WIP-LASH
INJURY CARE
Neck · Back · Headaches
Dr. James Sansone

Patient Information

If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.
(Please Print)

Date _____

Name _____ S/S _____-_____-_____ Birthdate ____/____/_____
First MI Last

Address _____ City _____ State _____ Zip _____

Home Phone # _____ Work Phone # _____ Gender: Female Male

Receive calls at: ☐ Home ☐ Work ☐ Either Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed # of children _____

Email: _____

Your employer _____ Occupation _____

Spouse's or parent's name _____ Workplace _____ Work phone _____

Emergency Contact name _____ Phone _____

Referred to our office by _____

HIPPA Release of Information Authorization Form

Patient Name _____
Patient Address _____
Date of Birth _____

I hereby authorize the following person(s) with access to any and all Health Information contained in my medical records pertaining to patient relationship with Whiplash Injury Care, Inc. or any affiliate referral, or transitioning care. I authorize the release of information via phone or in person.

Authorized person(s)

Name: _____ Relationship _____
Name: _____ Relationship _____
Name: _____ Relationship _____

Patient Signature _____ **Date** _____
Or Signature of patient's Representative: _____
Relationship : _____ **Date** _____

"HURT IN A CRASH, CALL WIP-LASH"™
"WHERE ACCIDENT VICTIMS COME FOR CARE"™
1-844-WIP-LASH (947-5274)
6775 APPLEWOOD BLVD. • BOARDMAN, OH 44512 • PH: 330-758-2353 • FAX: 330-758-9733

Effective April 2003 federal law requires us to offer you a copy of our privacy notice and to obtain your acknowledgement that we offered you a copy. Please tell us if you would like one, and sign below.

I have been offered a copy of James J. Sansone, D.C. Privacy Notice.

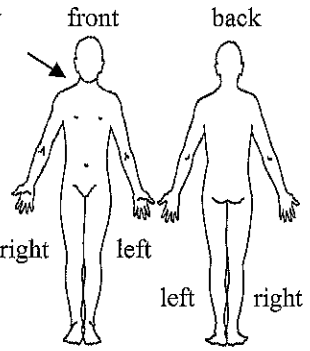
Signature _____ Date _____

Symptoms

Reason for visit _____ When did you first notice the symptoms? _____

Is this condition getting progressively worse? _____ Where specifically is the problem(s) located? _____

Circle on the picture where you continue to have pain, tightness, numbness, and/or tingling



What is your condition preventing you from doing?

At Home _____

_____

At Work _____

_____

Leisure Time _____

Treatment you've received for your condition? Medication Surgery Physical Therapy Other

Name of other doctor(s) who have treated you for this condition: _____

Health History

Mark "Yes" or "No" to indicate if you have had any of the following:

Yes No AIDS/HIV	Yes No Diabetes	Yes No High Cholesterol	Yes No Prostate Problems
Yes No Allergy Shots	Yes No Emphysema	Yes No Kidney Disease	Yes No Rheumatoid Arthritis
Yes No Appendicitis	Yes No Fractures	Yes No Liver disease	Yes No Stroke
Yes No Arthritis	Yes No Gout	Yes No Migraine Headache	Yes No Thyroid Problems
Yes No Asthma	Yes No Heart Disease	Yes No Multiple Sclerosis	Yes No Tuberculosis
Yes No Bleeding Disorders	Yes No Hepatitis	Yes No Osteoporosis	Yes No Ulcers
Yes No Bronchitis	Yes No Hernia	Yes No Pacemaker	Yes No Other
Yes No Cancer	Yes No Herniated Disc	Yes No Parkinson's Disease	
Yes No Depression	Yes No Herpes	Yes No Pinched Nerve	

(Women) Are you pregnant? Yes No Due Date _____ Taking Birth Control Pills? Yes No

List any types of injuries or surgeries which you have had and the dates which they occurred:

_____

_____

Please list all medications you are currently taking: _____

Allergies: _____

Authorization

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the release of my medical records to Applewood Injury Care Inc. DBA Wip-lash Injury Care Center. I authorize Wip-lash Injury Care Center to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such chiropractic care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the chiropractor or chiropractic group insurance benefits otherwise payable to me. I understand that my chiropractic insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X _____

SIGNATURE OF PATIENT (or parent if a minor) DATE

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INFORMED CONSENT TO CHIROPRACTIC CARE

Patient: Please discuss any questions or concerns with the Doctor *before* signing this consent.

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctors of chiropractic named above.

I have had the opportunity to discuss with the doctor and/or other office or clinic personnel the purpose and benefits of the chiropractic adjustments and other treatments outlined below. Alternatives to treatment have been reviewed.

Though chiropractic adjustments and treatments are usually beneficial and seldom cause any problem, I understand and am informed that there are some risks to treatment. Risks include, but are not limited to, fractures, disc injuries, strokes, dislocations and sprains.

I understand that I may be receiving the following treatment:

- Manipulation - manually or by an adjusting instrument
- Interferential - electric stimulation
- Intersegmental traction
- Cervical traction
- Decompression
- Physical Therapy
- Ultrasound
- Rehabilitation
- Hot/Cold packs

I understand that chiropractic is not an exact science and that, therefore, reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the chiropractic treatment that I have requested and authorized. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction. I consent to the proposed treatment.

Please Print Name_____ Date_____

Signature of Patient_____ Date_____

Signature of Parent/Guardian_____ Date_____
(If patient is a minor)

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www.wip-lashinjurydocs.com

Graduate: Los Angeles Chiropractic College • Board Certified: Chiropractic Sports Physician • American Medical Athletic Association • American Chiropractic Sports Council
Diplomat: National Board of Chiropractic Examiners • Member: American Chiropractic Association • Ohio State Chiropractic Association • Past President: Eastern Ohio Chiropractic Society, Ohio Chiropractic Radiology Association
Advanced Training: Ergonomics, MRI, Activator Methods and Rehabilitation • Lecturer: Local Civic Organizations • Industrial Consultant • Independent Medical Examiner • Qualified Expert Witness • Over Three Decades of Experience

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OFFICE AND FINANCIAL POLICY

1. **For patients with No insurance, or whose insurance is Out-of-Network or Non-Contracted,** this facility offers a discount program.
   Payment **must be received** prior to or **at the time of service**.
2. For in-network or contracted insurances, this office follows insurance policies and guidelines as required for all discounts and write-offs.
3. Patient acknowledges and understands that per his/her personal contract with personal insurance carrier and this office policy, that **PATIENT IS REQUIRED TO MAKE ALL CO-PAYMENTS OR FEES-AT-TIME-OF-SERVICE EITHER PRIOR TO OFFICE VISIT OR NO LATER THAT THE ACTUAL TIME OF SERVICE.**(Patient financial responsibilities will be discussed with the office Financial Administrator.)
4. Any change in insurance coverage or information **must be communicated to office staff as immediate as possible to insure correct billing.**
5. Patient acknowledges that insurance coverage verification, which is obtained from insurance carriers by this facility, **is not a guarantee** of benefits and that benefits are determined as claims are processed.
6. This facility applies a **$30 FEE to any checks returned as NSF** (Non-Sufficient Funds.)
7. **Insurance and Patient information** for Personal Injury and Workman's Compensation claims **must be received no later than the 3rd visit following injury**, to allow for timely billing of insurance. If this information is not received, this office reserves the right to bill the entire balance due and payable immediately to the patient or guardian if patient is a minor. **There is a $15.00 for any work forms.**
8. All financial arrangements and payment schedules and agreements must be made with the office Financial Administrator or billing personnel.
9. **This facility allows a maximum family balance of $250.** Should a personal balance meet or exceed this maximum allowed, it is required that payment arrangements be discussed with office Financial Administrator.
10. Patient or guardian is personally liable for payment of services and supplies that may be received. This includes but is not limited to: Personal Injury Liens, services unpaid by insurance and all amounts listed as patient responsibility on insurance remittance.
11. Patient/Guardian understands that once a financial agreement has been put into place on his/her behalf, that missed payments or failure to comply with this said agreement, patient/guardian will immediately be considered in breach of this agreement and therefore the said account is subject to alternative collection efforts.
12. **Effective January 1, 2016 patient statements that have patient responsible account balances will incur 18% interest monthly, on any "past due" amounts that appear on our statements.** To avoid this cost entirely, please pay any known insurance co-pays at the time of service, or any patient responsible balances after your insurance pays, beginning with the first statement you receive from our office with a balance due.
13. **Our Chart Copying Fee** is $3.02 per page for the first 10 pages $0.63 for pages eleven through fifty for pages over 51 and higher $0.26 per page.

Patient Signature: _____ Date: _____

Patient/Guardian Signature: _____