



PATIENT INFORMATION

Today's Date: ___/___/_____
Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Sex: M F | Age: ___ Date of Birth: ___/___/_____
Occupation & Employer: _____
Cell #: _____
E-mail: _____
Name of Family Doctor: _____
Emergency Contact Name: _____
Emergency Contact Phone #: _____
Relation to you: _____
How did you hear about us? _____

AUTO INSURANCE CLAIM INFO

Date of Accident: ___/___/_____
Driver of Vehicle You Were In: _____
Driver's Insurance Company: _____
Driver's Policy #: _____
Medical Claim #: _____

Other Driver's Insurance : _____
Claim #: _____

Is an Attorney Involved? ___ Yes ___ No
Attorney's Name & Phone Number:

The above information is accurate to the best of my knowledge.

Patient Signature: _____ Date: ___/___/_____

OFFICE USE ONLY

Adjuster: _____
Adjuster Phone #: _____ Ext. #: _____
Medical Claim #: _____
Verified By: _____ Date: ___/___/_____

Private Insurance Information:
Ins. Co.: _____
Member ID: _____
Group #: _____



Use and Disclosures of Protected Health Information:

Your protected health information may be used and disclosed by your physician, our staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, pay your health care bills, to **support the operations of the physician’s practice, and any other use required by law.**

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your health care information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may disclose, as needed, your protected health information in order to support the business **activities of your physician’s practice. These activities include, but are not limited to, quality assessment activities,** employee review activities, training of medical students, licensing, marketing, and fund-raising activities, and conduction or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations included as required by law, public health issues, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, and organ donation. Required uses and disclosures under the law, we must make disclosures to you when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES WILL BE MADE ONLY WITH YOUR CONSENT, AUTHORIZATION OR OPPORTUNITY TO OBJECT UNLESS REQUIRED BY LAW.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician’s practice has taken an action in reliance on the use or disclosure indicated in the authorization.

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this Chiropractic office to provide me with chiropractic care, in accordance with this state’s statutes. If my insurance will be billed, I authorize payment of medical benefits to Accident Care Specialists of Portland Inc. for services performed.

Signature of Patient or Representative

_____/_____/_____
Date

Printed Name

_____/_____/_____
Date

ACCIDENTCARE



Informed Consent for Chiropractic Care

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures performed on me. This includes various modes of physical therapy, massage therapy and - if necessary - diagnostic x-rays by the clinic's physicians.

I have had the opportunity to discuss with the Chiropractic Physician the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I further understand and am aware that - as in all healthcare - there are some very slight risks to chiropractic treatment, including: muscle strains and sprains, disc injuries, fractures and - in very rare cases - strokes. I do not expect the doctor to be able to anticipate and explain all risks and complications and I wish to rely on the doctor/associates/personnel to exercise best judgment during the course of the procedure which they feel is at the time is in my best interest based upon the known facts,

I have read all of the above consent. I have also had the opportunity to ask questions about its content, and by signing below I agree to the above-mentioned chiropractic procedures. I intend for this consent form to cover the entire course of treatments.

Patient Signature

____ / ____ / ____
Date

Patient's Printed Name

Signature of Chiropractic Physician

ACCIDENTCARE

Patient Release of Medical Records Form

Patient's Name: _____, requests and gives permission to release my medical records for the time period dating from:

____ / ____ / _____ to ____ / ____ / _____ to the following Chiropractic clinic:

Accident Care Chiropractic & Massage

Beaverton Clinic
4130 SW 117th Ave. Suite F
Beaverton, OR 97005
Tel: 503-574-2222
Fax: 503-574-2220

Please release the following:

- All Charts/Progress Notes
- Diagnostic Imaging with Reports (X-rays, MRI, CT, labs, etc.)
- Exams/Evaluations
- Billing Ledger

Printed Patient's Name

____ / ____ / _____
Birth Date

Patient Signature

____ / ____ / _____
Today's Date

ACCIDENTCARE



ASSIGNMENT OF BENEFITS

You, Accident Care Specialists of Portland Inc., are authorized by me to release any information you deem appropriate concerning my health condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred at Accident Care Specialists of Portland Inc. by me. I authorize payment of medical benefits to the physician or supplier listed on the HFCA-1500 form used by Accident Care for services described on the said HFCA-1500 form. I authorize and assign the direct payment to Accident Care Specialists of Portland Inc. of any sum I now or hereafter owe you by my attorney out of the proceeds of any settlement of my case, and by any insurance company obligated to reimburse me for the charges for your services or otherwise obligated to make payment to me or you based in whole or in part upon the charges made for your services. I give assignment and lien against any claims against a third party whose negligence may have caused my injury, up to the amount of the bill for treatment. In the event any insurance company obligated by contractual agreement to make payment to me or to you, for the charges made for your services refuses to make such payment upon demand by you, I hereby assign and transfer to you the cause of action that exists in my favor against any such company and authorize you to prosecute said action either in my name or your name as you see fit and further authorize you to compromise, settle otherwise resolve said claim as you see fit. If insurance payment is not received within 60 days from the time insurance is filed, I understand that I will be billed for the remaining balance. I understand that interest in the amount of 1.5% per month will accrue for any balance over 30 days and that any balance over 90 days will be turned over to collections and I will be responsible for any and all collection and attorney fees.

Known by all these present that: the undersigned has made, constituted and appointed, and by these presents does hereby make, constitute and appoint ACCIDENT CARE SPECIALISTS OF PORTLAND INC. and any of its duly authorized agents and employees as and to be the undersigned's true and lawful attorney for and in the undersigned's name, place and stead to endorse any and all checks, drafts or money orders which are made payable to the undersigned alone or to the undersigned and ACCIDENT CARE SPECIALISTS OF PORTLAND INC. which checks, drafts or money orders are made payable for services which have been made by ACCIDENT CARE SPECIALISTS OF PORTLAND INC. at the request of with the knowledge and approval of the undersigned and/or maker of the check, draft or money order.

This assignment includes but is not limited to, all rights to collect benefits directly from my insurance company for services that I have received and all rights to proceed against my insurance company in any action including legal suit if for any reason my insurance company fails to make payments of benefits due to my assignee or me.

A photocopy of this document shall be as binding as an original signature page.

I, _____, hereby authorize _____
 (name of insured) (name of insurance company)

to pay to and mail directly to ACCIDENT CARE SPECIALISTS OF PORTLAND INC. the medical benefits otherwise payable to me for their services, but not to exceed the charges of those services. I hereby irrevocably assign to ACCIDENT CARE SPECIALISTS OF PORTLAND INC. and benefits under any policy of insurance, indemnity agreement, or any other collateral source as defined in state statutes for any services and charges provided by ACCIDENT CARE SPECIALISTS OF PORTLAND INC.

 Signature of Patient or Representative

____ / ____ / ____
 Date

 Patient's Printed Name

____ / ____ / ____
 Date

**INITIAL EVALUATION
Automobile Accident**

Last Name: _____ First Name: _____ Today's Date: ___/___/_____

What brings you into our office? **AUTOMOBILE ACCIDENT**

Date of accident? ___/___/_____

In your own words, please describe how the accident happened:

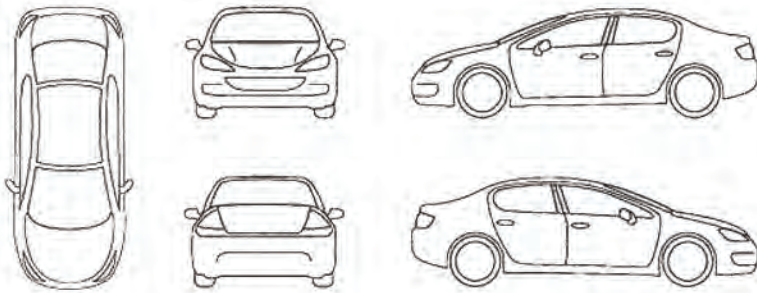
What was your position inside the vehicle?

___ Driver ___ Front Passenger ___ Middle Front Passenger
 ___ Rear (Passenger Side) ___ Rear (Driver Side) ___ Middle Rear Passenger

What was the damage to the vehicle?

___ Mild ___ Moderate ___ Extensive ___ Totaled

*Mark on the vehicle where damage occurred:



How was the visibility on the road?

___ Poor ___ Fair ___ Good

And the weather was:

___ Clear ___ Raining

How did the accident happen?

___ I hit another vehicle ___ Another vehicle hit me ___ I hit an object

Where was the point of impact?

___ Left Driver Side ___ Left Front
 ___ Left Rear ___ Right Passenger Side
 ___ Right Front ___ Right Rear
 ___ Front End ___ Rear End

Did you see the accident coming?
 ___ Yes ___ No

Were you braced for impact?
 ___ Yes ___ No

Were you wearing a seatbelt?
 ___ Yes ___ No

Did airbags deploy during the accident?
 ___ Yes ___ No

Does your vehicle have headrests?
 ___ Yes ___ No

Did you strike anything inside the vehicle?
 ___ Yes ___ No

Patient Signature: _____

Date: ___/___/_____

What inside your vehicle did you strike?

Airbag Armrest Center Console Rearview Mirror Roof
 Dashboard Gear Shift Lever/Knob Headrest Rear Window Back of Seat
 Side Side Window Wheel Windshield

Other: _____

Immediately after the accident, did you feel dazed?

Yes No

Did you lose consciousness?

Yes No

Was your head injured?

Yes No

Which way was your head turned during the accident?

Straight Forward Turned to Right
 Turned to Left Looking Backwards

Immediately after the accident, did you experience:

Headache Neck Pain Low Back Pain Other

Did you see a doctor before coming here?

Yes (Name: _____) No

Did you go to a hospital after the accident?

Yes (Hospital Name: _____) No

How did you get to the hospital?

Ambulance Drove myself Somebody else Police

Were any of the following tests performed at the hospital?

X-Rays MRI CT Scan Lab Work

Do you feel your condition is:

Improving Staying the same Getting worse

Have you lost time from work?
 Yes No

Can you perform physical work activities?
 Yes No

If no, because of:
 Pain Weakness Stress

Can you get to sleep without problems?
 Yes No

Do you awaken due to pain?
 Yes No

Did you have sleeping issues prior?
 Yes No

Patient Signature: _____

Date: ____/____/____

ACCIDENTCARE
PAST MEDICAL HISTORY

Allergies - Please select all items that you are allergic to:

None Food Chemical Environmental Seasonal Medication Other

Social History - Please answer the following:

Married Single Widowed Divorced Separated

Do you have any children?

Yes No If yes, how many? _____

Are you currently or possibly pregnant?

Yes No If yes, how many weeks? _____

Do you use:

Tobacco Alcohol Coffee

Do you take any medications?

Yes No List: _____

Past Surgeries/Hospital Stays?

Yes No List: _____

Previous and Current Illnesses: _____

Past Injuries or Broken Bones?

Yes No

Family History? (ie: Heart Disease, Cancer, etc.)

Have you been involved in a motor vehicle accident before?

Yes No

If yes, when? _____

Did you receive treatment for injuries?

Yes No

Did you experience any residual symptoms from the previous accident?

Yes No If yes, describe: _____

Patient Signature: _____

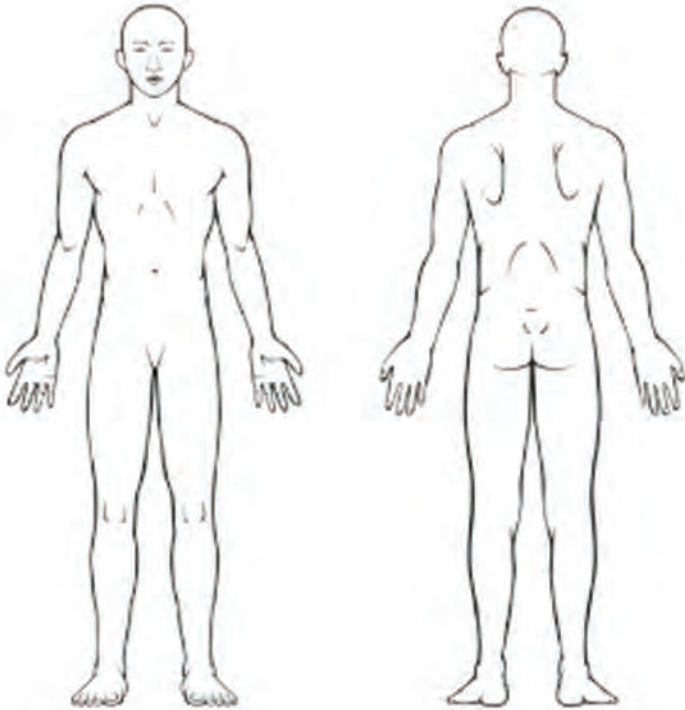
Date: ____/____/_____

Doctor Signature: _____

Date: ____/____/_____

By using the key below, please indicate on the body diagram where you are experiencing symptoms:

X = Sore N = Numbness B = Burning S = Sharp Pain T = Tingling D = Dull Ache



Activities of Daily Living - Please select all activities which you are currently experiencing problems:

- | | |
|------------------------------------|---|
| <input type="checkbox"/> Seeing | <input type="checkbox"/> Insomnia |
| <input type="checkbox"/> Dressing | <input type="checkbox"/> Using the Toilet |
| <input type="checkbox"/> Standing | <input type="checkbox"/> Loss of Sexual Desire |
| <input type="checkbox"/> Bending | <input type="checkbox"/> Restful Sleeping |
| <input type="checkbox"/> Sitting | <input type="checkbox"/> Loss of Concentration |
| <input type="checkbox"/> Irritable | <input type="checkbox"/> Changes in Personality |
| <input type="checkbox"/> Grooming | <input type="checkbox"/> Tactile Feeling |
| <input type="checkbox"/> Twisting | <input type="checkbox"/> Squatting |
| <input type="checkbox"/> Typing | <input type="checkbox"/> Pushing |
| <input type="checkbox"/> Walking | <input type="checkbox"/> Stooping |
| <input type="checkbox"/> Carrying | <input type="checkbox"/> Lifting |
| <input type="checkbox"/> Sports | <input type="checkbox"/> Exercising |
| <input type="checkbox"/> Driving | <input type="checkbox"/> Pulling |
| <input type="checkbox"/> Kneeling | <input type="checkbox"/> Reaching |

By using the key below, list and rate your complaints:

BODY REGION

(0-10)

FREQUENCY (circle one)

(Rate from Most Pain to Least Pain)

Example: Low Back

7/10

constant frequent occasional intermittent

1. _____ /10

constant frequent occasional intermittent

2. _____ /10

constant frequent occasional intermittent

3. _____ /10

constant frequent occasional intermittent

4. _____ /10

constant frequent occasional intermittent

5. _____ /10

constant frequent occasional intermittent

Doctor's Notes:

Patient Signature: _____

Date: ____/____/____

Doctor Signature: _____

Date: ____/____/____