



**ADULT – PERSONAL INJURY/AUTO ACCIDENT**

Name: \_\_\_\_\_ Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Age: \_\_\_\_ Sex:  M  F

Cell Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Social Security # \_\_\_\_\_ Referral/How did you hear about us? \_\_\_\_\_

Check One:  Married  Single  Widowed  Divorced  Separated

Have you ever had a different name, maiden name? Please list: \_\_\_\_\_

Business Employer: \_\_\_\_\_ Type of Work: \_\_\_\_\_

Business Phone: \_\_\_\_\_ Business Address: \_\_\_\_\_

Name of Spouse: \_\_\_\_\_ Email: \_\_\_\_\_

Spouse's Employer: \_\_\_\_\_ Type of Work: \_\_\_\_\_

Business Phone: \_\_\_\_\_ Business Address: \_\_\_\_\_

Names and Ages of Children: \_\_\_\_\_

Person to Call if Unable to Reach You: \_\_\_\_\_

Phone # \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Authorized Person to Discuss any Account/Health Information: \_\_\_\_\_

Phone # \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

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**PAST HEALTH CONDITION**

Previous illnesses you've had in your life: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you ever broken any bones? Which? \_\_\_\_\_

Allergies: \_\_\_\_\_

Previous Injury or Trauma: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Supplements and Medications:**

Do you take any of the following? (Please Circle) Multi-vitamin      Omega 3 fatty acid      Probiotic      Vitamin D

Other vitamins and supplements \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



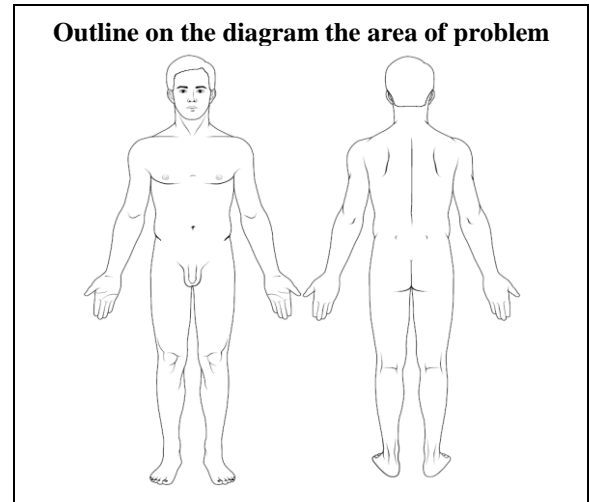
What over the counter and/or prescription medications do you take? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Surgeries: Date and type of surgery?** \_\_\_\_\_  
\_\_\_\_\_

**Females/ Pregnancies and outcomes: Are you currently pregnant?**  Yes  No Due Date: \_\_\_\_\_  
Pregnancies/Date of Delivery/Outcome/Miscarriages

**Family Health History:**  
- Associated health problems of relatives:  
\_\_\_\_\_  
\_\_\_\_\_

**Social and Occupational History:**  
**Job description:** \_\_\_\_\_  
\_\_\_\_\_  
**Work schedule:** \_\_\_\_\_  
\_\_\_\_\_



**OFFICE POLICIES**

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

**Please DO NOT wear strong perfumes or colognes.** We see many patients with allergies and respiratory problems, strong scents can impair their progress.

**Continued cancellations or missed appointments** may result in being released from care.

**Children are welcome here as patients and guests.** If you bring children with you for your appointment, you are responsible for their actions at all times. Our staff will be happy to assist you with your well behaved children.

Please notify the Doctor of **any changes** in your health status, regardless of the significance.

**Please silence cell phones or leave them in your car.**

Signature of Responsible Party: \_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_



## Accidental Injury Worksheet

Date of Accident: \_\_\_\_\_ Time: \_\_\_\_\_ Location: \_\_\_\_\_

Please describe nature of accident/injury:     Auto Accident     Work Related     Other

If not auto collision, please describes the circumstances: \_\_\_\_\_

If auto accident, were you     Driver     Passenger     Pedestrian

Were you struck from     Behind     Front     Vehicle was Stopped/not moving     R side     L side

Did your Vehicle strike the others(s) involved?     Yes     No

As a result of the accident, was a traffic citation issued to you?     Yes     No

Were traffic citations issued to the driver of your car?     Yes     No

Were you treated by paramedics?     Yes     No    Were you transported to the ER     Yes     No

List the extent of the injuries as you know them \_\_\_\_\_

Have you seen a doctor for this injury before coming to this office?     Yes     No

Did you receive treatment?     Yes     No    If yes, describe \_\_\_\_\_

Did you have X-Rays taken?     Yes     No    If yes, where? \_\_\_\_\_

**SYMPTOMS** Check ( ✓ ) symptoms you currently have or have had since the injury.

<p><b>GENERAL</b></p> <input type="checkbox"/> Fatigue <input type="checkbox"/> Tension <input type="checkbox"/> Headache <input type="checkbox"/> Loss of sleep <input type="checkbox"/> Fever <input type="checkbox"/> Irritability <input type="checkbox"/> Sleeping problems	<p><b>NERVOUS SYSTEM</b></p> <input type="checkbox"/> Nervous <input type="checkbox"/> Numbness <input type="checkbox"/> Paralysis <input type="checkbox"/> Dizziness <input type="checkbox"/> Forgetfulness <input type="checkbox"/> Confusion/Depression <input type="checkbox"/> Fainting <input type="checkbox"/> Convulsions <input type="checkbox"/> Cold/Tingling Extremities	<p><b>GASTROINTESTINAL</b></p> <input type="checkbox"/> Appetite poor / excessive <input type="checkbox"/> Gas/Bloating <input type="checkbox"/> Bowel changes <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Weight trouble <input type="checkbox"/> Excessive thirst <input type="checkbox"/> Indigestion / Heartburn <input type="checkbox"/> Nausea <input type="checkbox"/> Stomach pain <input type="checkbox"/> Vomiting	<p><b>GENTO-URINARY</b></p> <input type="checkbox"/> Blood/discolor in urine <input type="checkbox"/> Lack of bladder control <input type="checkbox"/> Painful urination
<p><b>MUSCLE / JOINT / BONE</b></p> <input type="checkbox"/> Neck pain <input type="checkbox"/> Mid back pain <input type="checkbox"/> Low back pain <input type="checkbox"/> Shoulder pain <input type="checkbox"/> Arm pain/numbness/weak <input type="checkbox"/> Leg pain/numbness/weak <input type="checkbox"/> Joint pain / Stiffness <input type="checkbox"/> Walking problems <input type="checkbox"/> Jaw pain	<p><b>CARDIO-VASC-RESP</b></p> <input type="checkbox"/> Chest pain <input type="checkbox"/> Blood pressure problems <input type="checkbox"/> Irregular heart beat <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Stroke <input type="checkbox"/> Blood clots <input type="checkbox"/> Swelling of ankles	<p><b>EYE, EAR, NOSE, THROAT</b></p> <input type="checkbox"/> Vision problems <input type="checkbox"/> Dental problems <input type="checkbox"/> Hearing difficulty <input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Earache <input type="checkbox"/> Persistent cough <input type="checkbox"/> Ringing in ears <input type="checkbox"/> Sinus problems	<p><b>SKIN</b></p> <input type="checkbox"/> Bruises <input type="checkbox"/> Rash

Have you lost days of work?     Yes     No    If yes, dates \_\_\_\_\_

Signature of Responsible Party: \_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_



### Insurance Information

**Office Policy:** We bill your PIP claim and they will get reimbursed if a third party is involved. We do not directly bill third party insurance.

**ALL SECTIONS ARE MANDATORY**  
**You may mark N/A if not applicable.**

#### Personal Injury Protection (PIP)

*PIP is insurance coverage you add to your auto policy. If you're in an auto accident it'll help pay for medical expenses (up to certain limits). PIP applies no matter who is at fault.*

*It's your choice. You don't have to buy PIP, but by law ([www.apps.leg.wa.gov](http://www.apps.leg.wa.gov)) your insurance company must offer it to you.*

*If you don't want PIP, you must reject it in writing. If you don't reject it in writing, your company has to add it to your policy and charge you for it.*

<http://www.insurance.wa.gov/your-insurance/auto-insurance/personal-injury-protection/> Updated 07/22/2013

My Auto Insurance Company \_\_\_\_\_ Billing Address: \_\_\_\_\_

Policy # \_\_\_\_\_ Claim # \_\_\_\_\_

Adjuster/Claims Manager \_\_\_\_\_ Phone # \_\_\_\_\_

Names of everyone on the claim \_\_\_\_\_

Have you been contacted by an insurance adjuster from your insurance?  Yes  No

#### Third Party

*A first party claim involves your insurance company, while a third party claim involves the insurance company of the other driver in an accident.*

Third Party's Name \_\_\_\_\_ Policy Holder's Name \_\_\_\_\_

Third Party's Ins. Company \_\_\_\_\_ Billing Address: \_\_\_\_\_

Adjuster/Claims Manager \_\_\_\_\_ Phone # \_\_\_\_\_

Policy # \_\_\_\_\_ Claim # \_\_\_\_\_

Have you been contacted by an insurance adjuster by a third party insurance?  Yes  No

#### Attorney

Do you have an Attorney?  Yes  No If yes, Name of Attorney \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

#### Personal Health Insurance

*If you do not have PIP coverage or your PIP coverage becomes exhausted, we will bill your personal insurance for any uncovered services.*

Health Insurance Company \_\_\_\_\_

Billing Address \_\_\_\_\_

Phone \_\_\_\_\_ ID # \_\_\_\_\_ Group # \_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of Chiropractic 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 Advantage Chiropractic and Massage, PS for services performed.

Print Patient's Name: \_\_\_\_\_ Date of Birth \_\_\_/\_\_\_/\_\_\_

Print Responsible Party's Name (if not the patient): \_\_\_\_\_

Signature of Responsible Party: \_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_



### Informed Consent for Chiropractic Care

When a patient seeks chiropractic health care, and we accept a patient for such care, it is essential for both to be working for the same objective. It is very 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. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks and alternatives.

Chiropractic is a science and art which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may effect the restoration and preservation of health. Health is a state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

One disturbance to the nervous system is called a vertebral subluxation. This occurs when one or more of the 24 vertebrae in the spinal column become misaligned and/or do not move properly. This causes alteration of the nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by an adjustment. An adjustment is the specific application of forces to correct and/or reduce vertebral subluxations. Our chiropractic method of correction is by specific adjustments of the spine. Adjustments are usually done by hand but may be performed by handheld instruments. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included.

If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

I have read and was supplied a copy of the **HIPPA guidelines**.

\_\_\_\_\_

Print Responsible Party's Name	Signature of Responsible Party	Date
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#### Informed Consent for Massage:

I understand any massage I may have is not a replacement for medical care and that no diagnosis will be made. I also understand that if I am pregnant or become pregnant it is my responsibility to inform the Licensed Massage Practitioner prior to my massage as it will affect the techniques used during the massage.

\_\_\_\_\_

Signature	Date
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#### Verification of Non-Pregnancy:

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

Date of last menstrual cycle: \_\_\_\_\_

\_\_\_\_\_

Signature	Date
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## Release of Authorization and Letter of Protection

I, \_\_\_\_\_, hereby authorize this office to furnish my attorney,  
(Patient)

\_\_\_\_\_, and/or \_\_\_\_\_ insurance company, or the designee of either,  
(Name of Attorney or N/A) (Name of Auto Insurance Company)

any medical information requested concerning the condition or treatment of injuries sustained by me or my children, on  
\_\_\_\_\_.  
(Date of accident)

I authorize and direct my attorney to pay from any insurance or other proceeds for any recovery made as a result of said injury, and unpaid balance due said doctor for professional services, including any expert witness fee, as a result of any treatment to myself, or my children. I understand that this in no way relieves me of my personal primary responsibility to pay my doctor for services when a statement is rendered and that I will receive customary billing for said services. I agree that this office be given a Power of Attorney to either endorse or sign my name on any and all checks presented to them for payment of my doctor's bill with or without direct notification to me.

I authorize my attorney or any third party liability carrier to disclose the settlement status, settlement statement and/or a copy of the settlement check if requested for our purposes. At the time of the settlement, the attorney is instructed that this office shall be furnished separate checks for the medical services which they have rendered for full balance due at that time.

In consideration for the furnishing of medical treatment to the patient herein named and/or his or her children and further agreement to furnish periodic reports concerning diagnosis and treatment of said patient or patients, the undersigned attorney for the patient or patients named above does agree to protect our interest for medical charges in as fair a manner as possible. Upon settlement of the underlying, the attorney's office will disburse funds directly to our office. The patient hereby acknowledges that should the net recovery to the patient not be sufficient to pay in full all amounts due this office with respect to the above stated matter, then the patient shall remain personally responsible for any unpaid balance. The undersigned attorney further agrees to furnish this office the status of the patient's claim upon request.

I hereby acknowledge that I am receiving (or about to receive) health care services at Advantage Chiropractic and Massage, P.S., and that I have been advised that the doctor(s) providing services is/are willing to wait for payment for these services provided that there continues to be reasonable chance that payment will be made either by insurance proceeds or out of the settlement of a liability claim. I understand that if it is determined that either:

- a. That there is no insurance company obligated to pay for the services, or if the insurance company involved refuses to acknowledge an assignment to the doctor(s), or make other provisions for the protection of the interest of the doctor(s): or
- b. If a liability claim exists, and my attorney refuses to agree to protect the interest of the doctor(s), or if I have not engaged the services of an attorney; then payment for services rendered by the doctor(s) at Advantage Chiropractic and Massage, P.S. will be made on a current basis and my bill will be paid in full as soon as my liability claim is settled, or the passage of three months from last treatment, whichever occurs first.

Print Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Print Responsible Party's Name (if not the patient): \_\_\_\_\_

Signature of Responsible Party: \_\_\_\_\_ Date: \_\_\_\_\_



## Diagram of Accident

Name \_\_\_\_\_ Date \_\_\_\_\_

Date of Injury \_\_\_\_\_ Location of Accident: \_\_\_\_\_

Please use the diagram below to describe your auto accident:  
(Please list street names)

A Your Vehicle

B Other Vehicle

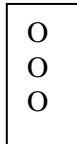
← ↑ → ↓ = Direction of travel



= Stop Sign



= Yield Sign



= Traffic Signal





### FINANCIAL POLICIES

**Payment is expected at the time of service.**

**We accept the following forms of payment;** Cash, Personal Checks, Debit Cards, Visa and MasterCard.

**No balance policy:** Any patient responsibility is expected at the time of service. Balances after insurance payments and any non-covered charges by insurance are due upon receipt of your statement.

**Payments:** Unless other arrangements are approved by us in writing, the balance on your statement is due and payable when the statement is issued, and is past due if not paid by the end of the month.

**Late Fee:** A late fee of \$10.00 will be imposed on each account that is over thirty (30) days past-due. All balances will accrue a \$10 late charge every billing cycle.

**Returned checks:** There is a \$25.00 fee for any checks returned by the bank.

**Massage no show/late cancellation fee:** If you do not show up for an appointment, or cancel with less than 24 hours' notice, a \$10.00 fee will be charged. This late no show /cancellation fee goes directly to our massage therapists for compensation of time loss.

**Past due accounts:** If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all of the collection costs which are incurred. All delinquent accounts bear interest at the legal rate. If we have to refer collection of the balance to a lawyer, you agree to pay all lawyers' fees which we incur plus all court costs. In case of suit, you agree the venue shall be in Cowlitz County, Washington.

**Waiver of confidentiality:** You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

**Insurance Billing:** If we are contracted with your insurance company, we must follow our contract and their requirements.

**Copays are due at the time of service.** It is the insurance company that makes the final determination of your eligibility.

We will bill your insurance company as a courtesy to you. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility.

**By signing below, I acknowledge that I understand the policies contained herein.**

Print Patient's Name: \_\_\_\_\_

Print Responsible Party's Name (if not the patient): \_\_\_\_\_

Signature of Responsible Party: \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

If you have any visit limit or dollar maximum it is your responsibility to keep track of this and be aware of your benefits.

Insurance coverage is never a guarantee of payment. If there are any problems between the insurance company and the patient, the patient would need to file a grievance directly with the insurance company. Your signature below indicates 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.

Your insurance company determines benefits when they receive our claims. Any statement made by our staff regarding your coverage is in no way a guarantee of payment for your services. I acknowledge that I am responsible for payment of all non-covered services.

**Non-Contracted Insurance Billing:** If you see a non-contracted (out of network) provider your insurance company may send you a check. You will need to sign the check and return it to our office for services rendered. I acknowledge that I am responsible for payment of all non-covered services.

**Medicare:** Medicare does not cover the following services at a Chiropractic office: Massage, Exams, Re-exams, X-Rays, Therapeutic exercises, Durable medical equipment or Supplements. We expect payment for any non-covered Medicare service at the time of your visit. If you have a copay with your supplemental insurance, it is to be paid at the time of your visit.

**No Insurance Coverage:** We do offer a time of service discount when services are paid in full at the time of the visit. By law, we must bill our full billable rate and cannot extend a discount if services are not paid for at the time of service.

We offer an additional 25% savings for all children and students as follows: newborn – age 18 and full time students to age 25.

**Workers Compensation:** We require approval/authorization by your employer and/or worker's compensation carrier. If your claim is denied, you will be responsible for payment in full.

In addition to this verification, we require that you allow us to bill your health insurance if your claim is denied. In the absence of insurance, other financial arrangements may be discussed. Payment of the bill remains the patient's responsibility.

**Personal Injury:** If you are being treated as part of a personal injury lawsuit or claim, we require verification from your attorney and/or insurance company. In addition to this verification, we require that you allow us to bill your health insurance if your claim is denied or you exceed your benefits. In the absence of insurance, other financial arrangements may be discussed. Payment of the bill remains the patient's responsibility.





## Neck Bournemouth Questionnaire

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**Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_ **Score** \_\_\_\_\_  
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**1 Over the past week, on average, how would you rate your neck pain?**

No pain \_\_\_\_\_ Worst pain possible  
0 1 2 3 4 5 6 7 8 9 10

**2 Over the past week, how much has your neck pain interfered with your daily activities (housework, washing, dressing, lifting, reading, driving)?**

No interference \_\_\_\_\_ Unable to carry out activity  
0 1 2 3 4 5 6 7 8 9 10

**3 Over the past week, how much has your neck pain interfered with your ability to take part in recreational, social, and family activities?**

No interference \_\_\_\_\_ Unable to carry out activity  
0 1 2 3 4 5 6 7 8 9 10

**4 Over the past week, how anxious (tense, uptight, irritable, difficulty in concentrating/relaxing) have you been feeling?**

Not at all anxious \_\_\_\_\_ Extremely anxious  
0 1 2 3 4 5 6 7 8 9 10

**5 Over the past week, how depressed (down-in-the-dumps, sad, in low spirits, pessimistic, unhappy) have you been feeling?**

Not at all depressed \_\_\_\_\_ Extremely depressed  
0 1 2 3 4 5 6 7 8 9 10

**6 Over the past week, how have you felt your work (both inside and outside the home) has affected (or would affect) your neck pain?**

Have made it no worse \_\_\_\_\_ Have made it much worse  
0 1 2 3 4 5 6 7 8 9 10

**7 Over the past week, how much have you been able to control (reduce/help) your neck pain on your own?**

Completely control it \_\_\_\_\_ No control whatsoever  
0 1 2 3 4 5 6 7 8 9 10

## Back Bournemouth Questionnaire

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**Name:**

**Date:**

**Score:**

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**1 Over the past week, on average, how would you rate your back pain?**

No pain Worst pain possible  
0 1 2 3 4 5 6 7 8 9 10

**2 Over the past week, how much has your back pain interfered with your daily activities (housework, washing, dressing, lifting, reading, driving)?**

No interference Unable to carry out activity  
0 1 2 3 4 5 6 7 8 9 10

**3 Over the past week, how much has your back pain interfered with your ability to take part in recreational, social, and family activities?**

No interference Unable to carry out activity  
0 1 2 3 4 5 6 7 8 9 10

**4 Over the past week, how anxious (tense, uptight, irritable, difficulty in concentrating/relaxing) have you been feeling?**

Not at all anxious Extremely anxious  
0 1 2 3 4 5 6 7 8 9 10

**5 Over the past week, how depressed (down-in-the-dumps, sad, in low spirits, pessimistic, unhappy) have you been feeling?**

Not at all depressed Extremely depressed  
0 1 2 3 4 5 6 7 8 9 10

**6 Over the past week, how have you felt your work (both inside and outside the home) has affected (or would affect) your back pain?**

Have made it no worse Have made it much worse  
0 1 2 3 4 5 6 7 8 9 10

**7 Over the past week, how much have you been able to control (reduce/help) your back pain on your own?**

Completely control it No control whatsoever  
0 1 2 3 4 5 6 7 8 9 10