Cornwell Clinic
788 N. Santa Fe Ave., Ste 100
Edmond, OK. 73003

Date:_____
Drivers License#_____
Email:_____

AUTO ACCIDENT HISTORY FORM

PERSONAL INJURY HISTORY INFORMATION

Name: _____ SSN: _____
Date of Birth_____/_____/_____ Age: _____ Gender: M F Marital Status: S M W D
Home Address: _____
City: _____ State: _____ Zip Code: _____
Home Phone: _____ Work: _____ Cell: _____
Employer: _____ Occupation/Title: _____
Spouse: _____ Spouse's Occupation: _____
Emergency Contact: _____ Phone: _____ Relationship: _____

LIABILITY INFORMATION:

Has the accident been reported to the liability insurance company? ❑ Yes ❑ No
Have you been contacted by any insurance company? ❑ Yes ❑ No
Insurance Carrier: _____ Phone:_____
Name of Insured: _____ Claim #:_____
Name of Adjuster: _____Phone: _____ Fax#:_____
Address for claim(s):_____ City: _____ State:_____ Zip:_____
Do you have a copy of the police report? ❑ Yes ❑ No **If yes, please provide us with a copy**

MEDPAY INFORMATION:

Have you contacted your Auto Insurance Company about the accident? ❑ Yes ❑ No
Do you have (MedPay) medical payments coverage through your Auto Insurance Company? ❑ Yes ❑ No
Insurance Carrier: _____ Phone: _____
Name of Adjuster: _____ Claim #: _____
Address: _____ City: _____ State: _____ Zip: _____

AUTO ACCIDENT INFORMATION:

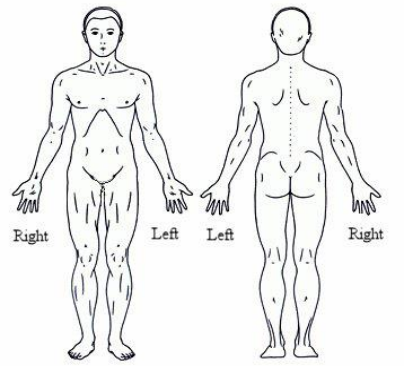
Date of Accident: _____ Time: _____ AM/PM Location of Accident: _____
City/State: _____ Closest bisecting street/town: _____
Driver of car: _____ Who owns vehicle? _____
Year/Make/Model of YOUR car: _____ Year/Make/Model of OTHER car: _____
Where were you seated? ❑ Driver ❑ Front center passenger ❑ Front right passenger
❑ Rear left passenger ❑ Rear center passenger ❑ Rear right passenger ❑ Pedestrian
Number of people in your vehicle: _____ Other vehicle: _____ Number of cars involved: _____
Road conditions at time of accident: ❑ Wet ❑ Dry ❑ Icy ❑ Clear ❑ Other_____
Visibility at time of accident: ❑ Good ❑ Fair ❑ Poor ❑ Other_____
Where was the vehicle struck ❑ Right ❑ Left ❑ Rear ❑ Front ❑ Side ❑ Other _____
Type of accident: ❑ Head-on collision ❑ Rear-end collision ❑ Broad-side collision ❑ Front impact
Non-collision (describe) _____
Did you see the accident coming? ❑ Yes ❑ No; Did you brace for the impact? ❑ Yes ❑ No;
Did car have a headrest? ❑ Yes ❑ No; Did your head hit the head rest? ❑ Yes ❑ No;
Airbags deployed ❑ Yes ❑ No ❑ Driver ❑ Front ❑ Side
At the time of the impact, was your vehicle: ❑ Stopped ❑ Moving; If moving how fast were you going?___mph
Estimate how fast other car was going? _____ mph; Which vehicle is responsible for accident? _____
Did the vehicle flip over? ❑ Yes ❑ No; Were you thrown out of your seat? ❑ Yes ❑ No
In your own words describe the accident:_____
_____
Did you receive any cuts or lacerations? ❑ Yes ❑ No; If yes, where? _____
Did you sustain any bruising because of accident? ❑ Yes ❑ No; If yes, where: _____
Head or body position at the time of impact: ❑ Head straight ahead ❑ Head turned to left/right
❑ Head looking back ❑ Body straight in sitting position ❑ Body rotated left/right ❑ Other_____
Did you feel immediate pain? ❑ Yes ❑ No; If yes, where? _____

Did you strike anything in the vehicle at time of impact? ❑ Yes ❑ No; If yes, what body part of your body struck what? ie: Head, Chest, Chin, Right / Left Shoulder, Right / Left Knee, Right / Left ankle, Right / Left wrist
❑ Steering Wheel _____ ❑ Dashboard _____ ❑ Windshield _____
❑ Roof _____ ❑ Driver Side Door _____ ❑ Passenger Door _____
❑ Driver Side Window _____ ❑ Passenger Window _____ ❑ Other _____
As a result of the accident you were: ❑ Unconscious ❑ Dazed/Dizzy ❑ In Shock ❑ Unphased ❑ Disoriented
❑ Nervous ❑ Nauseous ❑ Upset ❑ Weak ❑ Other: _____
Were you able to walk unaided after the accident ❑ Yes ❑ No
If no, why not? _____
Did you go to the emergency room/hospital after the accident? ❑ Yes ❑ No
If yes were you taken by: ❑ Ambulance ❑ Driven by another person ❑ Able to take yourself
Hospital / Clinic Name: _____ Dr. Name(s) _____
What treatment was given? ❑ none ❑ x-rayed ❑ given stitches ❑ given pain medication ❑ placed in cervical collar ❑ given instructions regarding sprains and strains ❑ Other _____
If x-rays what area(s) _____
Please describe how you felt immediately after the accident: _____
The next day: _____
List all medications/reasons you are currently taking because of the accident: _____
_____
Have you seen any other doctor for this accident? ❑Yes ❑No; Are you still treating with him/her? ❑Yes ❑ No
If yes, what treatment was given:_____
_____

Check symptoms since the accident: ❑ Headache ❑ Blurred vision ❑ Memory loss ❑ Neck pain ❑ Dizziness ❑ Jaw/TMJ pain ❑ Loss of Sleep ❑ Muscle spasms ❑ Loss of balance ❑ Finger/Toe Numbness ❑ Mid back pain ❑ Low back pain ❑ Ringing in the ears ❑ Confusion ❑ Fainting ❑ Extremity pain ❑ Loss of smell ❑ Loss of taste

Indicate your ability to perform the following activities because of this injury using codes:
N – Normal, L – Limited, D – Difficult, P – Painful, U – Unable

___ Walking short distance	____ Lying flat on stomach	____ Sex Activity	____ Gripping	____ Stooping
___ Lying on side with knees bent	____ Lying on back	____ Dressing Self	____ Reaching	____ Pushing
___ Standing for more than 1 hour	____ Coughing/Sneezing	____ Kneeling	____ Sitting at table	____ Pulling
___ Bending over forward	____ Turning over in bed	___ Bending forward to brush teeth		
___ Getting into/out of car				



CIRCLE AREA(S) OF PAIN

Severity of Pain: List region of pain and circle severity
1 low pain, 4 moderate pain, 7 intense pain, 10 emergency

EX _____ NECK _____
1 2 3 4 5 6 7 8 9 10

1. _____
1 2 3 4 5 6 7 8 9 10

2. _____
1 2 3 4 5 6 7 8 9 10

3. _____
1 2 3 4 5 6 7 8 9 10

4. _____
1 2 3 4 5 6 7 8 9 10

5. _____
1 2 3 4 5 6 7 8 9 10

MEDICAL HISTORY

What medications/drugs are you taking (not related to this injury)? _____
Date of last physical examination? _____
What operations have you had? Please include dates: _____

By signing below, I certify that the information I have written in all these pages is correct to the best of my knowledge.

_____
Print Name

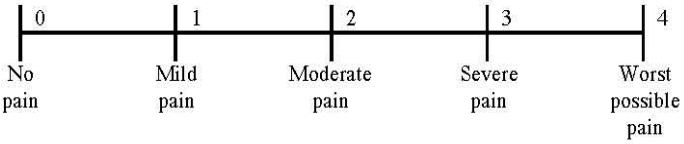
_____ _____
Patient Signature (or parent / guardian) Date

Functional Rating Index

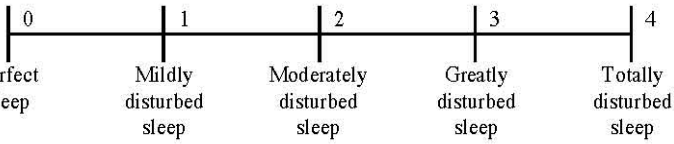
For use with **Neck and/or Back Problems** only.

In order to properly assess your condition, we must understand how much your **neck and/or back problems** has affected your ability to manage everyday activities. For each item below, **please circle the number which most closely describes your condition right now**.

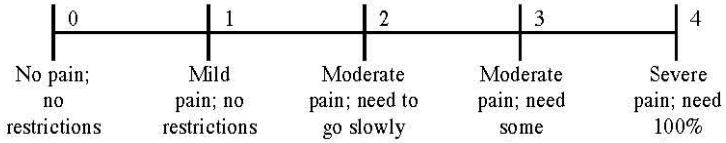
1. Pain Intensity



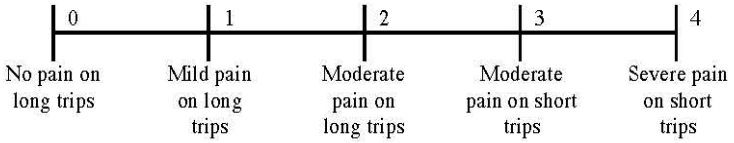
2. Sleeping



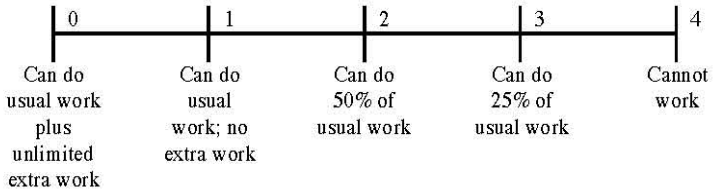
3. Personal Care (washing, dressing, etc.)



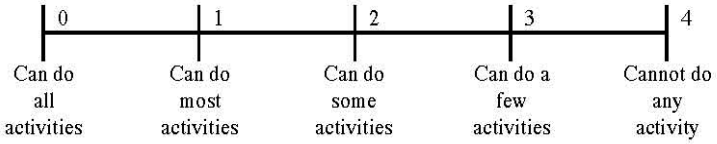
4. Travelling (driving, etc.)



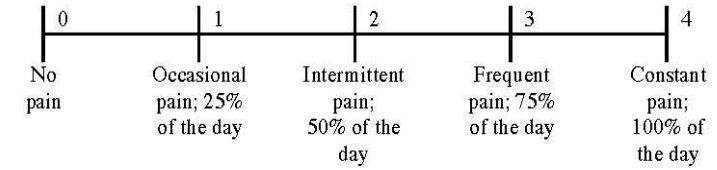
5. Work



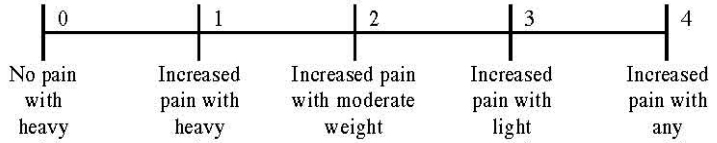
6. Recreation



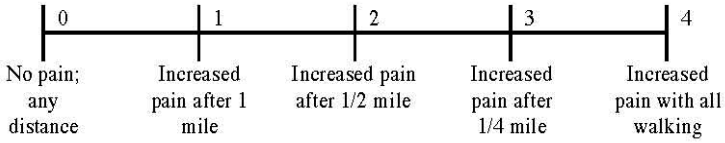
7. Frequency of Pain



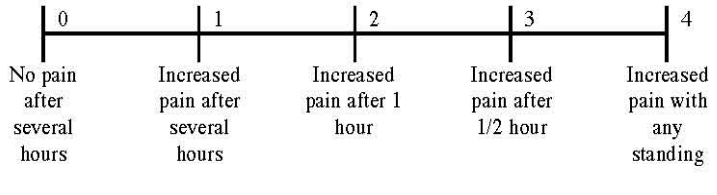
8. Lifting



9. Walking



10. Standing



Patient's Signature _____ **Date** _____

MEDICAL/INSURANCE INFORMTION

1. I authorize the release of any necessary past medical files or X-rays to Dr. Rondall Cornwell.
2. I authorize the release of information to family physicians, my insurance company, and my employer.
3. I authorize the performance of other diagnostic and therapeutic procedures, the of photographs and X-rays for treatment purposes.
4. I authorize my insurance benefits to be paid directly to Dr. Rondall Cornwell compensation claim, or for contracted (preferred provider plan) services with my insurance company.

NON-PREGNANCY VERIFICATION

1. I, _____, hereby notify all concerned, that I neither suspect nor know positively at this time that I may be or am pregnant. I release this clinic from any and all damages arising from any and all procedures, of a diagnostic or treatment nature, possibility of pregnancy.

PARENTAL CONSENT

1. I, _____, as legal guardian of _____, give my consent for any exams, diagnostic test (i.e. X-rays), and treatment needed for his/her care under the supervision of Dr. Rondall Cornwell.

AUTHORIZATION TO TREAT MINOR PATIENT IN ABSENCE OF PARENT/GUARDIAN

Name of minor patient: _____ Date of Birth: _____
I certify that I am the parent and/or legal guardian of _____
☐ I authorize _____ to bring my child to office visits with Dr. Rondall Cornwell
☐ I authorize the minor child named above to come alone to office visits with Dr. Rondall Cornwell and I consent to the examination and/or treatment of my child.

This authorization:
☐ is effective from _____to_____
☐ is effective until revoked by me in writing.

Parent/Legal Guardian Contact Information:
Home phone number_____ Office phone number_____
Cell phone number_____

I reserve the right to revoke this authorization at any time by writing to the above-named physician.

Parent/Guardian/Self Signature: _____ Date: _____

CORNWELL CLINIC / DR. RONDALL CORNWELL
788 N. SANTA FE AVE., STE 100
EDMOND, OK. 73003
405-330-2400
AUTHORIZATION AND ASSIGNMENT

To: CORNWELL CLINIC / DR. RONDALL CORNWELL, 285 S. Santa Fe Ave. Edmond, OK. 73003

In consideration of your undertaking to render care and treatment to me, I agree as follows:

1. _____ I authorize you to release any information to deem appropriate concerning my condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred for services rendered by you to me.

2. _____ I further authorize and direct any insurance company and/or my attorney, to pay directly to you such sums as may be due and owing for services rendered to me, and to withhold such sums from disability benefits, including, but not limited to, governmental agency benefits, medical payments benefits, health and accident benefits, workers compensation benefits, or any other insurance benefits or from any settlement, judgment or verdict on my behalf as may be necessary to adequately pay for any financial obligation owed to you by me.

3. _____ I further agree that, in the event an insurance company may be obligated to make payments to me for the charges made by you for services, and it reuses to make such payments, this agreement will serve as an assignment by me to you of all my rights and benefits to the extent of the charges for services provided. Further, I hereby assign and transfer to you any and all causes of action that I might have or that might exist in my favor against such insurance company and authorize you to prosecute said cause of action either in my name or in your name and further I authorize you as my assignee to compromise, settle, or otherwise resolve said claim or cause of action and I further understand and agree that I shall remain obligated and bound to pay you for your services in the event no sums are realized and received by you from my attorney or any insurance company.

4. _____ I hereby further grant to you a lien against, and an assignment of any and all insurance benefits that I may have and any and all proceeds of any settlement, judgment or verdict which may be due to me as result of the injuries or illness for which I may be treated by you.

5. _____ I authorize you to file my health insurance as it relates to this accident. I further understand that payment from my health insurance company will help defray costs of my medical bills not pay them in full.

6. _____ I attest that I have come to this clinic for purposes of acquiring medical care. I am here for help for my medical problems and have no intent to mislead or defraud my treating practitioners in any way that might result in inappropriate charges to third party payers, federal, state, or local governments, or insurance carriers. Further I attest that my injuries are real and that I am in pain and in need of medical treatment as a result of the medical condition for which I am consulting your clinic. I also attest that I understand the context of this statement with complete comprehension of this content.

DATE: _____ SIGNED: _____

PATIENTS NAME _____

WITNESS: _____

Date of injury: _____ Policy or Claim #: _____
Name of Insurance Company: _____
Patients Ins. Co.: _____ Policy #: _____

Informed Consent for Chiropractic Treatment

TO THE PATIENT: *You have a right to be informed about your condition, the recommended chiropractic treatment, and the potential risks involved with the recommended treatment. This information will assist you in making an informed decision whether or not to have the treatment. This information is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or refuse to give your consent to treatment.*

I request and consent to chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays. The chiropractic treatment may be performed by the Doctor of Chiropractic named below and/or other licensed Doctors of Chiropractic working at this clinic or office. Chiropractic treatment may also be performed by a Doctor of Chiropractic who is serving as a backup for the Doctor of Chiropractic named below

I have had the opportunity to discuss with the Doctor of Chiropractic named below, my diagnosis, the nature and purpose of my chiropractic treatment, the risks and benefits of my chiropractic treatment, alternatives to my chiropractic treatment, and the risks and benefits of alternative treatment, including no treatment at all.

I understand that, there are some risks to chiropractic treatment including, but not limited to:

- Broken bones
- Dislocations
- Sprains/strains
- Burns or frostbite (physical therapy)
- Worsening/aggravation of spinal conditions
- Increased symptoms and pain
- No improvement of symptoms or pain
- Infection (acupuncture)
- Punctured lung (acupuncture)
- Other _____

In rare cases there have been reported complications of vertebral artery dissection (stroke) when a patient receives a cervical adjustment. The complications reported can include temporary minor dizziness, nausea, paralysis, vision loss, locked in syndrome (complete paralysis of voluntary muscles in all parts of the body except for those that control eye movement), and death.

I do not expect the doctor to be able to anticipate and explain all risks and complications. I also understand that no guarantees or promises have been made to me concerning the results expected from the treatment.

TREATMENT PLAN: _____
_____
_____

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions. All of my questions have been answered to my satisfaction. By signing below, I consent to the treatment plan. I intend this consent form to cover the entire course of treatment for my current condition.

To be completed by the patient:

_____
print name

_____
signature of patient

_____
date signed

To be completed by the patient's representative:

_____
print name of patient

_____
print name of patient's representative

_____
signature of patient's representative

as:_____
relationship/authority of patient's representative

_____
date signed

To be completed by doctor or staff:

_____
witness to patient's signature

_____
translated by

_____
date

_____
date

PATIENT FINANCIAL POLICY

Your understanding of our financial policies is an essential element of your care and treatment. If you have any questions, please discuss them with our front office staff or supervisor.

- As our patient, you are responsible for all authorizations/referrals needed to seek treatment in this office.

- Unless, other arrangements have been made in advance by you, or your health insurance carrier, payment for office services are due at the time of services. We will accept VISA, MasterCard, Discover, cash, or check.

- Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctor. In other words, you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment.

- We have made prior arrangements with certain insurers and other health plans to accept an assignment of benefits. We will bill those plans with which we have an agreement and will only require you to pay the co-pay/co-insurance/deductible at the time of service.

- If you have insurance coverage with a plan with which we do not have a prior agreement, we will prepare and send the claim for you on a unassigned basis. This means your insurer will send the payment directly to you. Therefore, all charges for your care and treatment are due at the time of service.

- All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered," or you do not have an authorization, you will be responsible for the complete charge. We will attempt to verify benefits for some specialized services or referrals; however, you remain responsible for charges to any service rendered. Patients are encouraged to contact their plans for clarification of benefits prior to services rendered.

- You must inform the office of all-insurance changes and authorization/referral requirements. In the event the office is not informed, you will be responsible for any charges denied.

- By signing this agreement, you are indicating that you agree to the terms of this agreement, including being responsible for all legal fees, costs, and an annual interest rate of 22% in the event that you breach this agreement. This agreement will be considered breached by you if Cornwell Clinic has not received payment in full within 30 days of your receipt of the final bill. In the event of breach of this agreement, all parties stipulate that Oklahoma County will be the county of jurisdiction to hear any dispute arising hereto.

- There is a service fee of $25.00 for all returned checks. Your insurance company does not cover this fee.

Signature of Patient/Responsible Party: _____
Printed Name of Patient/Responsible Party: _____ Date: _____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

CORNWELL CLINIC / DR. RONDALL CORNWELL
788 N. Santa Fe Ave., Ste 100
Edmond, OK 73003
(405) 330-2400

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

PATIENT NAME:

_____

RELATIONSHIP TO PATIENT:

_____

SIGNATURE:

_____

DATE:

_____

OFFICE USE ONLY

*Signed form received by:

_____

*I attempted to obtain the patient's signature in acknowledgement on the Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

DATE:	INITIAL S	REASON:

Website Member Wellness Registration

To become a registered member with our office simply fill out the form below. Once your membership request has been approved you will be notified via email. Please, make sure the email address you provide is accurate.

Please, note that we respect your privacy, and will not loan, sell, or otherwise distribute your personal information to any third party.

General Information:

First Name: _____ Last Name: _____
Email Address: _____
Birthday: _____

Member Log-In: Specify desired username and password for website access
Username: _____
Password: _____

☐ **Yes, I would like to receive special announcements from the office and a free subscription to the Healthy Living Newsletter.**

Check off topics of interest:

☐ Backaches & Sciatica	☐ Headaches & Neck Pain	☐ Wellness Topics
☐ Diet & Nutrition	☐ Exercise & Fitness	☐ Women's Health Issues
☐ Children's Health Issues	☐ Stress Management	☐ Dr's Announcements