ATLAS SPINAL CARE
16500 SE 15th St Suite 160 Vancouver, WA 98683
Phone (360) 718- 7944
Fax (360) 718- 7931

MOTOR VEHICLE ACCIDENT INTAKE

PATIENT INFORMATION

Patient Name:_____ If a Minor, Responsible Party:_____

Gender Identity:_____ Legal Sex:_____ Preferred Pronouns:_____

Address:_____ City:_____ State:_____ Zip:_____

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

Occupation:_____ Employer:_____

Marital Status:_____ No. of children:_____ Email:_____

Home #:_____ Work #: _____Cell #: _____ Best way to contact:_____

Emergency Contact: Name: _____ Relationship:_____

Home #: _____ Cell #:_____

BILLING INFORMATION

Date of Accident: _____/_____/_____ Time of Day:____:____ AM / PM

Vehicle you were in: Year:_____ Make:_____ Model:_____

Name of Driver:_____

<u>YOUR</u> Insurance Company:_____ Phone #: _____-_____-_____

Has a **PERSONAL INJURY (PIP)** claim been filed? ☐ No ☐ Yes Claim #:_____

Name of Adjuster:_____

Other Vehicle: Year:_____ Make:_____ Model:_____

Name of Driver:_____

<u>OTHER DRIVER'S</u> Insurance Company:_____ Phone #: _____-_____-_____

Has a claim been filed? ☐ No ☐ Yes Claim #:_____

Name of Adjuster:_____

Is an attorney representing you? ☐ No ☐ Yes Name:_____ Phone #: _____

HEALTH HISTORY

What other treatments have you had for your current complaints?

☐ Chiropractic ☐ Physical Therapy ☐ Neurologist ☐ Medication ☐ Surgery ☐ Orthopedic

Other:_____

Name of Doctor(s) who have treated you for this condition:_____

Date of Last Physical Exam: _____ Spinal X-Ray:_____ MRI:_____ CT Scan:_____

List any allergies you currently have (food, medication, etc): _____

_____

List any medications you are currently taking:_____

_____

List any vitamins/herbs/minerals you are currently taking:_____

_____

Previous surgeries and dates:_____

Broken bones and dates:_____

Falls/injuries and dates:_____

**Female Patients* Are you pregnant? ☐ No ☐ Yes Beginning of last menstrual cycle: _____

Circle any of the following conditions you have had or are currently experiencing:

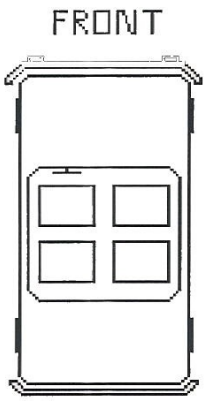
Earache	Epilepsy/Seizures	Anxiety/Depression	Arm/Shoulder Pain	Arthritis
Asthma	Bladder Problems	Cancer	Chronic Fatigue	Deafness
Diabetes-	Digestion Problems	Ear Ringing	High Blood Pressure	Headaches
Type 1 Type 2	Hepatitis	Herniated Disk	Insomnia	Kidney Problems
Heart Disease	Neck Pain	Mid-Back Pain	Migraines	
Leg Pain	Osteoporosis	Poor Circulation	Prostate Issues	
Low Back Pain	Scoliosis	Shingles	Rheumatoid Arthritis	

Stressors:

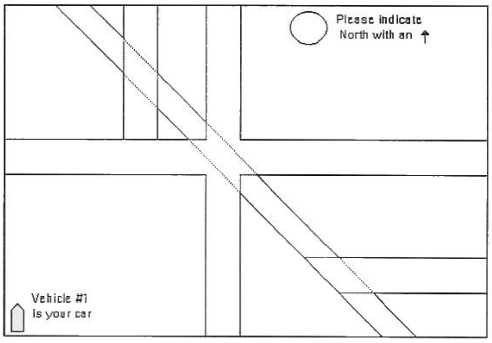
☐ Smoking Packs/Day_____
☐ Alcohol Drink/Week_____
☐ Caffeine Cups/Day_____
☐ High Stress Level Reason_____

Exercise:

☐ None
☐ Moderate
☐ Heavy
_____# of days/week



SHADE AREAS OF IMPACT



Describe how the accident occurred:_____

_____

Location of accident:_____ City:_____ State:_____

Was accident investigated by law enforcement? ☐No ☐Yes Which agency? City/County/Sheriff/State

Case #:_____ Did you complete a State Accident form? ☐No ☐Yes *(please provide report if yes)*

ACCIDENT ENVIRONMENTAL CONDITIONS

Circle What Applies:

A) The weather was: Clear / Cloudy / Foggy

B) The road conditions were: Dry / Wet / Icy / Snow Covered

C) The road surface was: Concrete / Asphalt / Dirt / Gravel

D) At the time of the accident, it was: Raining / Drizzling / Snowing / Hail / Dry

MECHANICS OF ACCIDENT

Your position in the car: ☐Driver ☐Front Passenger ☐Right Rear ☐Left Rear Other:_____

At the time of the accident, were you: ☐Looking Forward ☐Looking Right ☐Looking Left

At the time of the accident, were you: ☐ Stopped ☐ Moving Forward ☐Moving Backwards

Did you have a: ☐ Stop Sign ☐Yield Sign ☐Traffic Light- Color _____ ☐ No Traffic Control

This was a: ☐Head-on collision ☐Rear-end collision ☐T-Bone collision ☐ One Car Collision

☐ Car/Bicycle Collision ☐ Car/Pedestrian Collision

Were you wearing a seatbelt? Y N

Was there a headrest on your seat? Y N

Did an airbag deploy at your position? Y N

Did you brace for impact? Y N

Were you aware an accident was about to occur? Y N

Were you wearing a shoulder harness? Y N

ACCIDENT SYMPTOMS AND COMPLAINTS

What is your major symptom/problem?_____

Have you had this problem before? Y N Has the accident made the symptoms worse? Y N

Is this problem getting progressively worse? Y N

Have you experienced any of the following symptoms after the accident? *(Circle what applies)*

Loss of Consciousness / Dizziness / Confusion / Tingling in arms or legs / Disorientation

Headaches / Numbness in arms or legs / Neck Pain / Neck Stiffness / Low Back Pain

Low Back Stiffness / Blurred Vision / Warm Spots in Your Body / Cold Spots in Your Body

Have you had difficulty with any of the following daily activities since the accident?

Sleeping / Sitting / Walking / Eating / Reading / Concentrating / Bowel Movements

What makes your condition better? _____ What makes your condition worse?_____

Does your accident interfere with: ☐Work ☐Sleep ☐Daily ☐Routine Recreation ☐None

Activities/Movements that are painful to preform? ☐ Sitting ☐ Standing ☐Walking ☐ Bending

☐ Lying Down ☐Driving ☐Reading ☐ Other: _____

Circle the severity of your pain: (no pain) 1 2 3 4 5 6 7 8 9 10 (severe pain)

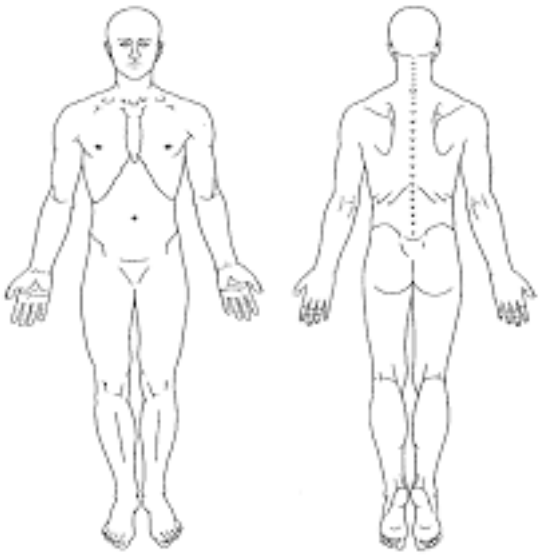
Please note on the diagrams any areas of contusions, bruising, cuts, lacerations or scrapes.

Did you receive any injuries, bruises or cuts as a result of the use of seat belts, shoulder harnesses, headrests or airbag deployment? Y N

IF YES, Please Describe:_____

_____

_____



The statements made on this form are accurate to the best of my knowledge and I agree to be examined at Atlas Spinal Care for treatment of my symptoms.

Patient Signature_____ Date_____

FUNCTIONAL LOSS PATIENT QUESTIONNAIRE

Patient Name_____ **Date**_____

	Left	Right
Neck Movement Limited	____	____
Shoulder Movement Limited	____	____
Elbow Movement Limited	____	____
Wrist Movement Limited	____	____
Hand Movement Limited	____	____
Finger Movement Limited	____	____
Upper Back Movement Limited	____	____
Lower Back Movement Limited	____	____
Hip Movement Limited	____	____
Numb Upper Leg	____	____
Knee Movement Limited	____	____
Numb Lower Leg	____	____
Ankle Movement Limited	____	____
Numb Foot	____	____
Foot Movement Limited	____	____

	Left	Right
Numb Face	____	____
Numb Neck	____	____
Numb Upper Arm	____	____
Numb Lower Arm	____	____
Numb Hand	____	____
Numb Upper Back	____	____
Numb Lower Back	____	____
Numb Hip	____	____

	Moderate	Severe	Mild
Neck Weakness	____	____	____
Shoulder Weakness	____	____	____
Upper Arm Weakness	____	____	____
Lower Arm Weakness	____	____	____
Wrist/Hand Grip Weakness	____	____	____
Upper Back Weakness	____	____	____
Lower Back Weakness	____	____	____
Hip Weakness	____	____	____
Upper Leg Weakness	____	____	____
Lower Leg Weakness	____	____	____
Ankle/Foot Weakness	____	____	____

Circle the following activities that are difficult:

Walking	Climbing Down Stairs	Speaking
Running	Putting on Pants	Hearing
Standing	Putting on Shoes/Socks	Headaches
Sitting	Buttoning Shirts/Pants	Migraines
Bending	Lifting One Arm	Forgetful of Numbers
Kneeling	Lifting Both Arms	Forgetful of Tasks
Crawling	Hand Coordination	Forgetful of Names
Stooping	Balancing While Standing	Breathing
Lifting	Sleeping	Bowel Movements
Twisting	Dizziness	Sexual Desire
Pushing	Sleeping - Pain in Neck	Sexual Ability
Pulling	Sleeping - Pain in Arm	
Tying Shoe Laces	Sleeping - Pain in Upper Back	
Grooming Finger Nails	Sleeping - Pain in Lower Back	
Grooming Toe Nails	Sleeping - Pain in Hip	
Climbing Up Stairs	Sleeping - Pain in Upper Leg	
Fatigue	Sleeping - Pain in Lower Leg	
Memory	Sleeping - Pain in Foot	

In your words, please describe how your life has been affected since the accident. Please be very descriptive in your explanation and use complete sentences.

Social: Dancing, sports, gardening, hobbies, family activities:

Work: Changes in preforming your job, changes in jobs:

THE RIVERMEAD POST-CONCUSSION SYMPTOMS QUESTIONNAIRE

After a head injury or accident some people experience symptoms which can cause worry or nuisance. We would like to know if you now suffer from any of the symptoms given below. As many of these symptoms occur normally, we would like you to compare yourself now with before the accident. For each one, please circle the number closest to your answer.

0 = Not experienced at all

1 = More of a problem

2 = A mild problem

3 = A moderate problem

4 = A severe problem

Compared with before the accident, do you now (i.e., over the last 24 hours) suffer from:

Headaches……..	0	1	2	3	4
Feelings of dizziness……..	0	1	2	3	4
Nausea and/or vomiting…….	0	1	2	3	4
Nose sensitivity, easily upset by loud noise……..	0	1	2	3	4
Sleep disturbance……..	0	1	2	3	4
Fatigue, tiring more easily…….	0	1	2	3	4
Being irritable, easily angered……..	0	1	2	3	4
Feeling depressed or tearful……..	0	1	2	3	4
Feeling frustrated or impatient……..	0	1	2	3	4
Forgetfulness, poor memory…….	0	1	2	3	4
Poor concentration…….	0	1	2	3	4
Taking longer to think……	0	1	2	3	4
Blurred vision……	0	1	2	3	4
Light sensitivity, easily upset by bright light……	0	1	2	3	4
Double vision……	0	1	2	3	4
Restlessness……..	0	1	2	3	4

Are you experiencing any other difficulties?

1._____	0	1	2	3	4
2._____	0	1	2	3	4

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INFORMED CONSENT FOR CHIROPRACTIC CARE

Washington State Law requires that chiropractic patients be provided with the following information prior to being treated.

Chiropractic examination and therapeutic procedures (including spinal adjustments, muscle therapy, exercise and traction) are considered safe and effective methods of care. Occasionally, however, complications may arise. Any procedure intended to help may have complications. While the chances of experiencing complications are small, it is the practice of this clinic to inform our patients about them. These complications include but are not limited to soreness, inflammation, soft tissue injury, dizziness and temporary worsening of symptoms. More serious complications are extremely rare.

Alternatives to chiropractic care include but are not limited to medical treatment, physical therapy, acupuncture and massage. If you have any questions, please feel free to discuss them with the doctor.

I have read, or have had read to me, the above consent. By signing below I agree to to the above and allow the doctor or associates, affiliated with *Atlas Spinal Care* to perform such. I intend this consent to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment. I also understand that there is no guarantee or warranty for a specific cure or result.

Patient Name (Printed):_____

Patient Signature:_____ Date:_____
(or patient representative) *(indicate relationship if signing for patient)*

Pregnancy Release:

This is to certify that to the best of my knowledge I am not pregnant and the doctor and/or associates have my permission to preform an x-ray evaluation. I have been advised that an x-ray can be hazardous to an unborn child.

Patient Signature:_____ Date:_____

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OFFICE POLICIES

Please be on time for your appointment. Being late or last minute cancellations can cause severe scheduling disruptions which can interfere with the quality of care you and other patients receive.

Please do not wear strong perfumes/colognes. We see many patients with allergies or respiratory problems. Strong scents can impair their progress.

Continued cancellations or missed appointments may result in being released from care. If you need to reschedule an appointment, please call within 24 hours of your scheduled appointment.

We may schedule you for multiple appointments. This will help insure convenient appointment times for you as well as provide you with the highest level of care possible. If you need to spend extra time discussing your health concerns with your doctor, please let our staff know so we may schedule your next appointment accordingly. Please notify your doctor of **any** changes in your health status regardless of the significance.

FINANCIAL POLICIES

We accept the following forms of payment: Cash, Personal Checks, Debit Cards, Visa, Discover, American Express and Master Card. There will be a 3% service fee for all payments made on a credit or debit card over $1,000.

Payment is expected at the time of your visit. We will bill your primary insurance company for Initial Intensive Care as a courtesy to you. The patient is always responsible for the payment of their care. We reserve the right to file a lien in the event of non-payment.

Insurance coverage is never guaranteed. If there are any problems between the insurance company and the patient, the latter may file a grievance directly with your insurance company. Your signature below assigns assignment to this office for collection of benefits and also authorizes this office to release daily chart notes when necessary for the processing of claims.

The office manager may approve account balances. Active monthly payments are required. Accounts with balances 30 days past due may be charged a service fee of 12% per year compounded monthly.

Any account where no payment has been received for sixty days may be sent to a third party collection agency. Any additional collection fees will be the responsibility of the patient. NSF checks or rejected credit card payments will be charged a service fee of $35 per occurrence.

We do offer a *at time of service discount* when services are paid in full at the time of the visit; however this discounted rate is no longer available once we are asked to bill any insurance.

In some cases, we may have a contract with your insurance company governing how we handle your account. This contract may prevent us from offering you our *time of service* discount. Please ask us if you have any questions.

Feel free to ask us any financial questions you may have. Our intent is to provide you with the highest level of service as well as care.

Your insurance company determines benefits when they receive our billings. Any statements made by our staff regarding your coverage in no way guarantees that your care here will be covered by your insurance company and you will be responsible for your account regardless of insurance.

By signing below, I acknowledge that I understand the polices as contained herein.

Patient Signature:_____ Date:_____

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USE YOUR PIP BENEFITS
OPEN YOUR PIP CLAIM IMMEDIATELY AFTER AN ACCIDENT

What is PIP?

Personal Injury Protection is coverage under your auto insurance policy that will pay your medical bills, wage loss and household services immediately after your accident.

Facts about PIP Benefits

- PIP is no-fault; it does not matter who caused the accident, you are covered.
- PIP does not have a deductible or co-payment.
- PIP must be included in your policy unless you **rejected** it in writing.
- By **LAW** your insurance company cannot raise your rates or cancel your policy for using PIP.

What if I excluded PIP on my insurance?

If PIP is excluded on your policy, we can bill your personal health insurance if you have chiropractic and/or massage coverage. You may need to contact your health insurance carrier to provide proof of no PIP coverage.

Can you bill the other driver's insurance? (3rd Party)?

We cannot bill the 3rd party insurance carrier. If you do not have PIP or health insurance, you may want to consult with an attorney to protect your rights.

Closed Claim

When a claim is closed, but not settled, our policy is to collect $10.00 per month to keep communication open between your attorney, you and our office.

In order to minimize your account balance, as well as cover our up-front expenses in providing care and maintaining your account, it is our policy that we receive a payment at the time of service for massage therapy. All charges will be posted to your account at our standard minimum fee. The deposit amounts required will be:

Massage $50.00

Payments will be applied to your account and will be reflected in any billing ledger provided to your or your attorney by request. Accounts with balances over 30 days due have a finance charge of 1% per month that may be added. All remaining account balances will be due and payable in full upon settlement of your case or at a time when it becomes apparent that a settlement may not be reached.

Patient Signature:_____ Date:_____

**Some information provided by Graham Lundberg & Peschel Attorneys At Law*

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PATIENT CONFIDENTIAL COMMUNICATION

Patient Name_____ DOB:_____

The Health Insurance Portability and Accountability Act (HIPAA) gives you the right to request that we communicate financial and/or medical information to you in confidence by a particular method. In order to protect the privacy and confidentiality of your information, please complete the following. This will tell us how you wish to be contacted and with whom we may discuss your healthcare.

You may contact me at the following phone numbers:
Home Phone:_____ Cell Phone:_____Work Phone:_____
☐Yes, you may leave a confidential message at: Home Cell Work
☐Yes, you may leave the minimum necessary information on my answering machine or voice mail.
☐Yes, you may provide Billing Information Treatment Information Scheduling Information to the individual(s) listed below:
Name:_____ Relationship:_____
Name:_____ Relationship:_____

Our office will continue to communicate with you according to your above response(s) until you change your preferences. You may do so by completing a new form. By signing below, you grant permission to the communication outlined above.

Patient Signature:_____ Date:_____
(or patient representative) *(indicate relationship if signing for patient)*

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

We keep a record of the health care services we provide you. You may ask to see and copy the record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting Atlas Spinal Care.

Our Notice of Privacy Practices describes in more detail how your health history information may be used and disclosed, and how you can access your information.

By my signature below, I acknowledge receipt of the Notice of Privacy Practices on the following page.

Patient Signature:_____ Date:_____
(or patient representative) *(indicate relationship if signing for patient)*

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NOTICE OF PRIVACY PRACTICES

Patient Name:_____ DOB:_____

This is an abbreviated Privacy Statement. Please see the front desk for a complete Privacy Statement.

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at this office. We need to this record to provide you with the highest quality of care and to comply with local, state, and federal laws. This notice will tell you about the ways we may use and disclose your medical health care information. We also describe your rights and duties we have regarding the uses and disclosure of your medical information.

Law requires us to:

- Keep your medical information private.
- Make this notice available to you describing your legal duties, privacy practices, and your rights regarding your medical information.
- Follow the terms of the notice that is now in effect.

We have a right to:

- Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.
- Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

Notice of changes to privacy practices:

- Before we make any important changes in our privacy practices, we will change this notice and make the revised notice available at our office upon request.

Use and disclosure of your medical information are as follows: treatment, payment or healthcare operations; appointment reminders; disaster relief; fundraising; research; funeral director, coroner or medical examiner; specialized government functions; court order; judicial and administrative proceedings; public health activities; victims of abuse, neglect, or domestic violence; workers compensation; health oversight activities; and law enforcement. In all cases, we will release only the minimum amount of information necessary.

You have the right to look at or get copies of your medical information; receive a list of our business associates; receive a list of accounting of disclosures; request that we place additional restrictions on disclosure; request that we communicate with you by different means or to different locations; request that we change your medical information.

If you have any questions about this notice or if you think we may have violated your privacy rights, please contact our privacy officer. You may also submit a written complaint with the U.S. Department of Health and Human Services. The address is 200 Independence Avenue, S.W., Washington, D.C. 20201. You can call toll-free at 1-877-696-6775. We will not retaliate in any way if you choose to file a complaint. **Note: This authorization may be revoked at any time by giving a written notice to Atlas Spinal Care. However, I understand that I may not revoke this authorization for any actions taken before receipt of my written notice to revoke this authorization.**