

# MESSAGE 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: \_\_\_\_\_  
Allergies to any oil, creams or fragrances? \_\_\_\_\_

DATE OF ACCIDENT: \_\_\_\_\_ TIME OF ACCIDENT \_\_\_\_\_ CITY & STATE \_\_\_\_\_

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

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

PLEASE BRIEFLY DESCRIBE WHAT HAPPENED: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List make and model of the vehicle you were in: Make \_\_\_\_\_ Model \_\_\_\_\_

List make and model of the other vehicle: Make \_\_\_\_\_ Model \_\_\_\_\_

Where was the location of impact: \_\_\_\_\_

Did your vehicle strike any other vehicles/objects? If yes, please describe: \_\_\_\_\_

Were you aware of the approaching collision prior to impact, or did the impact catch you by surprise? \_\_\_\_\_

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? Yes (\_\_\_) No (\_\_\_)
- Gaining speed? Yes (\_\_\_) No (\_\_\_)
- Traveling at a steady rate of speed? Yes (\_\_\_) No (\_\_\_)

Were you the driver or passenger: \_\_\_\_\_

**Where** were you seated in the vehicle? \_\_\_\_\_

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

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

Were you wearing a seatbelt? Yes (\_\_\_) No (\_\_\_) lap seatbelt or shoulder-lap seatbelt (please circle)

Does your vehicle have a headrest and was it set for you? \_\_\_\_\_

What were you doing just before the collision: \_\_\_\_\_

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 (\_\_\_)  
 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? \_\_\_\_\_

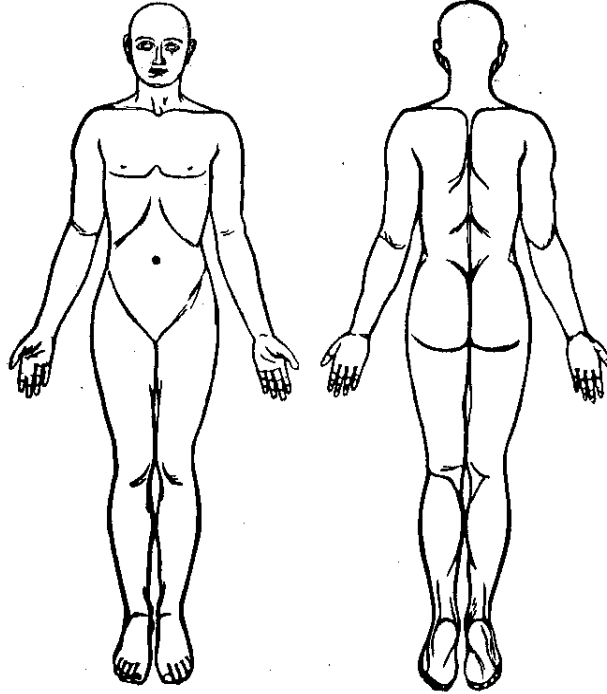
What was diagnosis? \_\_\_\_\_

Did you lose consciousness (black out) upon impact?                      Yes (\_\_\_)                      No (\_\_\_)

If you did lose consciousness, estimate for how long \_\_\_\_\_

What bruises did you get during this accident? \_\_\_\_\_

On what part of the auto did the following body parts hit (mark with an X):



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"/> Diarrhea        | <input type="checkbox"/> Other _____   |
| <input type="checkbox"/> Nervousness       | <input type="checkbox"/> Pins & Needles in Arms | <input type="checkbox"/> Loss of memory      | <input type="checkbox"/> Cold sweats     |  |
| <input type="checkbox"/> Tension           | <input type="checkbox"/> Numbness in fingers    | <input type="checkbox"/> Ears ring           | <input type="checkbox"/> Fever           |  |

Anything else I should know about the accident: \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_

\_\_\_\_\_  
 Patient or Guardian Signature

\_\_\_\_\_  
 Date

# MASSAGE THERAPY CANCELLATION POLICY

- Please give 24-hour notice if you need to cancel your appointment.
- If you do not give us notification to cancel your appointment, we may be unable to fill that time slot with other patient's needing care. Out of consideration for others, please call to cancel your appointment if you can not make it.
- **\$35.00** will be charged for missed appointment without 24-hours notice. However, this charge will be waived should your time slot later be filled.
- Insurance companies do not cover missed appointments and it is illegal for us to bill them for appointments the client did not receive.

Your signature below indicates you agree and will abide by this clinic policy.

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# Wellness for Life Chiropractic

6700 15<sup>th</sup> 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: \_\_\_\_\_

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### **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 converge, 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.

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### ***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