Anik J. St. Martin, DC, D.A.C.C.P.
Darin J. Shook, DC
Craig Werner, DC
John Dobosz, DC

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CHIROPRACTIC & MASSAGE

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## CHILDREN'S – PERSONAL INJURY/AUTO ACCIDENT

**Child's Name:** _____ Birth Date: _____ Age: _____ Sex: ☐ M ☐ F

Address: _____ City: _____ State _____ Zip _____

Lives with ☐ Both Parents ☐ Mother ☐ Father_____ Referral/How did you hear about us?_____

**Mother's Name:** _____ Email Address: _____

Address: _____ City: _____ State _____ Zip _____

Home Phone: _____ Cell Phone: _____

Business Employer: _____ Type of Work: _____

Business Phone: _____ Business Address: _____

**Father's Name:** _____ Email Address: _____

Address: _____ City: _____ State _____ Zip _____

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 Information:** _____

Phone # _____ Relationship: _____

Address: _____ City: _____ State _____ Zip _____

## 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 _____

_____

_____

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What over the counter and/or prescription medications does your child take? _____
_____
_____

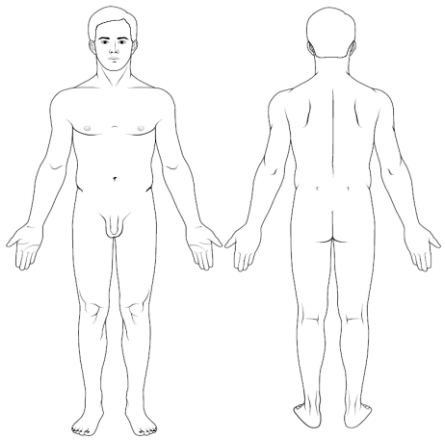
**Surgeries: Date and type of surgery?**_____
_____

**Family Health History:**

- Associated health problems of relatives:

_____
_____

**Outline on the diagram the area of problem**



## 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.

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

**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.

**For your children's safety** they may not play with the exercise equipment, adjusting tables or window blinds.

**Food is not allowed in the office** due to food allergies of other patients, especially children.

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

Signature of Responsible Party: _____ Date: _____

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# Accidental Injury Worksheet

**Please complete the following questions**:

Date of Accident:_____Time:_____Location:_____

Please describe nature of accident/injury: ☐ Auto Accident ☐ 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 parked ☐ 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

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_____

_____

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

**GENERAL**
- ☐ Fatigue
- ☐ Tension
- ☐ Headache
- ☐ Loss of sleep
- ☐ Fever
- ☐ Irritability
- ☐ Sleeping problems

**MUSCLE / JOINT / BONE**
- ☐ Neck pain
- ☐ Mid back pain
- ☐ Low back pain
- ☐ Shoulder pain
- ☐ Arm pain/numbness/weak
- ☐ Leg pain/numbness/weak
- ☐ Joint pain / Stiffness
- ☐ Walking problems
- ☐ Jaw pain

**NERVOUS SYSTEM**
- ☐ Nervous
- ☐ Numbness
- ☐ Paralysis
- ☐ Dizziness
- ☐ Forgetfulness
- ☐ Confusion/Depression
- ☐ Fainting
- ☐ Convulsions
- ☐ Cold/Tingling Extremities
- ☐ Stress
- ☐ Loss of balance

**CARDIO-VASC-RESP**
- ☐ Chest pain
- ☐ Blood pressure problems
- ☐ Irregular heart beat
- ☐ Shortness of breath
- ☐ Stroke
- ☐ Blood clots
- ☐ Swelling of ankles

**GASTROINTESTINAL**
- ☐ Appetite poor / excessive
- ☐ Gas/Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Weight trouble
- ☐ Excessive thirst
- ☐ Indigestion / Heartburn
- ☐ Nausea
- ☐ Stomach pain
- ☐ Vomiting

**EYE, EAR, NOSE, THROAT**
- ☐ Vision problems
- ☐ Dental problems
- ☐ Hearing difficulty
- ☐ Difficulty swallowing
- ☐ Earache
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems

**GENITO-URINARY**
- ☐ Blood/discolor in urine
- ☐ Lack of bladder control
- ☐ Painful urination

**SKIN**
- ☐ Bruises
- ☐ Rash

Have you missed any days at school? ☐Yes ☐ No If yes, dates_____

Signature of Responsible Party: _____ Date: _____

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# 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) 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.*

**Primary** Health Insurance Company _____
Billing Address _____
Phone _____ ID # _____ Group #_____
Policy Holder's Name: _____ DOB: _____

☐ I do not have personal health insurance. In the absence of insurance, any non-covered charges become patient responsibility.

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 ___/___/___

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## 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.**

## Consent to Evaluate and Adjust a Minor Child

I, _____ being a parent or legal guardian of _____ have read and
(Parent or Legal Guardian) (child)

fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care.

Signature of Responsible Party: _____ Date: _____

## AUTHORIZATION TO TAKE AND PUBLISH PHOTOGRAPHS

I, _____ authorize Dr. Darin Shook, Dr. Anik St. Martin or another person authorized by him/her to take and publish photographs of my child, _____, for clinical records. Such photographs may be used in publications for the purpose of scientific and/or clinical research, chiropractic education, and the promotion of chiropractic health care when the above named Doctor deems such publication will benefit these goals.

I also understand I will not be identified by name without additional authorization.

Signature of Responsible Party: _____ Date: _____

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# Release of Authorization and Letter of Protection

I, _____, hereby authorize this office to furnish my attorney,
(Parent or Legal Guardian)

_____, 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 my 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 ___/___/___

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# Diagram of Accident

Child's Name _____ Date _____

Date of Injury _____ Location of Injury _____

_____

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

O
O
O
= Traffic Signal

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# 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: A**ny 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.
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.

**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 ___/___/___