ACCIDENTCARE
Chiropractic & Massage

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 Insurace 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 #: _____

ACCIDENTCARE

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

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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
Portland Clinic
2440 SE 89th Ave Ste 1
Portland, OR 97216
Tel: 503-771-5555
Fax: 503-771-5556

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, settler 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

ACCIDENTCARE

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?

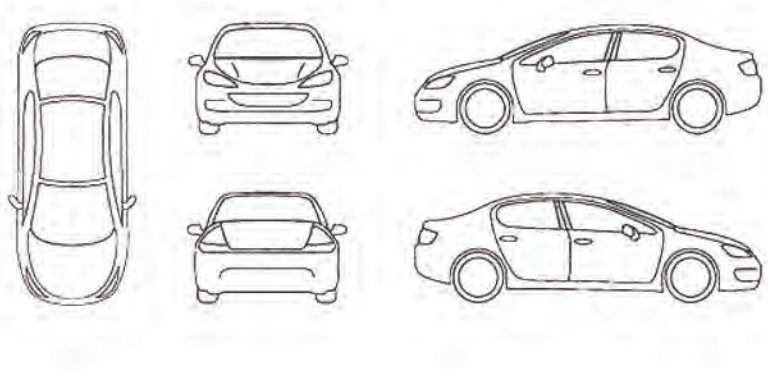
____Driver ____ Front Passenger ____ Middle Front Passenger

____ Rear (Passenger Side) ____ Rear (Driver Side) ____ Middle Rear Passegener

What was the damage to the vehicle?

____Mild ____ Moderate ____ Extensive ____ Totaled

*Mark on the vehicle where damage occured:



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 durring the accident?

____Yes ____ No

Does your vehicle have headrests?

____Yes ____ No

Did you strike anything inside the vehicle?

____Yes ____ No

Patient Signature: _____ Date: _____/_____/_____

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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 invovled 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: _____/_____/_____

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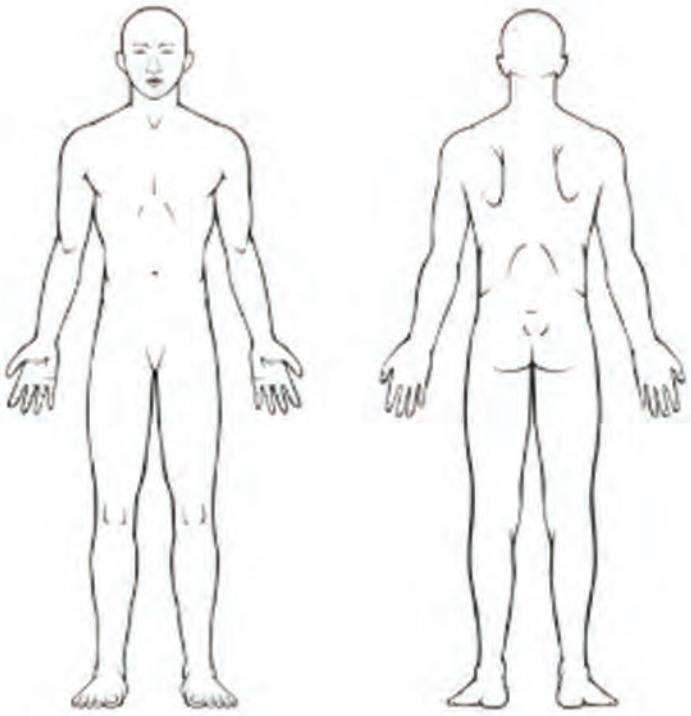
By using the key below, please indicate on the body diagram where you are experiencing symptoms:

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:

____Seeing	____Insomnia
____Dressing	____Using the Toilet
____Standing	____Loss of Sexual Desire
____Bending	____Restful Sleeping
____Sitting	____Loss of Concentration
____Irritable	____Changes in Personality
____Grooming	____Tactile Feeling
____Twisting	____Squatting
____Typing	____Pushing
____Walking	____Stooping
____Carrying	____Lifting
____Sports	____Exercising
____Driving	____Pulling
____Kneeling	____Reaching

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

BODY REGION (Rate from Most Pain to Least Pain)	**(0-10)**	**FREQUENCEY (circle one)**
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: _____/_____/_____