ProRehab
Integrated Healthcare Specialists LLC

Independent Providers

Kyle Tetz, DC

Services

Chiropractic Care
Physical Therapy
Acupuncture
Massage Therapy
Spinal Rehab
Sports Injury Rehab
Auto Injury Rehab
Corrective Exercises
Nutritional Counseling

Location

330 Rancheros Dr
Suite 202
San Marcos, CA
92069

Contact

P: 760.630.8060

ProRehabWellness.com

Preparing for Your First Appointment

Documents to Bring:

- ☐ Chiropractic Intake Forms
- ☐ Driver's license or ID
- ☐ Accident Photos - can be emailed to: Info@prorehabwellness.com
- ☐ Accident Report - if available
- ☐ Estimates of damage - if available
- ☐ X-Rays / MRI / Medical Records
- ☐ Med-Pay verification
- o Auto Insurance Declaration Statement
- o Auto Adjuster's Phone# and Claim#
- ☐ Attorney Information - if applicable
- ☐ Third Party Insurance Info.

About your Appointment:

- Allow up to 60 - 90 minutes for your first appointment. Please arrive 45-60 minutes early if you have not already completed your initial paperwork.
- Comfortable athletic clothing is highly recommended. This allows the doctor to properly evaluate injured areas.
- Failure to bring in above documents may delay the initiation of treatment.

Thank you for trusting ProRehab Integrated Healthcare Specialists with your health.

We look forward to meeting you soon!

ProRehab
Integrated Healthcare Specialists LLC

INSTRUCTIONS: Please use sections below to help you complete your forms.

[PAGE: 1]

Medical History Section

- ☐ Please include symptoms you are currently experiencing since the accident + before the accident.

[PAGE: 2]

It is HIGHLY important that you list all symptoms you are experiencing since your accident. You must separate symptoms in order of highest to lowest.

- ☐ Please write down symptoms on separate lines. Worst, Second Worst, Third Worst. (Section 5 for additional symptoms)

Remember use the sections 1, 2, & 3 in the order of most pain to least pain. Always provide a pain score 1-10, *10 means you are in the hospital*. Please use the pain scale attached to help you score your pains. Include how often you experience each symptom.

IF you have more than 3 complaints/ symptoms please use section 5.
To include 4th, 5th, 6th complaints/ symptoms please use same format.

- ☐ Section 4. Please use the keys to mark where you are having pain on the picture provided. Ex. "XXX" for pain, "///" for stiffness, "OOO" for numbness, "SSS" for stabbing.

ADL [activities of daily living]

- ☐ Mark ONE answer for each line, ONLY if it applies. If it does not apply to you, you can skip that line.
- ☐ Sign this form when finished.

Upper Extremity

- ☐ Complete this form, ONLY if you are having pain in areas: arms, hands, wrists...

Lower Extremity

- ☐ Complete this form, ONLY if you are having pain in the legs, knees, or feet.

Release form for medical records

- ☐ Only a signature is required.
- ☐ Leave blank.

Personal Injury Fee Schedule

- ☐ Please provide your insurance declarations page to help you determine if you have medical coverage under your auto insurance policy.
- ☐ Chiropractic treatments will be under a lien; however, supplies may include a small co-pay if no medical coverage is available to cover expenses.

PATIENT INFORMATION & MEDICAL HISTORY

First Name _____ Last Name _____ Middle Initial ____ Sex (M / F)

Address _____
(number) (street) (city) (state) (zip code)

Social Security# _____-_____-_____ Birth Date ____ / ____ / _____ Age _____

Phone # (_____) _____ - _____ Cell # (_____) _____ - _____Email_____

Married ( ) Single ( ) Other ( ) _____ Spouse's Name _____

Occupation _____ Employer _____ Work Address_____

IN CASE OF AN EMERGENCY, CONTACT_____
Name Relationship Phone #

Have you ever had chiropractic care before? (YES / NO) If yes, when was your last treatment? _____

Have you ever had a professional massage before? (YES / NO) If yes, when was your last massage? _____

What are your health goals? (Check one of the following)

( ) Reduce symptoms only ( ) Reduce symptoms and show me how to prevent flair-ups ( ) Reduce symptoms, prevent flair-ups and maintenance care

Do you have any type of health insurance? (YES / NO) Primary Insurance _____ Secondary Insurance_____

Is this injury work related? (YES / NO) Is this injury due to a motor vehicle accident? (YES / NO)

*** IF YOU ANSWERED YES TO EITHER OF THE TWO PREVIOUS QUESTIONS, PLEASE NOTIFY THE FRONT DESK ***

PAST YEAR MEDICAL HISTORY

*Check any of the following symptoms you are **currently experiencing or have experienced within the past 12 months.***

Musculoskeletal
__Low Back Pain
__Pain Between Shoulders
__Neck Pain
__Headaches
__Arm Pain/Numb/Tingling
__Leg Pain/Numb/Tingling
__Joint Pain/Stiffness
__Walking Problems
__Difficulty Chewing
__Weakness

EENT
__Vision Problems
__Dental Problems
__Sore Throat
__Ear Pain/Ringing
__Hearing Difficulty

General
__Allergies
__Loss of Sleep
__Fever/Night Sweats
__Eczema (skin rash)
__Weight Loss/Gain

Genitourinary
__Bladder Trouble
__Painful Urination
__ Excessive Urination
__Discolored Urine

Male Specific
__Difficulty Urinating
__Impotence
__Sterility

C-V-R
__Chest Pain
__Short of Breath
__Blood Pressure
__Heart Problems
__Wheezing
__Lung Problems
__Varicose Veins
__Arm/Leg Swelling
__Asthma
__High Cholesterol
__Bruise Easily

Female Specific
__Menstrual Irregularity
__Menstrual Cramping
__Sterility
__Breast Pain

*****ARE YOU PREGNANT? (YES / NO)*****

Nervous
__Numbness
__Paralysis
__Dizziness
__Forgetfulness
__Confusion
__Depression
__Fainting
__Convulsions
__ADHD/Hyperactivity
__Anxious
__Tremor/Shaking

Gastrointestinal
__Gas/Bloating
__Heartburn
__Poor Appetite
__Excessive Appetite
__Excessive Thirst
__Decreased Appetite
__Colitis
__Vomiting
__Diarrhea
__Constipation
__Black/Bloody Stool
__Hemorrhoids
__Liver Problems
__Abdominal Pain
__Frequent Nausea

Name of your family physician _____Last appointment with your physician _____Phone # _____
Do you give us permission to send your medical doctor an updated report on your health status? (YES / NO)
Have you been hospitalized in the past? (YES / NO) If yes when and why? _____
Please list any surgeries you have had and when.
_____
Please list any medications you are taking.
_____

PATIENT SIGNATURE _____ **DATE** _____

Patient Name:

Please review & use this pain scale to help you score your pain on the following pages.

0	No Pain
1	Minimal Pain (Annoyance)
2	Constant Minimal to Intermittent Slight Pain
3	Constant Slight Pain (Some Handicap)
4	Constant Slight to Intermittent Moderate Pain
5	Constant Slight to Frequent Moderate Pain
6	Intermittent Moderate Pain (Marked Handicap)
7	Frequent Moderate Pain
8	Constant Moderate Pain
9	Constant Moderate to Intermittent Severe Pain
10	Constant Severe Pain (Incapacitated)

9/10 = You should be thinking of going to Emergency or Urgent care

10/10= You should go to Emergency immediately

Signature:_____ Date: _____

SUBJECTIVE COMPLAINTS / INTENSITY / FREQUENCY

Name _____ **(Complete sections 1-6)** Date _____

1. What is your **WORST** complaint or symptom? _____

When and **How** did this condition begin? _____

Rate your pain/discomfort on the scale. (circle) (no pain) = **0 1 2 3 4 5 6 7 8 9 10** = (severe pain)

What % of the day or **Frequency** of this symptom experienced? (circle below)

0-5 6-10 11-15 16-20 21-25 26-30 31-35 36-40 41-45 46-50 51-55 56-60 61-65 66-70 71-75 76-80 81-85 86-90 91-95 96-100

Is this condition and symptom changing? (circle) **Improving** **Not Changing** **Worsening**

2. What is your **SECOND WORST** complaint or symptom? _____

When and **How** did this condition begin? _____

Rate your pain/discomfort on the scale. (circle) (no pain) = **0 1 2 3 4 5 6 7 8 9 10** = (severe pain)

What % of the day or **Frequency** of this symptom experienced? (circle below)

0-5 6-10 11-15 16-20 21-25 26-30 31-35 36-40 41-45 46-50 51-55 56-60 61-65 66-70 71-75 76-80 81-85 86-90 91-95 96-100

Is this condition and symptom changing? (circle) **Improving** **Not Changing** **Worsening**

3. What is your **THIRD WORST** complaint or symptom? _____

When and **How** did this condition begin? _____

Rate your pain/discomfort on the scale. (circle) (no pain) = **0 1 2 3 4 5 6 7 8 9 10** = (severe pain)

What % of the day or **Frequency** of this symptom experienced? (circle below)

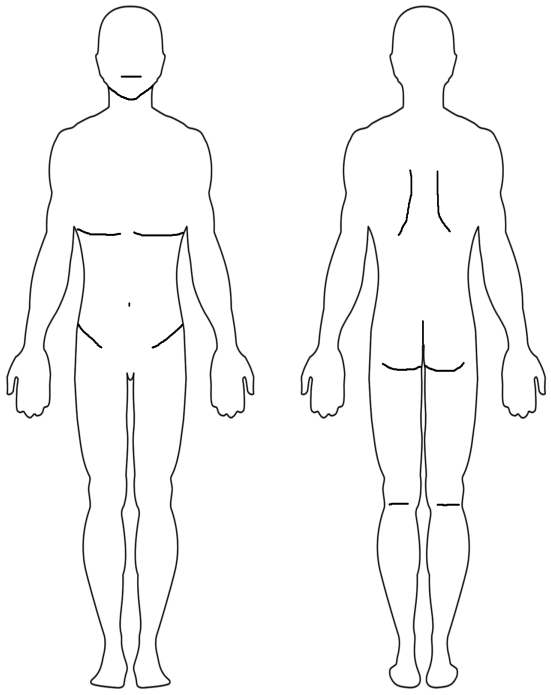
0-5 6-10 11-15 16-20 21-25 26-30 31-35 36-40 41-45 46-50 51-55 56-60 61-65 66-70 71-75 76-80 81-85 86-90 91-95 96-100

Is this condition and symptom changing? (circle) **Improving** **Not Changing** **Worsening**

4. Please indicate on the diagram to the right where you experience your symptoms using the key below.

KEY: Pain XXX Numbness OOO Tingling √ √ √

Stiffness / / / Burning + + + Stabbing SSS



5. Include additional symptoms using the same format as above. For each symptom, please rate your pain/ discomfort 1-10, % frequency, & if improving, not changing or worsening:

4th Complaint/ Symptom: _____

_____

5th Complaint/ Symptom: _____

_____

6th Complaint/ Symptom: _____

_____

6. **Patient Signature:** _____

Kyle Tetz Chiropractic Inc.— 330 Rancheros Dr, Ste 202, San Marcos, CA 92069—Ph: 760.630.8060

NEW PATIENT CURRENT COMPLAINTS & PAST HISTORY

Name _____ **(Complete #1-5)** Date _____

1. **CURRENT COMPLAINTS:** Please describe how your **CURRENT** condition(s) or symptom(s) began:

_____

_____

_____

2. Who have you seen for these **CURRENT** symptoms? (If Yes, check below which apply and continue section)

___No One ___Medical Doctor ___Chiropractor ___Physical Therapist ___Other (Describe)_____

Please list any names of providers seen for this current complaint: _____

What treatment(s) did you receive and when? _____

Circle any diagnostic testing have you had for your symptoms?

(X-Rays) date:_____ (CT Scan) date:_____ (MRI) date:_____ (Other) _____

3. **PAST HISTORY:** Have you had similar symptoms in the **PAST or SIGNIFICANT injuries**? (YES / NO) (If Yes, continue section)

If Yes, what symptom or condition did you have in the past: _____

Was this past condition due to an accident or injury? (YES / NO) If yes, describe injury and approximate date: _____

_____

When was the last time you experienced those symptoms? _____

How long did those past symptoms last for? _____

Did your condition require any surgeries? (YES / NO) If Yes, When was the surgery:

_____

Did your symptoms and condition(s) resolve? (YES / NO) If No, what condition remained: _____

Did you see a medical provider / chiropractor or other specialist for that past condition? (YES / NO)

If Yes, who did you see? (Please list names of providers)

Name: _____ Specialty: MD / DC / PT Name: _____ Specialty: MD / DC / PT

4. What is your occupation? _____ Are you required a disability note for your employer / teacher? (YES / NO)

5**. Family History:** Does anyone in your immediate family (including your grandparents) have any of the conditions listed?
(Circle all that apply) **Arthritis, Asthma, Birth Defects (i.e. heart defects), Cancer, Diabetes, Genetic Conditions (i.e. Cystic Fibrosis), Heart Disease, Mental Illnesses (i.e. Alzheimer's, Parkinson's), Obesity, Osteoporosis, Seizures**

DOCTORS NOTES: _____

PATIENT NAME:

ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by state and federal law, and not by a lawsuit or resort to court process, except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration. Further, the parties will not have the right to participate as a member of any class of claimants, and there shall be no authority for any dispute to be decided on a class action basis. An arbitration can only decide a dispute between the parties and may not consolidate or join the claims of other persons who have similar claims.

Article 2: All Claims Must be Arbitrated: It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, as to whether this agreement is unconscionable, and any procedural disputes, will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the health care provider, including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and the health care provider and/or other licensed health care providers, preceptors, or interns who now or in the future treat the patient while employed by, working or associated with or serving as a back-up for the health care provider, including those working at the health care provider's clinic or office or any other clinic or office whether signatories to this form or not.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the health care provider, and/or the health care provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages. This agreement is intended to create an open book account unless and until revoked.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days, and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees, or other expenses incurred by a party for such party's own benefit. Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder, any existing court action against such additional person or entity shall be stayed pending arbitration. The parties agree that provisions of state and federal law, where applicable, establishing the right to introduce evidence of any amount payable as a benefit to the patient to the maximum extent permitted by law, limiting the right to recover non-economic losses, and the right to have a judgment for future damages conformed to periodic payments, shall apply to disputes within this Arbitration Agreement. The parties further agree that the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this Arbitration Agreement.

Article 4: General Provision: All claims based upon the same incident, transaction, or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the health care provider within 30 days of signature and, if not revoked, will govern all professional services received by the patient and all other disputes between the parties.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment), patient should initial here. _____. Effective as of the date of first professional services.

If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this Arbitration Agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

Patient Name: _____ Signature: _____ Date: _____

Parent or Guardian: _____ Signature: _____ Date: _____

Witness Name: _____ Signature: _____ Date: _____

ALSO SIGN THE INFORMED CONSENT ON REVERSE SIDE

Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures, if indicated. Any examinations or tests conducted will be carefully performed, but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including, but not limited to, hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an arterial dissection that involves an abnormal change in the wall of an artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. This occurs in 3-4 of every 100,000 people, whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately, a percentage of these patients will experience a stroke. As chiropractic can involve manually and/or mechanically adjusting the cervical spine, it has been reported that chiropractic care may be a risk for developing this type of stroke. The association with stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: _____ Signature: _____ Date: _____

Parent or Guardian: _____ Signature: _____ Date: _____

Witness Name: _____ Signature: _____ Date: _____

ALSO SIGN THE ARBITRATION AGREEMENT ON REVERSE SIDE

ProRehab Integrated Healthcare Specialists LLC

Acknowledgement of Receipt of Notice of Privacy Practices

This form will be retained in your medical record.

NOTICE TO PATIENT

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice.

Patient Name:_____ **Date of Birth:**_____

I acknowledge that I have **received and had the opportunity to review** the Notice of Privacy Practices on the date below on behalf of _____**ProRehab Integrated Healthcare Specialists LLC.**

I understand that the Notice describes the uses and disclosures of my protected health information by **ProRehab Integrated Healthcare Specialists LLC** and informs me of my rights with respect to my protected health information.

_____ _____

Patient's Signature or that of Legal Representative *Printed Name of Patient or that of Legal Representative*

_____ _____

Today's Date *If Legal Representative, Indicate Relationship*

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- ☐ The patient refused to sign.
- ☐ Due to an emergency situation it was not possible to obtain an acknowledgement
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ Other (please specify):_____

_____

_____ _____

Employee Name *Today's Date*

OFFICE POLICIES / PROCEDURES AGREEMENT AND CUSTOMARY FEE SCHEDULE

FINANCIAL ARRANGEMENTS

I understand and agree that health and accident policies are an arrangement between an insurance company carrier and myself. Furthermore, I understand that this 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 office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to 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 to me will be immediately due and payable.

INSURANCE BILLING/PAYMENT

Patients are ultimately fully responsible for services provided by our office. For your convenience, our office will make an effort to verify your insurance benefits. However, please note that verification of benefits is not guaranteed. Your insurance company makes the final determination of insurance benefits when they consider the claim. Patients are fully responsible for payment of services not authorized or covered by their insurance company. Patients that are represented by an attorney in PI cases must notify our office the same day if changing or canceling representation.

PAYMENT ARRANGEMENTS

We understand that occasions arise when it may be necessary for you to request to be billed rather than pay at the time of service. This may include setting up a payment plan for those who may require extensive treatments. Payment is due within 30 days of the service rendered. If there are legitimate financial problems, please discuss them with our office manager prior to the 30 days so that we may find a workable solution. If an account is not paid within 30 days and no payment arrangements have been made, you will be responsible for legal fees, collection agency fees, and any other expenses incurred in collecting your account. You will also be charged an interest of up to 15% per annum based off your principal balance until all fees are paid.

APPOINTMENT SCHEDULING

Canceling or rescheduling appointments requires a 24 hour notice otherwise you may be charged a $50 fee for the missed scheduled service.

NOTICE OF PRIVACY POLICY

We are required by law to make sure your medical information is protected; give you notice describing our legal duties and privacy practices with respect to medical information about you; and follow the terms of the notice that is currently in effect. By signing below you are acknowledging that you have received or had the opportunity to view our Notice of Privacy Policy.

NOTICE OF PRIVATE PRACTICES/ BUSINESSES AND PATIENT'S FREEDOM OF CHOICE FOR PROVIDERS

There are separate practices/ businesses within this office. Each entity is owned and operated as separate businesses and may have separate fee schedules and different treatment techniques. I understand that each service offered at this facility are owned and operated as separate businesses and hold each business harmless from any act or omission which may occur by any of the other businesses during the course of my treatment at this facility. Circumstances may arise such as emergencies, or doctor vacation or sick leave and you may request to be treated by another doctor within this office. If you are treated by another doctor you may be charged a different fee. Patients are free to choose any doctor or organization that may be recommended by our doctors. You do not have to use the facilities at our office for treatments and we can assist you on finding an alternative locations or sources.

SECTION 1785.27 CIVIL CODE

A holder of this medical debt contract is prohibited by Section 1785.27 of the Civil Code from furnishing any information related to this debt to a consumer credit reporting agency. In addition to any other penalties allowed by law, if a person knowingly violates that section by furnishing information regarding this debt to a consumer credit reporting agency, the debt shall be void and unenforceable.

CURRENT CUSTOMARY FEE SCHEDULE / TIME OF SERVICE DISCOUNT / WAIVER OF NO SURPRISE ACT

You may request a statement or receive an insurance explanation of benefits (EOB) which will reflect services provided and the associated insurance billing codes which are shown below. According to (California Business and Professions Code 657), we offer a Pay at Time of Service Discount (TOS) which you may qualify for. All fees listed below may change without notice. Waiver of No Surprise Act: With my signature I am saying I agree to get any services listed below and am consenting of my own free will and not being coerced or pressured that I am giving up some consumer billing protections under federal law. I may get a bill for the full charges for these services or have to pay out-of-cost sharing under my health plan. I fully and completely understand that some or all amounts I pay might not count toward my health plan's deductible or out-of-pocket limit. I can end this agreement by notifying the provider or facility in writing before getting services.

Initial Exam	99202	Expanded	$150.00	**Re-Exam**	99211	Minimal	$50.00	
(New Patient)	99203	Detailed	$250.00	*(Established Patient)*	99212	Limited	$125.00	
	99204	Comprehensive	$375.00	*(Treated within 3 years)*	99213	Expanded	$175.00	
	99417	Prolonged Eval	$200.00		99214	Detailed	$250.00	

Chiropractic	98940	$60.00	1-2 regions	**Manual Therapies**	97140	$60.00	**Durable Medical Equipment**		
Adjustments	98941	$80.00	3-4 regions	**Therapeutic Exercises**	97110	$75.00	Traction Pump	E0860	$40.00
	98942	$90.00	5 regions	**Therapeutic Activities**	97530	$80.00	BioFreeze	A9720	$20.00
	98943	$60.00	Extremities	**Massage (15min)**	97124	$55.00	TENs Unit	E0730	$75.00

X-Rays	**Cervical Spine**			**Thoracic Spine**			**Lumbar Spine**		
	72040	$110.00	2-3 views	72070	$110.00	2 views	72100	$120.00	2-3 views
	72050	$145.00	4 views	72072	$125.00	3 views	72110	$145.00	4 views
	72052	$170.00	5 views				72114	$170.00	6 views

PRINT NAME _____ SIGNATURE _____ DATE _____

ACCIDENT / INJURY QUESTIONS

Patient: _____ **Date:** _____

Date of Accident: ___ / ___ / ____ **Time of Accident:** ___: ____ **AM / PM** **Place (City/State):** _____

What was the cause of your Accident / Injury? **(Circle)** **Automobile Accident** **Work Injury** **Slip/Fall**

Describe in your own words what happened: _____

_____

_____

How did you feel immediately after the accident? (eg. Confused, dazed, dizzy, nervous, scared, nausea, etc…)

_____

Where did you immediately develop pain following the accident? _____

_____

Are there additional symptoms that developed hours, days or weeks after the accident? (eg. Headaches, tingling…)

_____

EMERGENCY CARE

Did you receive any medical care at the scene of the accident? (eg. Paramedics) **(YES / NO)**

Have you been to the hospital for this accident? **(YES / NO)** If yes, what hospital? _____Date: _____

Were you taken to the hospital by ambulance? **(YES / NO)** Other: _____

Please list the areas of your body where (**X-Rays / CT / MRI)** were taken: _____

Have you been prescribed any medications for this accident? **(YES / NO)** List: _____

List ***any other Doctors' names and specialties with appointment dates*** you have seen for this accident?

_____

AUTOMOBILE ACCIDENT

What ***year and type*** of automobile were you driving? _____Your approximate speed: ____ MPH

What parts of your vehicle were struck during the collision? _____

If struck by another vehicle, what type of vehicle was it? _____Approximate speed: ____ MPH

What was the total damage estimate of your vehicle? **$**_____ Vehicle Totaled: **(YES / NO)**

Did the police arrive at the scene and was a report of the accident taken? **(YES / NO)**

Were you wearing your seatbelt? **(YES / NO)** Did the airbags deploy? **(YES / NO)**

Did you strike your head? **(YES / NO)** If yes, circle what your head hit: **Headrest, Airbag, Steering Wheel, Window, Other**

Did you strike any other body part? (eg. Knees against dashboard, etc…) **(YES / NO)** _____

Did you expect the vehicle was going to hit you? **(YES / NO)** Were you able to brace yourself? **(YES / NO)**

Was your head turned **(Right or Left)**, or looking **(Up or Down)** at the time of the impact? _____

Did you lose consciousness? **(YES / NO)** If yes, how long would you estimate you were out? _____

Patient Signature: _____ **Doctor Signature:** _____

Patient's Name: _____ Date of Injury: _____ Today's Date: _____

Documenting Your Airbag Deployment Injuries

According to the history you have provided us, your recent motor vehicle collision caused your airbag supplemental restraint system to deploy. Because of the potential for serious injuries resulting from such an event, it is important that you complete the following form to the best of your recollection. Thank you for your assistance.

A. Within moments after the time of impact, did you: ***(circle all that apply)***

1. Black-out (lose consciousness)? If so, for approximately how long were you unconscious? _____
2. Become significantly disoriented? If so, for approximately how long were you disoriented? _____
3. Experience any nose bleeds, cuts, abrasions, bruises or burns? If so, please detail: _____
4. Have double-vision and/or blurred vision? If so, for how long? _____
5. Experience hearing loss or ringing in the ears? If so, for how long? _____
6. Experience jaw pain, facial numbness/tingling? If so, for how long? _____

Comments: _____

_____

B. At any point *after* the impact, did you experience any of the following symptoms? ***(circle all that apply)***

Suspected Brain Trauma

1. Nausea
2. Vertigo/dizziness/lightheadedness
3. Neck pain/stiffness
4. Headache
5. Photophobia (sensitivity to light)
6. Phonophobia (sensitivity to loud noises)
7. Tinnitus (ringing in the ears)
8. Impaired memory
9. Difficulty concentrating
10. Impaired comprehension or awareness
11. Prolonged, unexplained staring
12. A feeling of having a "brain fog"
13. Forgetfulness
14. Impaired logical thinking
15. Difficulty with new or abstract concepts
16. Insomnia (difficulty sleeping)
17. Fatigue
18. Apathy
19. Outburst of anger
20. Mood swings
21. Depression
22. Loss of libido (sex drive)
23. Personality change
24. Intolerance to alcohol

Suspected TMD

25. Clicking in the jaw
26. Popping in the jaw
27. Locking of the jaw
28. Side shift of the jaw upon maximum opening
29. Inability to open the mouth wide
30. Pain on chewing
31. Facial pain
32. Grinding your teeth
33. Jaw muscles sore upon waking
34. Chewing on one side of your mouth
35. Painful teeth
36. Loose teeth
37. Very tender muscles in the front of the neck

Misc.

38. Painful swallowing
39. Difficulty swallowing
40. Intolerance to strong odors
41. Decreased ability to smell things
42. Decreased ability to taste foods/drinks
43. Vision changes

Comments:

_____

_____

_____

C. If any of the above symptoms were present before the motor vehicle collision, please list them below. Be sure to also identify their intensity, approximate date of onset, and their duration.

_____

_____

_____

_____

_____

_____

BACK BOURNEMOUTH QUESTIONNAIRE

Patient Name _____ Date _____

Instructions: The following scales have been designed to find out about your back pain and how it is affecting you. Please answer ALL the scales, and mark the ONE number on EACH scale that best describes how you feel.

1. Over the past week, on average, how would you rate your back pain?

No pain — Worst pain possible

0 1 2 3 4 5 6 7 8 9 10

2. Over the past week, how much has your back pain interfered with your daily activities (housework, washing, dressing, walking, climbing stairs, getting in/out of bed/chair)?

No interference — Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

3. Over the past week, how much has your back pain interfered with your ability to take part in recreational, social, and family activities?

No interference — Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

4. Over the past week, how anxious (tense, uptight, irritable, difficulty in concentrating/relaxing) have you been feeling?

Not at all anxious — Extremely anxious

0 1 2 3 4 5 6 7 8 9 10

5. Over the past week, how depressed (down-in-the-dumps, sad, in low spirits, pessimistic, unhappy) have you been feeling?

Not at all depressed — Extremely depressed

0 1 2 3 4 5 6 7 8 9 10

6. Over the past week, how have you felt your work (both inside and outside the home) has affected (or would affect) your back pain?

Have made it no worse — Have made it much worse

0 1 2 3 4 5 6 7 8 9 10

7. Over the past week, how much have you been able to control (reduce/help) your back pain on your own?

Completely control it — No control whatsoever

0 1 2 3 4 5 6 7 8 9 10

_____
Examiner

OTHER COMMENTS: _____

With Permission from: Bolton JE, Breen AC: The Bournemouth Questionnaire: A Short-form Comprehensive Outcome Measure. I. Psychometric Properties in Back Pain Patients. *JMPT* 1999; 22 (9): 503-510.

NECK BOURNEMOUTH QUESTIONNAIRE

Patient Name _____ Date _____

Instructions: The following scales have been designed to find out about your neck pain and how it is affecting you. Please answer ALL the scales, and mark the ONE number on EACH scale that best describes how you feel.

1. Over the past week, on average, how would you rate your neck pain?

No pain — Worst pain possible

0 1 2 3 4 5 6 7 8 9 10

2. Over the past week, how much has your neck pain interfered with your daily activities (housework, washing, dressing, lifting, reading, driving)?

No interference — Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

3. Over the past week, how much has your neck pain interfered with your ability to take part in recreational, social, and family activities?

No interference — Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

4. Over the past week, how anxious (tense, uptight, irritable, difficulty in concentrating/relaxing) have you been feeling?

Not at all anxious — Extremely anxious

0 1 2 3 4 5 6 7 8 9 10

5. Over the past week, how depressed (down-in-the-dumps, sad, in low spirits, pessimistic, unhappy) have you been feeling?

Not at all depressed — Extremely depressed

0 1 2 3 4 5 6 7 8 9 10

6. Over the past week, how have you felt your work (both inside and outside the home) has affected (or would affect) your neck pain?

Have made it no worse — Have made it much worse

0 1 2 3 4 5 6 7 8 9 10

7. Over the past week, how much have you been able to control (reduce/help) your neck pain on your own?

Completely control it — No control whatsoever

0 1 2 3 4 5 6 7 8 9 10

_____
Examiner

OTHER COMMENTS: _____

With Permission from: Bolton JE, Humphreys BK: The Bournemouth Questionnaire: A Short-form Comprehensive Outcome Measure. II. Psychometric Properties in Neck Pain Patients *JMPT* 2002; 25 (3): 141-148.

HEADACHE DISABILITY INDEX

Patient Name _____ Date _____

INSTRUCTIONS: Please CIRCLE the correct response:

1. I have headache: (1) 1 per month (2) more than 1 but less than 4 per month (3) more than one per week
2. My headache is: (1) mild (2) moderate (3) severe

Please read carefully: The purpose of the scale is to identify difficulties that you may be experiencing because of your headache. Please check off "YES", "SOMETIMES", or "NO" to each item. Answer each question as it pertains to your headache only.

YES	SOMETIMES	NO		
_____	_____	_____	E1.	Because of my headaches I feel handicapped.
_____	_____	_____	F2.	Because of my headaches I feel restricted in performing my routine daily activities.
_____	_____	_____	E3.	No one understands the effect my headaches have on my life.
_____	_____	_____	F4.	I restrict my recreational activities (eg, sports, hobbies) because of my headaches.
_____	_____	_____	E5.	My headaches make me angry.
_____	_____	_____	E6.	Sometimes I feel that I am going to lose control because of my headaches.
_____	_____	_____	F7.	Because of my headaches I am less likely to socialize.
_____	_____	_____	E8.	My spouse (significant other), or family and friends have no idea what I am going through because of my headaches.
_____	_____	_____	E9.	My headaches are so bad that I feel that I am going to go insane.
_____	_____	_____	E10.	My outlook on the world is affected by my headaches.
_____	_____	_____	E11.	I am afraid to go outside when I feel that a headaches is starting.
_____	_____	_____	E12.	I feel desperate because of my headaches.
_____	_____	_____	F13.	I am concerned that I am paying penalties at work or at home because of my headaches.
_____	_____	_____	E14.	My headaches place stress on my relationships with family or friends.
_____	_____	_____	F15.	I avoid being around people when I have a headache.
_____	_____	_____	F16.	I believe my headaches are making it difficult for me to achieve my goals in life.
_____	_____	_____	F17.	I am unable to think clearly because of my headaches.
_____	_____	_____	F18.	I get tense (eg, muscle tension) because of my headaches.
_____	_____	_____	F19.	I do not enjoy social gatherings because of my headaches.
_____	_____	_____	E20.	I feel irritable because of my headaches.
_____	_____	_____	F21.	I avoid traveling because of my headaches.
_____	_____	_____	E22.	My headaches make me feel confused.
_____	_____	_____	E23.	My headaches make me feel frustrated.
_____	_____	_____	F24.	I find it difficult to read because of my headaches.
_____	_____	_____	F25.	I find it difficult to focus my attention away from my headaches and on other things.

OTHER COMMENTS: _____

_____
Examiner

With permission from: Jacobson GP, Ramadan NM, et al. *The Henry Ford Hospital headache disability inventory (HDI)*. Neurology 1994;44:837-842.

ADL (ACTIVITIES OF DAILY LIVING & FUNCTIONAL ASSESSMENT)

Patient Name: _____ **Date of Injury:** _____ **Date:** _____

Instructions: Please check the activities that currently bother you. Only check one box from each column.

ACTIVITY	ANNOYS ME ONLY	SLOWS ME DOWN	HARD TO PERFORM	UNABLE TO PERFORM
Bending head and neck				
Turning head and neck				
Bending waist – lower back				
Twisting waist – lower back				
Sitting				
Standing				
Walking				
Driving a car				
Riding a bicycle				
Reaching hands over head or shoulder level				
Household chores / cleaning / vacuuming etc.				
Combing / Brushing hair / Bathing				
Typing on a keyboard / Using home computer				
Carrying objects in hand				
Gripping objects or using wrists or hands				
Sleeping / Lying in bed				
Recreational or hobby activities				
Running or jogging				
Sports activities				
Yard work / Gardening etc.				
Using cell phone or tablet				
Crouching or squatting				
Kneeling				
Pushing or pulling with arms /hands				
Reading or Writing				
Dressing myself				
Playing with my children				
Going up or down stairs				
I have pain sitting and doing nothing				
Participating in sexual activity				
SCORE 30 Total Choices				
	(0-25%)	**(26-50%)**	**(51-75%)**	**(76-100%)**

Patient Signature: _____

Office Notes: ADL Total ____ **/ 30** _____

_____

_____ **Doctor Signature:** _____

Symptoms

Patient _____ Date _____ Date of Injury _____

Please fill in all symptoms you currently have that you did not have before the accident.

Orthopedic & Musculoskeletal Symptoms

- ☐ "Clunk" sound with neck movements
- ☐ Neck pain
- ☐ Upper back pain
- ☐ Low back pain
- ☐ Shoulder pain ☐ Left ☐ Right
- ☐ Upper arm pain ☐ Left ☐ Right
- ☐ Elbow pain ☐ Left ☐ Right
- ☐ Forearm pain ☐ Left ☐ Right
- ☐ Wrist pain ☐ Left ☐ Right
- ☐ Hand pain ☐ Left ☐ Right
- ☐ Hip pain ☐ Left ☐ Right
- ☐ Upper leg pain ☐ Left ☐ Right
- ☐ Knee pain ☐ Left ☐ Right
- ☐ Lower leg pain ☐ Left ☐ Right
- ☐ Ankle pain ☐ Left ☐ Right
- ☐ Foot pain ☐ Left ☐ Right
- ☐ Jaw pain
- ☐ Clicking in Jaw
- ☐ Pain when chewing
- ☐ Face pain
- ☐ Chest pain
- ☐ Stomach pain
- ☐ Bruise to _____
- ☐ Scrape/Cut to _____
- ☐ Other Symptom _____
- ☐ Other Symptom _____

Neurological Symptoms

- ☐ Numb/Tingling Arm / Hand L R
- ☐ Numb/Tingling Leg / Foot L R
- ☐ Weakness Arm / Hand L R
- ☐ Weakness Leg / Foot L R

Symptoms Associated with Injuries

- ☐ Stiffness or limited movement in joint(s)
- ☐ Headaches
- ☐ Muscle spasms/sore muscles
- ☐ Dizziness, lightheaded, woozy feeling
- ☐ Visual disturbances or vision change
- ☐ Sleep changes/disruption of patterns
- ☐ Pain radiates from one place to another
- ☐ Anxiety or nervous when driving
- ☐ Irregular Heartbeat or uneven pulse
- ☐ Feeling depressed about things
- ☐ I am taking the following medications _____

_____

Brain/Neuropsych/MTBI/PTSD Symptoms

- ☐ I prefer being alone now (not socializing)
- ☐ I am sleepy, tired during day or doze off easily
- ☐ Upset stomach, nausea, heartburn or vomiting
- ☐ Difficulty concentrating, mind wanders easily
- ☐ I get overwhelmed easily
- ☐ Mood swings, happy one moment then sad
- ☐ Agitation (can't sit still, need to move around)
- ☐ Sadness, tearful episodes, crying easily
- ☐ Blurry vision, had to get or change glasses
- ☐ Asking people to repeat things or hearing problem
- ☐ I make wrong turns driving or can't remember time
- ☐ I get confused easily or cannot multi-task anymore
- ☐ I have difficulty finding some words when talking
- ☐ Bright lights bother me
- ☐ I cannot pay attention as long as before
- ☐ I am eating more or less than normal
- ☐ Room spins, lightheaded or woozy feeling
- ☐ Balance problems
- ☐ I feel like my head is "Foggy"
- ☐ I have forgotten computer passwords or ATM PIN
- ☐ I have to re-read things to understand what I read
- ☐ My thinking is slowed down
- ☐ Difficulty with adding/subtracting numbers
- ☐ Fear I will never be the same again
- ☐ Difficulty learning new things
- ☐ Difficulty understanding what people say to me
- ☐ Difficulty remembering or memory problems
- ☐ Cannot take on any more responsibility
- ☐ I can't make decisions as quickly as before
- ☐ Loss of libido or lack of sexual desire
- ☐ I do not feel as confident of my abilities
- ☐ I get panic attacks, fast heartbeat, nervous
- ☐ I am more irritable than usual
- ☐ Some food or drink tastes "Funny" to me now
- ☐ I get frustrated very easily
- ☐ Difficulty planning my life or organizing my work
- ☐ Flashbacks or frightening thoughts about accident
- ☐ I have had bad dreams about the accident
- ☐ I avoid places & objects that remind me about it
- ☐ I feel emotionally numb-no interest in my hobbies
- ☐ I'm feeling strong guilt, worry or depression
- ☐ I am having trouble remembering the accident
- ☐ I am easily startled since the accident - "jumpy"
- ☐ I feel tense or "on edge" most of the time
- ☐ I am having difficulty sleeping
- ☐ I get angry easily or even yell at people now

SECTION 1785.27 CIVIL CODE
A holder of this medical debt contract is prohibited by Section 1785.27 of the Civil Code from furnishing any information related to this debt to a consumer credit reporting agency. In addition to any other penalties allowed by law, if a person knowingly violates that section by furnishing information regarding this debt to a consumer credit reporting agency, the debt shall be void and unenforceable.

MEDICAL LIEN AGREEMENT

PATIENT NAME: _____ DATE OF INJURY/INCIDENT: _____
PROVIDER NAME: _____
ATTORNEY NAME: _____ LAW FIRM NAME: _____

Patient ("Patient") desires medical treatment by Provider, including all entities and specialists that provide services for, at or through Provider (collectively, "Provider") for injuries sustained in a personal injury incident ("Incident"). Patient has or shall retain Attorney ("Attorney") to seek compensation ("Litigation"). At Patient's request, Provider agrees to treat Patient on a "lien" basis ("Medical Lien"), establishing a debtor-creditor contractual relationship, whereby Patient remains responsible to pay Provider's bill ("Bill"), but Provider agrees wait to be paid until the conclusion of the Litigation. However, if any provision of this Medical Lien is not strictly complied with by Patient or Attorney, Provider may declare a breach of this Medical Lien agreement, and Patient agrees to then pay the full balance owed Provider immediately; and, if Patient fails to timely pay, Provider may immediately file a lawsuit for the monies owed plus any other claims and/or entitlements based upon the number, type and extent of the breach(es) involved. The following terms and conditions apply:

1. Provider's Medical Lien is against all payments arising from the Incident, including but not limited to, settlement proceeds, "med pay", or payment of a judgment arising from the Litigation ("Proceeds").
2. Patient and Attorney acknowledge that even if Attorney drops Patient in the Lawsuit, or, the Litigation results in no recovery, Patient must still pay Provider the full Bill amount regardless of the Litigation outcome. Patient and Attorney further acknowledge there is no requirement that Provider discount the Bill.
3. Provider considers lien reduction requests on a case-by-case basis, provided Patient and Attorney are timely, fully cooperative, and provide all information requested by Provider. Any reduction on Patient's Bill must be agreed to by Provider in writing. Bill reduction requests should be made prior to any Lawsuit settlement, so that Patient knows if, and the extent, Provider is willing to reduce the Bill.
4. All Bill reductions are contingent upon Provider receiving the agreed payment within 10 calendar days of receipt by Attorney or Patient of any Proceeds, or within sixty 60 calendar days from the date of Provider's signed reduction agreement, whichever occurs first (even if no expiration period is stated in the Bill reduction letter or agreement). If payment is not timely received by Provider, the prior Bill reduction agreement is rendered null and void, and the full Bill is due and owing (and Attorney or Patient will need to make a new reduction request which Provider is not obligated to accept).
5. Any modification of this Medical Lien not initialed by Provider in writing, will result in the original non-modified Medical Lien as originally presented by Provider (prior to any attempted changes) being the binding Medical Lien, without the modifying language.
6. All "med pay" arising from the Incident is expressly and permanently assigned by Patient to Provider and will be immediately paid to Provider if received by Attorney or Patient. Med pay received will reduce the outstanding Bill by the amount of the "med pay" received by Provider.
7. Any sums owing to Provider shall accrue interest at the rate of ten percent (10%) per annum from the date of treatment until the outstanding balance is fully paid ("the full Bill"). Provider is also entitled to any consequential damages incurred (e.g., costs of third party collection services, administrative fees/costs to address matter with Attorney and/or Patient). The prevailing party in any action to enforce this Medical Lien shall be entitled to their reasonable attorney's fees and costs. Venue for any disputes arising under this Medical Lien shall be in the county where Provider is located. If Patient is or becomes unrepresented by an attorney or brings a Small Claims action rather than a Lawsuit in Municipal or Superior Court, then Provider may declare a breach of this Medical Lien. Attorney and Patient shall keep Provider or Provider's agent updated on the Lawsuit status, communicate timely the date of filing of a Complaint, setting or moving of trial/arbitration/mediation, filing a Small Claims action, any change in Patient's representation or if co-counsel brought in to try the matter (co-counsel to be bound by this same Medical Lien). Best efforts shall be used, and time is of the essence, for all performances under this Medical Lien. This Medical Lien may be sold, transferred or assigned by Provider to a third party.

ALL THE ABOVE IS AGREED TO:

PATIENT (SIGN): _____ DATE:_____
ATTORNEY (SIGN): _____ DATE: _____
PROVIDER (SIGN): _____ DATE: _____

ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO DOCTOR
PRIVATE AND GROUP ACCIDENT AND HEALTH INSURANCE

Patient Name _____
Claim/Group# _____
SS#/ID# _____

I hereby instruct and direct the _____ Insurance Company to pay by check made out to and mailed directly to:

Kyle Tetz Chiropractic Inc.
330 Rancheros Dr Suite 202
San Marcos, CA 92069

for professional or medical expense benefits allowable under my current insurance policy as payment toward the total charges for professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional fees for non-covered services and/or fees over and above the insurance payment or as required by my insurance policy.

A photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this claim. .

Date _____

_____ _____
Signature of Policyholder Witness

_____
Signature of Claimant, if other than Policyholder

ProRehab
Integrated Healthcare Specialists LLC

AUTHORIZATION FOR RELEASE OF RECORDS FROM:

_____

_____

_____

_____

_____

I HEREBY REQUEST AND AUTHORIZE THE RELEASE OF RECORDS TO:

Dr. Kyle Tetz, DC
Kyle Tetz Chiropractic Inc.
330 Rancheros Dr Suite 202
San Marcos, CA 92069
PH/FAX: 760-630-8060
EMAIL: info@prorehabwellness.com

☐ ALL RECORDS

☐ HEALTH RECORDS DATE(S):_____ TO _____

☐ X-RAY, MRI, CT REPORTS

☐ OTHER: _____

PATIENT'S NAME: _____

PATIENT'S SIGNATURE: _____

PATIENT'S DATE OF BIRTH: _____

DOCTOR'S SIGNATURE: _____

Auto Insurance Information

Patient Name: _____
Date of Birth: _____

Your Auto Insurance Company

Name of Insurance Company: _____
Name of Insured: _____
Claim Number: _____
Insurance Adjuster's Name: _____
Insurance Adjuster's Phone Number: _____

Third Party Insurance Company (other driver)

Name of Insurance Company: _____
Name of Insured: _____
Claim Number: _____
Insurance Adjuster's Name: _____
Insurance Adjuster's Phone Number: _____

Attorney Information

Name of Attorney: _____
Phone Number: _____