               | <input type="checkbox"/> Standing from sitting | <input type="checkbox"/> Lifting       | <input type="checkbox"/> Vision              |
| <input type="checkbox"/> Eating                 | <input type="checkbox"/> Standing              | ○ - heavy                              | <input type="checkbox"/> Feeling             |
| <input type="checkbox"/> Bathing                | <input type="checkbox"/> Walking               | ○ - medium                             | <input type="checkbox"/> Tasting             |
| <input type="checkbox"/> Getting dressed        | <input type="checkbox"/> Sitting               | ○ - light                              | <input type="checkbox"/> Smelling            |
| <input type="checkbox"/> Going to the bathroom  | <input type="checkbox"/> Exercise              | <input type="checkbox"/> Driving a car | <input type="checkbox"/> Emotional stability |
| <input type="checkbox"/> Typing on the keyboard | <input type="checkbox"/> Running               | <input type="checkbox"/> Riding a car  | <input type="checkbox"/> Housework           |

PATIENT NAME: \_\_\_\_\_  
TODAY'S DATE \_\_\_\_\_

Date of Birth: \_\_\_\_\_

**LIFESTYLE**

Were you pregnant at the time? Y / N

Recovering from surgery? Y / N

Describe your lifestyle before the accident:

Active / Moderately active / Inactive

Describe your lifestyle since the accident:

Active / Moderately active / Inactive

Describe any other physical changes you have noticed: \_\_\_\_\_

Name the activities you used to do before the accident: (please check)

- |                                     |  |   |                                    |
|-------------------------------------|--|---|------------------------------------|
| <input type="checkbox"/> Job        | <input type="checkbox"/> Marital relations | <input type="checkbox"/> Sports                         | <input type="checkbox"/> Fishing   |
| <input type="checkbox"/> Second job | <input type="checkbox"/> Volunteer work    | <input type="checkbox"/> Carrying/playing with children | <input type="checkbox"/> Yard work |
| <input type="checkbox"/> Crafting   | <input type="checkbox"/> Exercise          | <input type="checkbox"/> Hunting                        |                                    |
| <input type="checkbox"/> Housework  | <input type="checkbox"/> Dance             |   |                                    |

How have your injuries affected your ability to do these activities? Explain \_\_\_\_\_

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

PATIENT NAME: \_\_\_\_\_  
TODAY'S DATE \_\_\_\_\_

Date of Birth: \_\_\_\_\_

## Neck Disability Index (Vernon - Minor)

This questionnaire has been designed to give the doctor Information as to how your neck pain has affected your ability to manage everyday life. Please answer every section and mark in each section only the 'ONE', box that applies to you. We realize you may consider that two of the statements in any one section relate to you, but please just mark the box that most closely describes your problem.

### SECTION 1-PAIN INTENSITY

- I have no pain at the moment.
- The pain is very mild at the moment.
- The pain is moderate at the moment.
- The pain is fairly severe at the moment.
- The pain is very severe at the moment
- The pain is the worst imaginable at the moment.

### SECTION 2- PERSONAL CARE (Washing, Dressing, etc.)

- I can look after myself normally without causing extra pain.
- I can look after myself normally but it causes extra pain.
- It is painful to look after myself and I am slow and careful.
- I need some help but manage most of my personal care.
- I need help everyday in most aspects of self-care.
- I do not get dressed; I wash with difficulty and stay In bed.

### SECTION 3- LIFTING

- I can lift heavy weights without extra pain.
- I can lift heavy weights but It gives extra pain.
- Pain prevents me from lifting heavy weights off of the floor, but I can manage if they are conveniently positioned (e.g. on a table).
- Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
- I can lift very light weights
- I cannot lift or carry anything at all.

### SECTION 4- READING

- I can read as much as I want with no pain in my neck.
- I can read as much as I, want with slight pain in my neck.
- I can read as much as I, want with moderate pain in my neck.
- I can't read as much as I want because of moderate pain in my neck
- I can hardly read at all because of severe pain in my neck.
- I cannot read at all.

### SECTION 5- HEADACHES

- I have no headaches at all.
- I have slight headaches, which come infrequently.
- I have moderate headaches, which come infrequently.
- I have moderate headaches, which come frequently.
- I have severe headaches, which come frequently.
- I have headaches almost all the time.

### SECTION 6- CONCENTRATION

- I can concentrate fully when I want to with no difficulty.
- I can concentrate fully when I want to with slight difficulty.
- I have a fair degree of difficulty in concentrating when I want to.
- I have a lot of difficulty in concentrating when I want to.
- I have a great deal of difficulty in concentrating when I want to.
- I cannot concentrate at all.

### SECTION 7-WORK

- I can do as much work as I want to.
- I can only do my usual work, but no more.
- I can do most of my usual work, but no more.
- I cannot do my usual work.
- I can hardly do any work at all.
- I can't do any work at all.

### SECTION 8- DRIVING

- I can drive my car without any neck pain.
- I can drive my car as long as I want with slight pain in my neck.
- I can drive my car as long as I want with moderate pain in my neck.
- I can't drive my car as long as I want because of moderate pain in my neck.
- I can hardly drive at all because of severe pain in my neck.
- I can't drive my car at all.

### SECTION 9-SLEEPING

- I have no trouble sleeping.
- My sleep is slightly disturbed (less than 1 hr. sleepless).
- My sleep is mildly disturbed (1-2 hrs. sleepless).
- My sleep is moderately disturbed (2-3 hrs. sleepless).
- My sleep is greatly disturbed (3-5 hrs. sleepless).
- My sleep is completely disturbed (5-7 hrs. sleepless).

### SECTION 10-RECREATION

- I am able to engage in all my recreation activities with no neck pain at all.
- I am able to engage in all my recreation activities with some neck pain at all.
- I am able to engage in most, but not all of my usual recreation activities because of pain in my neck.
- I am able to engage in a few of my usual recreation activities because of pain in my neck.
- I can hardly do any recreation activities because of pain in my neck
- I can't do any recreation activities at all

Pain Severity Scale: Rate the severity of your pain by circling a number on the following scale

No Pain    

1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	----

    Excruciating Pain

PATIENT NAME: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

TODAY'S DATE \_\_\_\_\_

# Low Back Pain and Disability Questionnaire (Revised Oswestry)

This questionnaire has been designed to give the doctor information as to how your back pain has affected your ability to manage everyday life. Please answer every section and mark in each section only the 'ONE' box that applies to you. We realize you may consider that two of the statements in any one section relate to you, but please just mark the box, which most closely describes your problem.

## SECTION 1- PAIN INTENSITY

- The pain comes and goes and is very mild.
- The pain is mild and does not vary much.
- The pain comes and goes and is moderate.
- The pain is moderate and does not vary much.
- The pain comes and goes and is severe.
- The pain is severe and does not vary much.

## SECTION 2- PERSONAL CARE

- I would not have to change my way of washing or dressing in order to avoid pain.
- I do not normally change my way of washing or dressing even though it causes some pain.
- Washing and dressing increase the pain but I manage not to change my way of doing it.
- Washing and dressing increase the pain and I find it necessary to change my way of doing it.
- Because of the pain I am unable to do some washing and dressing without help.
- Because of the pain I am unable to do any washing and dressing without help.

## SECTION 3- LIFTING

- I can lift heavy weights without extra pain.
- I can lift heavy weights but it causes extra pain.
- Pain prevents me from lifting heavy weights off the floor.
- Pain prevents me from lifting heavy weights off the floor, but I manage if they are conveniently positioned (e.g. on a table).
- Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
- I can only lift very light weights at the most.

## SECTION 4-WALKING

- I have no pain on walking.
- I have some pain on walking but it does not increase with distance.
- I cannot walk more than one kilometer (km.) without increasing pain.
- I cannot walk more than ½ km. without increasing pain.
- I cannot walk more than ¼ km. without increasing pain.
- I cannot walk at all without increasing pain.

## SECTION 5- SITTING

- I can sit in any chair as long as I like.
- I can only sit in my favorite chair as long as I like.
- Pain prevents me from sitting more than one hour.
- Pain prevents me from sitting more than ½ hour.
- Pain prevents me from sitting more than 10 minutes.
- I avoid sitting because it increases pain straight away.

## SECTION 6- STANDING

- I can stand as long as I want without pain.
- I have some pain on standing but it does not increase with time.
- I cannot stand for longer than one hour without increasing pain.
- I cannot stand for longer than ½ hour without increasing pain.
- I cannot stand for longer than 10 minutes without increasing pain.
- I avoid standing because it increases the pain straight away.

## SECTION 7- SLEEPING

- I get no pain in bed.
- I get pain in bed but it does not prevent me from sleeping well.
- Because of pain, my normal nights sleep is reduced by less than ¼.
- Because of pain, my normal nights sleep is reduced by less than ½.
- Because of pain, my normal night's sleep is reduced by less than ¾.
- Pain prevents me from sleeping at all.

## SECTION 8-SOCIAL LIFE

- My social life is normal and gives me no pain.
- My social life is normal but increases the degree of pain.
- Pain has no significant effect on my social life apart from limiting my more energetic interests (e.g. dancing, etc.).
- Pain has restricted my social life and I do not go out very often.
- Pain has restricted my social life to my home.
- I have hardly any social life because of the pain.

## SECTION 9- TRAVELLING

- I get no pain whilst traveling.
- I get some pain whilst traveling but none of my usual forms of travel make it any worse.
- I get extra pain while traveling but it does not compel me to seek alternative forms of travel.
- I get extra pain while traveling which compels me to seek alternative forms of travel.
- Pain restricts all forms of travel.
- Pain prevents all forms of travel except that done tying down.

## SECTION 10-CHANGING DEGREE OF PAIN

- My pain is rapidly getting better.
- My pain fluctuates but overall is definitely getting better.
- My pain seems to be getting better but improvement is slow at present.
- My pain is neither getting better nor worse.
- My pain is gradually worsening.
- My pain is rapidly worsening.

Pain Severity Scale: Rate the severity of your pain by circling a number on the following scale

No Pain    

1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	----

    Excruciating Pain

PATIENT NAME: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

TODAY'S DATE: \_\_\_\_\_

# **INSURANCE**

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## Responsible Parties Insurance

Name: \_\_\_\_\_ Phone # \_\_\_\_\_

Address: \_\_\_\_\_

Policy #: \_\_\_\_\_ Claim # \_\_\_\_\_

## **Health Insurance**

Name of Insurance Company \_\_\_\_\_ Insurance Company Phone # \_\_\_\_\_

Policy #: \_\_\_\_\_ Group # \_\_\_\_\_ Name of Insured \_\_\_\_\_

## **Car Insurance**

Name \_\_\_\_\_ Adjuster's Name \_\_\_\_\_

Address: \_\_\_\_\_ Vin#: \_\_\_\_\_

Phone # \_\_\_\_\_ Policy #: \_\_\_\_\_ Claim # \_\_\_\_\_

## **Attorney Information**

Attorney Name \_\_\_\_\_ Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Phone \_\_\_\_\_

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

Guarantor (if minor) \_\_\_\_\_

**Turn in any photos of the accident damage to you or your car for scanning into your file.**

PATIENT NAME: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

TODAY'S DATE \_\_\_\_\_

# Certification and Assignment

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my Doctor if I or my minor child ever has a change in health.

I certify that I, and/or my dependent(s) have insurance with the aforementioned Insurance Companies and assign directly to Chiropractic Works Health Center all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Chiropractic Works Health Center may use my health care information and may disclose such information to the above named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature of Patient, Parent, Guardian or Personal Representative below:

Signed \_\_\_\_\_ Dated: \_\_\_\_\_

PRINT YOUR NAME: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

## Authorization to Release Med Pay Information

Patient Name: \_\_\_\_\_

Claim #: \_\_\_\_\_

Date of Loss: \_\_\_\_\_

To All Insurance Carriers and Agents:

I am currently being treated at Chiropractic Works Health Center for injuries sustained as a result of an injury accident. Please be advised of the following:

- I. I do hereby authorize you to disclose any and all information regarding Med Pay, to include amounts, calendar year, number of visits and any other pertinent information, as it pertains to my personal injury case.
  
- II. I authorize a Photostatic copy of this authorization be accepted with the same authority as the original.
  
- III. This authorization expires upon resolution of this claim.

\_\_\_\_\_  
Patient Signature (or Guardian if Minor)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Social Security Number

\_\_\_\_\_  
Date of Birth

## Assignment of Benefits

TO: Attorney / Insurance Carrier  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Dr. Kenneth R. Weil, P.C.  
1715 Howell Mill Rd NW C-12  
Atlanta, Georgia 30318

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Policy/Claim #: \_\_\_\_\_

### **RE: Patient Records, Service Lien, and Assignment of Benefits**

I do hereby authorize the above Dr. Kenneth R. Weil, P.C. or Chiropractic Works Health Center to furnish you, my attorney/insurance carrier, with a full report of their case history, examination, diagnosis, prognosis and service of/to myself in regard to my accident/illness which occurred/began on \_\_\_\_\_.

I do hereby irrevocably give a lien to Dr. Kenneth R. Weil, P.C. or Chiropractic Works Health Center on any settlement, claim, judgment or verdict as a result of said accident / illness. I authorize and direct you, my attorney / insurance carrier, to pay directly to Dr. Kenneth R. Weil, P.C. or Chiropractic Works Health Center such sums from such settlement, claim, judgment or verdict as may be necessary to protect Dr. Kenneth R. Weil, P.C. or Chiropractic Works Health Center adequately.

I agree never to rescind this document and that my attorney will not honor a rescission, I hereby instruct that, in the event another attorney is substituted in this matter, the new attorney honor this lien as inherent to the settlement and enforceable upon the case as if he executed it.

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 but may declare the entire balance due and payable.

I fully understand that I am directly and fully responsible to Dr. Kenneth R. Weil, P.C. or Chiropractic Works Health Center for all just bills submitted by them for service rendered me, and that this agreement made solely for Dr. Kenneth R. Weil, P.C. or Chiropractic Works Health Center's protection and in consideration of their awaiting payment. I further understand that such payment is not contingent on any settlement, claim, judgment or verdict by which I eventually recover said fee.

Dated: \_\_\_\_\_ Patient's Signature: \_\_\_\_\_

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

Dated: \_\_\_\_\_ Attorney's Signature: \_\_\_\_\_  
Dated: \_\_\_\_\_ Insurance Company's Signature: \_\_\_\_\_

**\*\*NOTE: PLEASE DATE, SIGN AND RETURN ONE COPY TO DOCTOR'S OFFICE. ALSO KEEP ONE COPY FOR YOUR RECORDS.**

Chiropractic Works Health Center

Dr. Kenneth R. Weil, P.C.  
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[www.AtlantaChiro.com](http://www.AtlantaChiro.com)  
**(404) 350-8000**



**New Patient Consent to the Use and Disclosure of Health Information  
for Treatment, Payment, or Healthcare Operations**

At Chiropractic Works Health Center, we are committed to protecting your privacy of your personal health information. Federal guidelines have been developed, to protect this information.

I understand that as part of my health care, Chiropractic Works Health Center originates and maintains paper and / or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care
- A means, of communication among the many health professionals who contribute to my care
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand that I have the following rights and privileges:

- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out
- Treatment, payment, or health care operations

I understand that Chiropractic Works Health Center is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations and any and all fees for services provided will be immediately due.

I further understand that Chiropractic Works Health Center reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations, should Chiropractic Works Health change their notice, they will send a copy of any revised notice to the address provided (US mail).

I wish to have the following restrictions to the use disclosure of my health information:

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I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and accept the terms of this consent.

\_\_\_\_\_  
Patient's / Guardian's Signature

\_\_\_\_\_  
Date

Patient Name \_\_\_\_\_

Date of Birth \_\_\_\_\_