Chiropractic, Acupuncture & Massage Center

Dr. Amir Ahmadiyar, D.C.

Your Back to Health Choice for All Ages

Authorization to Pay Physician

I hereby authorize _____ Insurance Company to pay by check and mail directly to:

Greater Falls Church Chiropractic Center
6521 Arlington Boulevard, Suite 100
Falls Church, VA 22042

Ashburn Chiropractic Center
44121 Harry Byrd., Suite 145
Ashburn, VA 20147

If my current policy prohibits direct payment to the doctor, I hereby also instruct and direct you to make out the check to me and mail it to the above named address for the professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the 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 service charges over and above the insurance payment.

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 case.

I authorize the doctor to initiate a complaint to the insurance commissioner for any reason on my behalf.

_____ _____

Print Name **Date**

_____

Signature

CHIROPRACTIC, ACUPUNCTURE & MASSAGE CENTER
Dr. Amir Ahmadiyar, D.C.

PART 1

AUTO ACCIDENT INJURY INFORMATION

1. What was you position in the vehicle?
_____ Driver _____ The rear passenger _____Other: _____
_____ The front passenger _____ A pedestrian

2. What type of vehicle were you driving?
_____ Compact car _____ Full size car _____ Full size truck _____ Full size van
_____ Mid size car _____ Compact truck _____ Mini Van _____ Motocycle
_____ Compact sport utility vehicle _____ Motorhome _____ Bicycle
_____ Full size sport utility vehicle _____ Other _____

3. What speed were you traveling at the time of accident?
_____ Stopped at a stop light _____At a complete stop _____ Moving slowly
_____ Merging into traffic _____ Slowing down at an intersection
_____ Travelling faster than 65mph _____Travelling at approximately ( ) mph
_____Other _____

4. Who hit whom?
_____ Was struck by another vehicle _____ Struck a stationary object _____ Struck another vehicle
_____ Other _____

5. What was your vehicle's point of impact?
_____ On the front _____ On the left front _____ On the rear _____On the left rear
_____On the right front _____ On the middle front _____ On the right rear
_____ On the middle rear _____ On the right side _____ On the right rear side _____ On the left side
_____ On the front right side _____ On the middle right side _____ On the front left side
_____ On the rear left side _____ Other _____

6. What speed was the other vehicle traveling?
_____ Stopped at a stop light _____ At a complete stop _____ Moving slowly
_____ Slowing down for an intersection ____ Merging into traffic ____ Travelling faster than 65mph
_____ Travelling at approximately ( ) mph _____ Other _____

7. What was the other vehicle's point of contact?
_____ On the front _____ On the left front _____ On the rear _____ On the right front
_____ On the middle front _____ On the right rear _____ On the left rear _____ On the right side
_____ On the right rear side _____ On the middle rear _____ On the front right side
_____ On the left side _____ On the middle right side _____ On the rear left side
_____ On the front left side _____ On the middle left side _____ Other _____

8. Were you wearing seat restraints?
_____ Was wearing a full lap and shoulder restraint _____ Was wearing a shoulder restraint
_____ Was wearing a lap restraint _____ Was not wearing any restraints _____ Other _____

9. What position were your vehicle head rests in?
_____ Did have a head rest which was adjusted in the lowest position
_____ Did have a head rest which was adjusted in the middle position
_____ Did have a head rest which was adjusted in the highest position
_____ Was not equipped with a head rest?
_____ Other _____

10. Did your air bag deploy?
_____ Air bags were deployed _____ Air bags were not deployed _____ Other _____

11. Were you prepared for the impact?
_____ Was completely surprised by the accident _____ Saw the collision coming
_____ Saw the collision coming and braced appropriately _____ Other _____

12. What position was your body in just prior to impact?
_____ A straight position _____ A tiled position _____ A position rotated to the left
____ A position rotated to the right ____ A position that cannot be remembered ____ Other _____

12. What happened to your body the moment of impact?
_____ Body was tensed for impact _____ Body violently torqued and twisted
_____ Body was thrown over the seat _____ Body whipped violently forward and backward
_____ Body was thrown from the vehicle _____ Body was pinned in the vehicle
_____ Body was badly cut and bruised _____ Other _____

13. What was your mental / emotional state immediately following the accident?
_____ Was not rendered unconscious by the impact of the accident
_____ Was not rendered unconscious but was shaken and disoriented
_____ Was not rendered unconscious was shaken up
_____ Was not rendered unconscious by the impact of the accident
_____ Other _____

14. Did you receive medical attention at the scene of the accident?
_____ Was taken to the hospital _____ Was taken to a personal physician
_____ Was taken home _____ Was taken to this office _____ Resumed activities
_____ Other _____

PART 2
LIST EACH OF THE BODY PART THAT STRUCK THE FOLLOWING VEHICLE PARTS DURING THE ACCIDENT

1. DASHBOARD

_____ Right side of the head _____ Right arm _____ Right wrist _____ Right knee
_____ Right shoulder_____ Right elbow _____ Right hip _____ Right ankle
_____ Left side of the head _____ Left arm _____ Left wrist _____ Left knee
_____ Left shoulder _____ Left elbow _____ Left hip _____ Left ankle _____ Other

2. WINDSHIELD

_____ Right side of the head _____ Right arm _____ Right wrist _____ Right knee
_____ Right shoulder _____ Right elbow _____ Right hip _____ Right ankle
_____ Left side of the head _____ Left arm _____ Left wrist _____ Left knee
_____ Left shoulder _____ Left elbow _____ Left hip _____ Left ankle _____ Other

3. STEERING WHEEL

_____ Right side of the head _____ Right arm _____ Right wrist _____ Right knee
_____ Right shoulder _____Right elbow _____ Right hip _____ Right ankle
_____ Left side of the head _____ Left arm _____ Left wrist _____ Left knee
_____ Left shoulder _____ Left elbow _____ Left hip _____ Left ankle _____ Other

4. RIGHT DOOR

_____ Right side of the head _____ Right arm _____ Right wrist _____ Right knee
_____ Right shoulder _____ Right elbow _____ Right hip _____ Right ankle
_____ Left side of the head _____ Left arm _____ Left wrist _____ Left knee
_____ Left shoulder _____ Left elbow _____ Left hip _____ Left ankle _____ Other

5. LEFT DOOR

_____ Right side of the head _____ Right arm _____ Right wrist _____ Right knee
_____ Right shoulder _____ Right elbow _____ Right hip _____ Right ankle
_____ Left side of the head _____ Left arm _____ Left shoulder _____ Left elbow
_____ Left wrist _____ Left knee _____ Left hip _____ Left ankle _____ Other

6. SEAT FRAME

_____ Right side of the head _____ Right arm _____ Right wrist _____ Right knee
_____ Right shoulder _____ Right elbow _____ Right hip _____ Right ankle
_____ Left side of the head _____ Left arm _____ Left wrist _____ Left knee_____ Left ankle
_____ Left shoulder _____ Left elbow _____ Left hip _____ Other

7. UNKNOWN OBJECT

_____ Right side of the head _____ Right arm _____ Right wrist _____ Right knee
_____ Right shoulder _____ Right elbow _____ Right hip _____ Right ankle
_____ Left side of the head _____ Left arm _____ Left wrist _____ Left knee
_____ Left shoulder _____ Left elbow _____ Left hip _____ Left ankle _____ Other

CHIROPRACTIC, ACUPUNCTURE & MASSAGE CENTER

DR. AMIR AHMADIYAR, D.C.

Your Back to Health Choice for All Ages

Confidential Health History

Last Name: _____ First Name: _____
Address: _____

City:_____ State:_____ ZIP: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Email Address: _____

Date of Birth: _____ Age: _____ Sex: _____ Female: _____ Male

SS#: _____ Driver's License #: _____

Employer:_____ Type of Work: _____

Employment Status: _____Full Time _____ Part Time _____ Not Employed _____Retired_____

Marital Status: _____ Single _____ Married _____Widowed: _____Divorced _____ Separated: _____

Name of Spouse:_____Spouse SS#: _____

Spouse Employer:_____ Work Phone:_____

Emergency Contact Name:_____ Phone:_____

******Referred to this office by:_____**

PLEASE CIRCLE TYPE OF PATIENT:

SELF PAY INSURANCE AUTO ACCIDENT WORKER'S COMP

HEALTH INSURANCE INFORMATION

Primary Insurance: _____
Policy Holder: Self Spouse Other _____

ID#: _____
Group #: _____

Policy Holder's Name: _____

Date of Birth: _____

SS #: _____

Sex: _____ Male _____ Female

Secondary Insurance: _____
Policy Holder: Self Spouse Other_____

ID#:_____
Group #: _____

Policy Holder's Name:_____

Date of Birth: _____

SS #: _____

Sex: _____ Male _____ Female

****

I understand and agree that health and accident insurance policies are an arrangement between insurance carriers and my self. Furthermore, I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized should be paid directly to the Doctor's Office will be credited to me account on receipt. However, I clearly understand and agree that 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. In the event my account is past due for 60 days from the date of service, and is turned over to an attorney for collection, I will also be liable for attorney's fees in the amount 1/3 of the principal balance, plus court costs.

PATIENT'S SIGNATURE:_____ DATE: _____

CHIROPRACTIC, ACUPUNCTURE & MASSAGE CENTER
Dr. Amir Ahmadiyar, D.C.

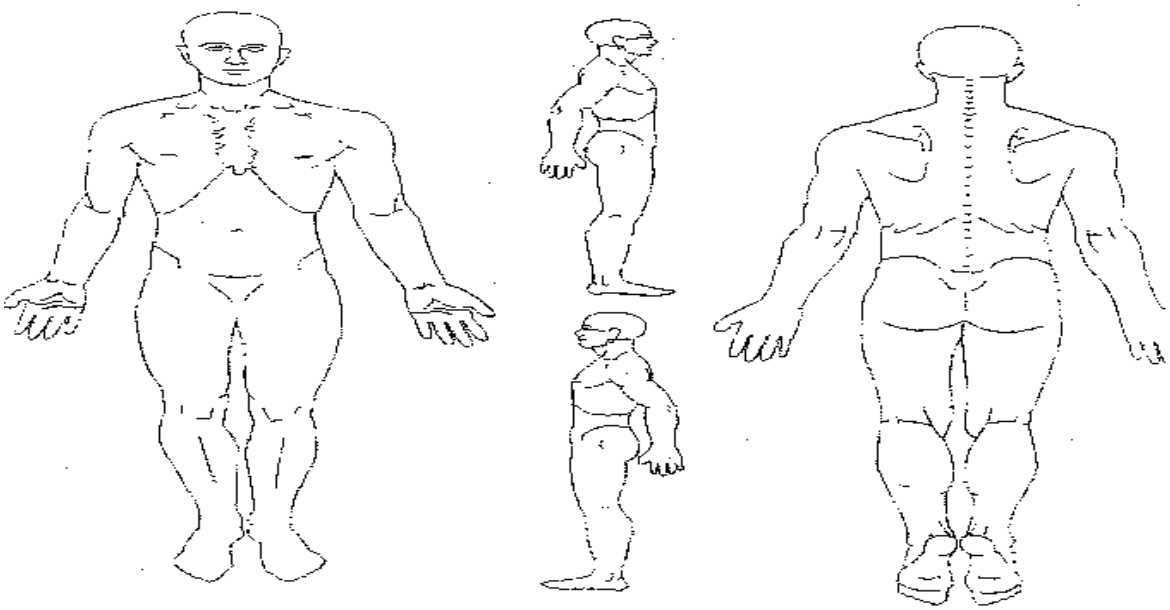
Health History Form

1. Reason for seeking chiropractic care
   a. PRIMARY REASON _____
   b. SECONDARY REASON _____
2. How long have you had this problem? _____ Years _____ Months _____ Weeks
3. Is this your first episode of this pain? _____ YES _____ NO
4. Does anything make the complaint better? _____
5. Does anything aggravate the complaint? _____
6. Have you seen another doctor for this problem? _____ YES _____ NO
7. Please circle the quality of pain: Dull Aching Sharp Shooting Burning Throbbing Deep Nagging Other _____
8. Grade intensity/severity (0-No pain. 10 Worst pain) 0 1 2 3 4 5 6 7 8 9 10
9. Rate Frequency: Occasional (20% awake time) Intermittent (26-50% of awake time) Frequent (51-75% of awake time) Constant (76-100% of awake time)

****

Please mark the location of your pain or discomfort on the images below.
Use symbols shown to represent type (s) of pain.

D – DULL
S – STABBING
B – BURNING
T – TINGLING (PINS & NEEDLES)
N – NUMB
C – CRAMPING



Name: _____ Date: _____

Signature: _____

****

FOR DOCTOR USE ONLY

DIAGNOSIS: ___.__ ___.__ ___.__ TREATMENT PLAN: _____

CHIROPRACTIC, ACUPUNCTURE & MASSAGE CENTER
Dr. Amir Ahmadiyar, D.C.
Your Back To Health Choice For All Ages

AUTO INSURANCE INFORMATION FORM

Patient Name: _____

Date of Accident: _____

Is a Lawyer Hired? **YES NO**

Lawyer's Name: _____

Lawyer's Telephone #: _____

Lawyer's Fax #: _____

Lawyer's Address: _____

_____

Patient's Auto Insurance Name: _____

Patient's Auto Insurance Policy # : _____

Patient's Claim # : _____

Medical Expenses (MED PAY)? YES NO How Much? $_____

Patient's Auto Insurance Telephone #: _____

Patient's Auto Insurance Fax #: _____

Patient's Auto Insurance Adjustor's Name: _____

Patient's Auto Insurance Address: _____

_____

Third Party Auto Insurance Name: _____

Third Party Auto Insurance Policy # : _____

Third Party Claim #: _____

Third Party Auto Insurance Telephone #:_____

Third Party Auto Insurance Fax #: _____

Third Party Auto Insurance Adjustor's Name: _____

Third Party Auto Insurance Address: _____

_____

CHIROPRACTIC, ACUPUNCTURE & MASSAGE CENTER

Dr. Amir Ahmadiyar, D.C.

Notice of Practices Acknowledgement

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 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 description of the uses and disclosures of my health information. I understand that this organization has the right to charge its Notice of Privacy Practices from time to time and that I may contact the organization at any time at the address above to obtain a current copy of the 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 and 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 such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

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: _____ Initials: _____ Reason: _____

CHIROPRACTIC, ACUPUNCTURE & MASSAGE CENTER

Dr. Amir Ahmadiyar, D.C.

Your Back to Health Choices for All Ages

Notice of Doctor's Lien

PATIENT: _____ DATE OF ACCIDENT: _____

I do hereby authorize DR. AMIR H. AHMADIYAR AT GREATER FALLS CHURCH CHIROPRACTIC CENTER to furnish you, my attorney, with a full report of his examination, diagnosis, treatment, prognosis, etc. of myself in regard to the accident in which I was recently involved.

I hereby authorize and direct you, my attorney, to pay directly to said doctor such sums as may be due and owing him for medical services rendered me both by reason of this accident and by reason of any other bills that are due his office and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect and fully compensate said doctor. And I hereby further give a Lien on my case to said doctor against any and all proceeds from my settlement, judgment, or verdict which may be paid to you, my attorney, or myself, as a result of the injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by him for services rendered me and this agreement is made solely for said doctor's additional protection and in consideration of his awaiting payment. And I further understand that such payment is not contingent upon any settlement, judgment, or verdict by which I may eventually recover said fee.

I agree to promptly notify said doctor of any change or addition of attorney(s) used by me in advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment but may declare the entire balance due and payable.

_____ _____

PATIENT SIGNATURE DATE

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

_____ _____

ATTORNEY SIGNATURE DATE

Please date, sign, and return one copy to doctor's office. Also keep one copy for your records.

Dr. Amir H. Ahmadiyar, Clinic Director

6521 Arlington Boulevard, Suite 100, Falls Church, Virginia 22042 Tel. (703) 538-6666 Fax (703) 538-6675