

CHIROPRACTIC AUTOMOBILE ACCIDENT INTAKE

~ Please answer all questions completely ~

NAME: _____ DATE: _____ SSN: _____
Address: _____ City: _____ Zip: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____
Occupation: _____ Age: _____ Birth Date: _____ Marital Status: M S W D
EMAIL: _____ Referred by: _____

DATE OF ACCIDENT: _____ TIME OF ACCIDENT _____ CITY & STATE _____

PATIENT'S AUTO INSURANCE CO.: _____
POLICY #: _____ CLAIM #: _____
NAME OF YOUR INSURANCE ADJUSTER: _____
PHONE #: _____ FAX #: _____

NAME OF DRIVER OF OTHER VEHICLE : _____ PHONE #: _____
OTHER DRIVER INSURANCE CO.: _____ PHONE #: _____
INSURANCE ADJUSTER: _____
POLICY #: _____ CLAIM #: _____

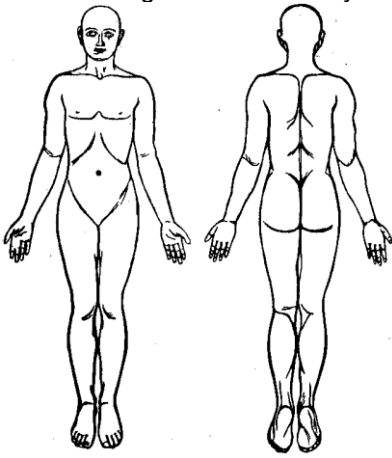
Name of driver of vehicle if you were a passenger: _____
Other drivers insurance company: _____ Policy #: _____ Phone #: _____
Insurance adjuster: _____ Claim #: _____

HAVE YOU RETAINED AN ATTORNEY? () YES () NO
ATTORNEY NAME: _____ PHONE #: _____

PLEASE DESCRIBE YOUR ACCIDENT IN DETAIL: _____

Please describe your present complaints.

Please outline on the diagram the area of your discomfort.



Were you heading: North (___) South (___) East (___) West (___)
 On (street or highway) _____
 Other vehicle was heading: North (___) South (___) East (___) West (___)
 On (street or highway) _____
 Road conditions at the time of accident: Wet (___) Dry (___) Icy (___) Other (___)
 Did the police come to the accident scene? Yes (___) No (___)
 Were you taken to the hospital? Yes (___) No (___)
 If yes, what hospital? _____ How did you get to hospital? _____
 What parts of your body were x-rayed at the hospital? _____
 What treatment was given? _____
 What was the diagnosis? _____
 Was another doctor consulted after your accident? Yes (___) No (___) Doctor's name: _____
 What treatment was given? _____
 What was diagnosis? _____

THE FOLLOWING QUESTIONS PERTAIN TO YOU, THE PATIENT AND THE VEHICLE YOU WERE IN:

List the year, make, and model of the vehicle you were in:
 Year _____ Make _____ Model _____
Where were you seated in the vehicle? _____
 Were you aware of the approaching collision prior to impact, or did the impact catch you by surprise? _____
 Did you lose consciousness (black out) upon impact? Yes (___) No (___)
 If you did lose consciousness, estimate for how long _____
 How far is the top of the headrest or seatback from the top of your head (approximately) _____ inches above / below
 Were you wearing a seatbelt? Yes (___) No (___) lap seatbelt or shoulder-lap seatbelt (please circle)
 Was your car stopped at the time of impact? Yes (___) No (___)
 If "yes" was the driver's foot also on the brake? Yes (___) No (___)
 If "no" please estimate the speed of the vehicle you were in _____ m.p.h.
 If the vehicle was moving at the time of impact, was it: Slowing down? Yes (___) No (___)
 Gaining speed? Yes (___) No (___) Traveling at a steady rate of speed? Yes (___) No (___)
 What bleeding cuts did you get during this accident? _____

What bruises did you get during this accident? _____

On what part of the auto did the following body parts hit:
 Head hit _____ Chest Hit _____
 Right/left shoulder hit _____ Right/left arm hit _____
 Right/left hip hit _____ Right/left leg hit _____
 Right/left knee hit _____ Other _____

What is the cost damage to the vehicle you were in? _____

What of the following car parts broke during the accident:
 Windshield (___) Front seat back (___) Right/left side window (___) Steering wheel (___)

Were you facing straight forward at the time of collision? Yes (___) No (___)

If "no", which direction were you turned and by how much? _____

- Check symptoms you have noticed since accident:
- | | | | | |
|--|---|--|--|--|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Irritability | <input type="checkbox"/> Numbness in toes | <input type="checkbox"/> Face Flushed | <input type="checkbox"/> Feet cold |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Buzzing in ears | <input type="checkbox"/> Hands cold |
| <input type="checkbox"/> Neck Stiff | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Loss of balance | <input type="checkbox"/> Stomach upset |
| <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Head seems too heavy | <input type="checkbox"/> Depression | <input type="checkbox"/> Fainting | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Pins & Needles in Legs | <input type="checkbox"/> Lights bother eyes | <input type="checkbox"/> Loss of smell | <input type="checkbox"/> Cold sweats |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Pins & Needles in Arms | <input type="checkbox"/> Loss of memory | <input type="checkbox"/> Loss of taste | <input type="checkbox"/> Fever |
| <input type="checkbox"/> Tension | <input type="checkbox"/> Numbness in fingers | <input type="checkbox"/> Ears ring | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Other _____ |

Have you lost time from work as a result of this accident? Yes (___) No (___)

If yes, please complete this question:
 • Last day worked: _____
 • Type of employment: _____

THE FOLLOWING QUESTIONS PERTAIN TO THE OTHER VEHICLE INVOLVED IN THE ACCIDENT:

What is the year, make, and model of the other vehicle?

Year _____ Make _____

Model _____

Was the other vehicle moving at the time of the collision?

Yes (___) No (___)

If "yes", what was its approximate speed? _____ m.p.h.

If the other vehicle was moving at the time of collision, was it:

- Slowing down?
- Gaining speed?
- Traveling at a steady rate of speed?

Yes (___) No (___)

Yes (___) No (___)

Yes (___) No (___)

Patient or Guardian Signature

Date

Wellness for Life Chiropractic

Personal Injury Policy

Personal Injury (*auto accident and personal accidents*) is covered for chiropractic care.

If you have been injured in an accident we will bill your insurance carrier for you. If you have PIP coverage on your auto policy your insurance will cover your care here even if you were not at fault. Your carrier will then be reimbursed by the responsible carrier at the time you settle your claim.

If you have an attorney for your claim please advise our office of the name and address so that we may keep their office up to date on your care and billings from this office.

If you do not have PIP coverage on your auto insurance policy and have only third party as insurance this office recommends you to have an attorney for your claim. This is to protect our fees and we will wait to be paid at settlement if you have an attorney and we have the appropriate forms and information regarding the accident. If you choose not to have an attorney in this instance, you may be required to either pay for your care as you go or if you have group medical insurance we will bill them for you.

If you are represented by an attorney we will ask you to sign an Attorney Lien Form authorizing your attorney to withhold from your settlement any amounts still due our office at the time of settlement.

It is quite common for insurance companies to require additional information (*from doctor and patient*) before paying for services. Please notify our office *as soon as possible* so we can help you receive your full benefits under your personal injury policy.

Print Name: _____

Patient's/Guardian's Signature: _____

Date: _____

I fully understand that I am directly and fully responsible for all services rendered to me. I further understand that payment for services is not contingent on any settlement, judgment or verdict by which I may eventually recover.

Patient's/Guardian's Signature: _____

Date: _____

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of another health care provider.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, _____ have read and fully understand the above statements.
(print name)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

(signature)

(date)

Consent to evaluate and adjust a minor child

I, _____ being the parent or legal guardian of
_____ have read and fully understand the above terms of
acceptance and hereby grant permission for my child to receive chiropractic care.

(Parent or Guardian signature)

(date)

Wellness for Life Chiropractic

6700 15th Ave NW
Seattle, WA 98117
206-784-3494

Notice of Privacy Practices Acknowledgment

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 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 Practice Practices containing a more complete description of the uses and disclosures of my health information. I understand that this practice 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 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 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: _____

Signature: _____

Relationship if other than patient: _____

Date: _____

FOR OFFICE STAFF ONLY

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

Date: _____

Reason: _____

Name: _____

Notice of Privacy Practices

This notice describes how medical information about you may be used, disclosed and how you can get access to this information.

Please review it carefully

The Health Insurance Portability and Accountability Act of 1996 HIPAA is a Federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form; whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may disclose your medical record only for each of the following purposes: **Treatment, payment and health care operations.**

- **Treatment** means providing coordinating or managing health care and related services by one or more health care providers. Examples of this would include your primary care physician, physical or massage therapist, etc.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost management analysis, and customer service. An example would be internal quality assessment review.

We may also create and distribute the identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken action relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer to be forwarded to medical records.

- The right to request restrictions on certain uses and disclosures of protected health information including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of April 14, 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in affect. We reserve the rights to change the terms of our *Notice of Privacy Practices* and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised *Notice of Privacy Practices* from this office.

You have recourse if you feel your privacy protections have been violated. You have the right to file a written complaint with our office, or with the Department of Health and Human Services, Office of Civil Rights about violations of the provisions of this notice. We will not retaliate against you for filing a complaint.

Please feel free to contact us for more information.

For more information about HIPAA or to file a complaint:

The U.S. Department of Health & Human Services
Office of Civil Rights

200 Independence Avenue SW

Washington, DC 20201

(202) 619-0257 Toll Free; (877) 696-6775