Timothy P. Kelly D.C.
3575 Piedmont Road N.E.
15 Piedmont Center, Suite Plaza 130
Atlanta, Ga. 30305.
Phone: 404-477-1589 Fax: 404-477-1590

Date: ____________

Case, Claim #_______________________________ DOA: ___________

Personal Injury / Accident Medical History

Name: ___________________________E-mail: _____________________Gender: M ☐ F ☐ Age:___ Birth Date: __________

Address: ____City: ________________ State: ______ Zip: __________

Driver's License #: _____________________ Cell Phone: (___) ______________ Home Phone:(__) _____________________

Fax: (___) _______________ Work Status: Full-Time ☐ Part-Time ☐ Retired ☐ Student ☐ Marital Status: S ☐ M ☐ D ☐ W ☐

Name of Spouse ☐, Parent ☐, or Guardian ☐: _____________________________ Age: ____ Phone: (___) __________________

Emergency Contact: ____________________________Phone:(___) __________________Relationship: _________________

Employer: ___________________________ Occupation: _____________________ Work Phone: (___) __________________

INSURANCE/ATTORNEY INFORMATION

Do you have Med-Pay? ☐ Yes ☐ No

Insurance Company of the person at Fault: ____________________________ Name of Agent: __________________________

Insurance Company Address: _____________________________ City: ________________ State: _____ Zip_______________

Insurance Company Phone #: _______________________ Agent's Phone #: _______________________________________

Claim Number: ____ Have you retained an attorney? ☐ Yes ☐ No

Your Attorney's Name: __________________________________ Your Attorney's Phone #: ___________________________

Your Attorney's Address: _______________________________ City: ___________________State: ____ Zip: ____________

ACCIDENT INFORMATION

Date of Accident: _____/_____/_____ Time of Accident: ____ a.m. ____ p.m. Was the sun up? ☐ Yes ☐ No

Your Vehicle: Year __________ Make ____________________ Model ___________________ Your Speed ____________

Other Vehicle: Year __________ Make _____________________ Model __________________ Other Vehicle Speed _______

Accident Type: ☐ Rear ended ☐ Head-on ☐ Drivers side ☐ Passenger side ☐ Other______________________________

Damage to your vehicle: _____________________________ Other Vehicle Damage: ___________________________

The Road was: ☐ Dry ☐ Wet ☐ Icy _______ The Weather was: ☐ Sunny ☐ Cloudy ☐ Light rain ☐ Heavy rain ☐ Other__________

Describe Accident: ____

____

Were you the... ☐ Driver ☐ Passenger Were you wearing your seatbelt? ☐ Yes ☐ No If passenger, where were you sitting? ☐ Yes ☐ No

Impending Collision, were you ☐ Aware ☐ Unaware. Did you brace for impact? ☐ Yes ☐ No … ☐ With my hands ☐ With my feet

Which way were you facing at the time of impact… ☐ Straight ahead ☐ Left ☐ Right Did the Airbag Deploy? ☐ Yes ☐ No

Did you strike anything in vehicle at time of impact? ☐ Yes ☐ No

If yes, specify what part of your body struck what: i.e.… Head Chest Chin Shoulder Right / Left Knee

☐ Steering Wheel______________________ ☐ Dashboard __________________ ☐ Windshield ________________________

☐ Roof_______________________ ☐ Left Side Door _____________________ ☐ Right Side Door______________________

☐ Left Side Window. __________________ ☐ Right Window _____________________ ☐ Other _________________________

IMMEDIATELY FOLLOWING THE ACCIDENT

☐ Ambulance/ Paramedics were called ☐ I was treated at the scene

☐ I was transported to the Hospital by Ambulance ☐ I went to the hospital on my own ☐ X-ray/ MRI were taken at the hospital

☐ Was diagnosed at the hospital ☐ Medication was prescribed ☐ Follow-up was recommended

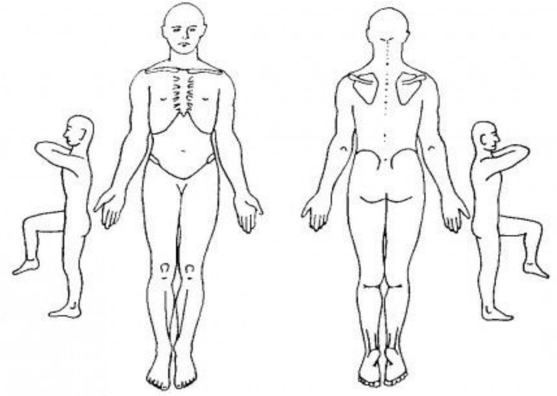
How did you feel? ☐ Dizzy/Dazed ☐ Disoriented ☐ Unconscious ☐ Saw a Flash of Light Upon Impact ☐ Nervous ☐ Nauseous ☐Upset ☐ Weak ☐ Other ____

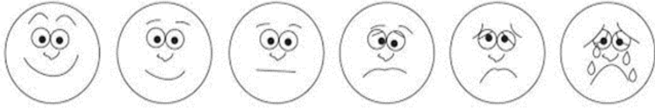
Other doctors seen: ☐ ER Doctor ☐ Chiropractor ☐ Orthopedist ☐ Other_____________ Was it a Job or Work injury? ☐ Yes ☐ No

PLEASE CIRCLE - WHAT, WHERE, AND HOW MUCH IT HURTS USE CODES AND PAIN NUMBERS SHOWN BELOW.

AA= ACHE, **NN**= NUMBNESS, **TT**= TINGLING,
SS=SHARP/STABBING, **SH**= SHOOTING, **SO**= SORENESS,
SW=SWELLING **XX**=OTHER, PLUS THE PAIN INTENSITY NUMBER
(shown below)

EXAMPLE: CIRCLE LOW BACK AND MARK; **AA7, NN5,**
CIRCLE INSIDE RIGHT KNEE AND MARK; **SO4**





Pain 0-1 2-3 4-5 6-7 8-9 10

COMPLAINTS

On a Scale of 1-10 RATE YOUR PAIN and put it on the lines below related to you injured areas.

If the Pain Changes During the day or Night, Use **2 Numbers** for example; Pain Ranges from 2-6 or 5-8...

Headache____, Neck R L____, Shoulder R L____, Mid back R L____, Rib R L____, Low back R L____, Hip R L____,
Thigh R L____, Knee R L____, Calf R L____, Ankle R L____, Foot R L____, Elbow R L____, Wrist R L____, Hand R L____,
Ringing in Ears R L____, Blurry Vision____, Dizziness____, Nervousness____, Fatigue____, Anxiety ____, Depression____,
Excessive irritability____, Fear of Driving in a Car____, Loss of concentration____, Jaw clenching____, Grinding teeth at night____,
Nightmares____, Decreased Sex Desire____, Stomach Upset____, Changes in Bowel Routine____,
Other Complaints: ____

DESCRIBE YOUR SYMPTOMS

___Shooting ___Burning ___Radiating ___Aching ___Cramping ___Tingling ___Numbness
___Throbbing ___Spasm ___Stiffness Other Symptoms/ Complaints____

How many days out of an average week do you have pain? ____________
How much time out of an average day are you in pain? _____________
What are the worst times of the day for the pain? ____________________
Describe the overall severity of the pain Mild Nuisance ☐ Mild to moderate ☐ Moderate ☐ Severe ☐
What are the best times of day for the pain? ___________________________
What do you do to relieve the pain? ____

DAILY ACTIVITIES

How do the following activities affect your pain?

	PAINFUL	NO PAIN	HELPS PAIN
Sitting	☐	☐	☐
Walking	☐	☐	☐
Standing	☐	☐	☐
Lying Down	☐	☐	☐
Looking Down	☐	☐	☐
Looking Up	☐	☐	☐
Lifting	☐	☐	☐

PROGRESSION

How is your pain compared to when the pain episode first started
☐ Much improved
☐ Somewhat Improved
☐ No Change
☐ A little worse
☐ Much worse

Please mark each that apply to your Daily Activities:

☐ Has difficulty climbing stairs
☐ Walks more slowly ☐ only walk short distances
☐ Has to use handrails to get up stairs
☐ Has to hold onto something to sit or stand from a chair
☐ Has to get other people to do things for you
☐ Changes position frequently to try and get comfortable
☐ Does not do jobs around the house because of the problem
☐ Has to lie down and rest frequently due to the problem
☐ Has a loss of appetite due to the problem
☐ Has become more irritable because of the problem
☐ Has difficulty: ☐ bending or kneeling, ☐ getting dressed, ☐ turning over in bed, ☐ sleeping, ☐ Other_______________

List your Hobbies and Exercise Activities and limitations because of these injuries _________________________________
What are some recreational activities that you participated in before this current problem and which ones cannot be done to the same extent: ____

MEDICAL HISTORY WITH THIS ACCIDENT

List other practitioners you have seen for this problem: ____

List current Medications: ____

List the treatments you have had for your problem:

- ☐ Chiropractic
- ☐ Massage
- ☐ Electrical Stimulation
- ☐ Ultrasound
- ☐ Steroid Injections
- ☐ Strengthening Exercises
- ☐ Aerobics
- ☐ Gravity Inversion-Traction
- ☐ Osteopathy
- ☐ Naturopathy
- ☐ Biomat Far Infrared
- ☐ Trigger Point Injections
- ☐ Acupuncture
- ☐ Dry Needling
- ☐ Back or Neck Brace
- ☐ TENS Unit

List When and Where Diagnostic Testing that has been performed for this problem and Results/Findings

- ☐ X-Rays ____
- ☐ MRI Scan ____
- ☐ CT Scan ____
- ☐ Blood Work ____

RESULTS: ____

List Past Surgeries: ____ ☐ None

List Past Hospitalizations: ____ ☐ None

MEDICAL HISTORY OF THE PAST 5 YEARS

Mark if you have had any of the following symptoms in the past 5 years:

- ☐ Dizziness standing up
- ☐ Night sweats
- ☐ Weight loss of 10 lbs or more
- ☐ Difficulty Losing Weight
- ☐ Excessive fatigue
- ☐ Hair Loss
- ☐ Loss of appetite
- ☐ Unusual stress at work
- ☐ Unusual stress at home
- ☐ Easy bruising
- ☐ Excessive bleeding
- ☐ Lumps in neck, back or armpits
- ☐ Chest pain or tightness
- ☐ Persistent or unusual cough
- ☐ Difficulty sleeping
- ☐ Wake at 2 AM up for an Hour
- ☐ Joint pain or swelling
- ☐ Swollen ankles
- ☐ Stomach pain, Indigestion
- ☐ Change in bowel habits
- ☐ Persistent diarrhea
- ☐ Excessive constipation
- ☐ Dark black stools
- ☐ Blood in stools
- ☐ Pain-burning when urinating
- ☐ Difficulty urinating- start/ stop
- ☐ Blood in urine
- ☐ Need to urinate more at night
- ☐ Morning stiffness
- ☐ Persistent eye redness
- ☐ Muscles tenderness
- ☐ Dry eyes or mouth
- ☐ Skin rashes
- ☐ Trouble breathing lying flat or with Exertion

Females-Mark if you have the following:

- ☐ Painful menstrual periods
- ☐ Vaginal bleeding other than period
- ☐ Abnormal Pap smear within last two years
- ☐ Back pain with menstrual periods
- ☐ Other menstrual problems

Since the accident, do you have current problems with:

- ☐ Anxiety
- ☐ Depression
- ☐ Irritability

Have you had previous injuries or accidents? ☐ Yes ☐ No

Description of previous Accident: ____

Description of previous injuries: ____

Is there any residual pain from the previous injury? ☐ Yes ☐ No

How much better did you feel prior to your current condition? (Example 100%, 80% etc.) _________

CHIROPRACTIC INFORMED CONSENT TO TREAT

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, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic indicated below and/or other licensed doctors of chiropractic and support staff who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not. I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and procedures. I understand that results are not guaranteed. I understand and am informed that, as in the practice of medicine and like all other health modalities, results are not guaranteed, and there is no promise of cure. I further understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests. I further understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include, but not limited to, self-administered, over-the-counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; physical therapy; steroid injections; bracing; and surgery. I understand and have been informed that I have the right to a second opinion and to secure other opinions if I have concerns as to the nature of my symptoms and I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

____ __________________

Patient's Signature Date

Timothy P. Kelly, D.C., Buckhead Wellness Center PH 404-477-1589 FAX 404-477-1589
3575 Piedmont Rd. N.E., 15 Piedmont Center, Suite P 130 Atlanta, Ga. 30305

Patient Consent for Use and Disclosure of Protected Health Information

- *This form is necessitated by HIPAA Federal Privacy Regulations.*
- I hereby give consent to Timothy P. Kelly, D.C. and the staff of Buckhead Wellness Center (The Office), to use and disclose protected health information (P.H.I.) about me to and to carry out Treatment, and obtain Payment, and perform healthcare Operations (T.P.O.).
  The Office Notice of Privacy Practices provides a more complete description of such uses and disclosures.
- I have the right to review the Notice of Privacy Practices prior to signing this consent. The Office reserves the right to revise its Notice of Privacy Practices at any time. A revised and current Notice of Privacy Practices may be obtained by forwarding a written request to:
- Timothy P. Kelly, D.C.3575 Piedmont Rd. N.E., 15 Piedmont Center, Suite Plaza 130 Atlanta, Georgia 30305
- With this consent, The Office may contact my home or alternate locations and with an email, text, leave a message on voice mail or in person in reference to any items that assist the practice in carrying out T.P.O., such as insurance inquiries, appointment reminders, financial statements, missed appointment notification, birthday or holiday cards, information about treatment alternatives or other health related information.
- I have the right to request, in writing, that The Office restrict how it uses my P.H.I. to carry out T.P.O. However, the practice is not required to agree to my requested restrictions, but if it does agree, it is bound by this agreement. By signing this agreement, I am consenting to The Office the use and disclosure of my P.H.I. to carry out T.P.O.
- I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, The Office may decline to provide treatment to me.

Consent to Treat a Minor: I hereby authorize the doctor and/or staff of Buckhead Wellness, to tender any form of treatment of Chiropractic as permitted by law and which in their sole discretion would benefit my minor child. ______________

Pregnancy Declaration:
I verify that my last menstrual period was _________ and that I am not pregnant. The doctor and/or staff have been informed of my condition and are not responsible for any problems as a result of diagnostic x-rays taken.

Payment Policy:
We accept cash, check, Visa, MasterCard, American Express, and Discover. Payment is due at time of service, unless a payment arrangement is made with the office manager. If insurance is being filed, co-pays and any deductibles are due at time of service.

Assignment of Payment:
I hereby authorize and direct my insurance company and/or attorney to pay the doctor directly any monies due him on my account. I hereby, further, give a lien on my case to said doctor against any and all proceeds of my settlement as the result of the injuries for which I am treated. This payment shall be made first before all other payment obligations.
I fully understand that I am directly and fully responsible for all medical bills for services rendered to me, and this agreement is made solely for said doctor's additional protection and consideration of his awaiting payment. I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.
I have read and understood how my Patient Health Information will be used and I agree to the policies and procedures of this office.

Name of Patient: ____ Date ________________

Signature of Patient/ Guardian____

Print Name & Relationship to Patient: ____

Timothy P. Kelly, D.C., 3575 Piedmont Rd. N.E. 15 Piedmont Center, Suite P 130 Atlanta, Ga. 30305 404-477-1589

LIEN ON PERSONAL INJURY RECOVERY

This agreement is entered into between **Timothy P. Kelly, D.C.** (hereinafter "Provider"), and
____ (hereinafter "Patient"),
in consideration of the obligations set forth herein and establishes certain obligations and responsibilities relating to Patient's accident of ________________20____, (hereinafter "claim").

- I authorize and direct my insurance company, my attorney, to pay directly to: Timothy P. Kelly, D.C., any sums as may be due this Office for services rendered to me.
- Patient hereby gives a lien to Provider against all proceeds derived from this claim (whether by settlement, judgment, or otherwise) to secure payment of all fees owed to Provider by Patient for health care services and supplies arising out of injuries sustained, as of the time such proceeds are paid. This lien shall have priority over any subsequent lien or assignment of patient's interest.
- Patient hereby directs patient's attorney and all responsible parties to pay such sums as are secured hereby directly to Provider, as soon as possible after any proceeds are received.
- Patient hereby expressly recognizes that even though this lien has been given, Patient still remains personally responsible for Provider's fees and that payment of such fees must be made by Patient regardless of whether any money is received through Patient's personal injury claim.
- Patient hereby authorizes Provider to furnish Attorney, at reasonable intervals upon Attorney's request, complete reports of Patient's medical condition, care and cost of treatment. Provider agrees to furnish these reports within a reasonable time, and at a reasonable cost.
- Provider hereby agrees to await Patient's payment of Provider's fees until this claim is concluded, or until the expiration of two years, whichever first occurs, except to the extent that payment is available from insurance which provided health care or medical payment benefits for Patient. Provider agrees to be available to Patient's Attorney, upon reasonable notice and for reasonable compensation for consultations, depositions and court appearances. In the event Provider is requested or subpoenaed to testify, Provider shall be entitled to reasonable compensation as an expert witness.
- In the event of any dispute between the Provider and the Patient concerning Provider's fees, Attorney shall hold in trust until such dispute is resolved, or to deposit with the Court, a sufficient amount of Patient's proceeds to satisfy Provider's claimed fee.
- Patient hereby agrees to notify Provider immediately, should Patient retain new legal counsel. Patient agrees to direct new legal counsel to execute another copy of this Claim Agreement and Lien when one is furnished by Provider. Should new legal counsel fail or refuse to execute another copy of this lien agreement within ten days after being provided a copy, then Patient's bill shall become immediately due and payable in full.
- Should any party seek judicial enforcement of this Agreement, the prevailing party shall be entitled to reasonable attorney's fees.
- This Claim Agreement and Lien cannot be modified, changed, or revoked by any party without the express written consent of all parties.
- A faxed signature on this Lien, a photocopy of this form can serve as an original.

____________________________ ____________________________ ____________
Print Patient Name Signature of Patient/Guardian Date

____________________________ ____________________________
Print Guardian Name Description of Guardian

____________________________ ____________
Provider Date

The undersigned Attorney acknowledges receipt of a copy of this lien and agrees to be bound hereby.

____________________________ ____________
Attorney Date