Motor Vehicle Accident History

(Please Print)

Patient Information

Acct#_______________

Dr./Mr./Mrs./Ms./Miss (circle one)

____

Last Name First Name Middle Initial Nick Name

____

Responsible Party

Name of person responsible for payment of this account _______________________

Relationship to patient _______________________ Phone# _______________________

____

Address City State Zip Code

Insurance Information

If you have any insurance information please give it to the staff person assisting you.

Accident/Injury History

1. Date of Accident: ____________ Time of Day: ________ Road Condition: ( ) Dry ( ) Wet
2. Were you: ( ) Driver ( ) Passenger ( ) Front Seat ( ) Back Seat
3. Number of people in your vehicle? __________
4. Were you wearing a seat belt? ( ) Y ( ) N If no, go to question #6
5. If yes, were you wearing a lap belt? ( ) Y ( ) N Lap belt and shoulder harness? ( ) Y ( ) N
6. What direction were you headed? ( ) North ( ) South ( ) East ( ) West

   On (name of street and city):

   ____
7. What direction was the other vehicle headed? ( ) North ( ) South ( ) East ( ) West

   On (name of street and city):

   ____
8. Were you struck from: ( ) Behind ( ) Front ( ) Left Side ( ) Right Side

   Other combination, please describe:

   ____
9. What was the position of your head during the accident:

   ( ) Straight Ahead ( ) Turned Right ( ) Turned Left ( ) Other

   ____
10. Did any part of your body strike/hit anything inside of your vehicle(steering wheel, dashboard, etc.)?

    ( ) Y ( ) N

    If yes, please explain: ____

11. Did any items become displaced in the vehicle (rearview mirror, ashtray, packages, etc.)?

( ) Y ( ) N

If yes, please describe: ____

12. Approximate speed of your car: _________ mph Estimated speed of the other car: ________ mph

13. Make/model of your car: __________________ Make/model of the other vehicle: ________________

14. Were the police notified? ( ) Y ( ) N ***Please provide this office with a copy of the police report.***

15. In your own words, please describe the accident: ____

____

____

16. Did you have any physical complaints BEFORE the accident? ( ) Y ( ) N

If yes, please describe in detail: ____

____

17. Please describe how you felt:

a. DURING the accident: ____

b. IMMEDIATELY AFTER the accident: ____

c. LATER THAT DAY: ____

d. THE NEXT DAY: ____

18. Were you knocked unconscious? ( ) Y ( ) N If yes, for how long? ________________

19. Where were you taken after the accident? ____

20. Have you been treated by another doctor since this accident? ( ) Y ( ) N

If yes, please list the doctor's name and address: ____

____

What type of treatment did you receive? ____

____

21. Did this accident occur while you were performing your regular job duties? ( ) Y ( ) N

22. How do you feel now, what is your **number one** problem or the **one area** of greatest pain?

____

23. Please rate the level of this pain on the following scale: **0 is no pain, 10 is severe pain** or the worst pain you have ever felt. If your pain varies from day to day, please circle two numbers to indicate a range of your pain. 0 1 2 3 4 5 6 7 8 9 10

24. Since this injury occurred, is your pain: ( ) Improving ( ) Getting Worse ( ) Staying the Same

25. How often do you experience the pain?

____ 1-2 hours per day ____ About half of the day

____ Most of the day ____ The pain never goes away

26. How does the pain affect your daily activities?

___ It does not affect my daily activities ___ I have had to change how I do things

___ I have had to stop doing some of my daily activities ___ I am unable to perform daily activities

27. What **increases** your pain?

____

28. What **decreases** your pain? ____

29. Have you ever experienced this problem before? [ ] Y [ ] N When? ____________________

30. Do you have a previous illness/disease which affects your present condition? ( ) Y ( ) N

If yes, please describe: ____

31. List any other complaints currently bothering you and rate your pain level for each.

a. ______________________ **0 1 2 3 4 5 6 7 8 9 10**

b. ______________________ **0 1 2 3 4 5 6 7 8 9 10**

c. ______________________ **0 1 2 3 4 5 6 7 8 9 10**

d. ______________________ **0 1 2 3 4 5 6 7 8 9 10**

32. Have you lost time from work as a result of this accident? ( ) Y ( ) N

a. Type of employment: ____

b. Last day worked: ____

33. Have you ever been involved in an accident before? ( ) Y ( ) N

a. If yes, when?

b. Describe the accident(s): ____

____

c. Were you injured? [ ] Y [ ] N Explain: ____

____

34. List all medication you are currently taking *(prescribed and over the counter)*

____

35. List all surgeries you have had *(with date)*

____

If you have experienced any of the following conditions in the past, mark a "**P**" on the line provided. If you are currently experiencing any of the following conditions please mark a "**C**" on the line provided.
(check all that apply)

___ heart attack ___ stroke ___ arthritis ___ gall bladder trouble
___ diabetes ___ glaucoma ___ fainting spells ___ kidney stones
___ difficulty with urination ___ bloody stools ___ difficulty with bowel movements
___ prostate trouble ___ anemia ___ cancer ___ asthma
___ AIDS ___ ulcers ___ diverticulosis ___ menstrual cramping
___ dizziness ___ loss of memory ___ chest pain ___ shortness of breath
___ constipation ___ diarrhea ___ general fatigue ___ sudden weight loss
___ nausea ___ muscle cramping ___ soreness in joints ___ loss of hearing
___ ears ringing ___ headache ___ migraine ___ epilepsy
___ gout ___ tuberculosis ___ syphilis ___ sprained ankle [ ] R [ ] L
___ knee/hip replacement ___ broken bones *(specify)*

General Activities *(check all that apply)*

___ sleep on waterbed ___ read in bed ___fall asleep in recliner/on couch
___ sleep on stomach ___ needlepoint/knitting ___ use two or more pillows to sleep with
___ sewing ___ lift weights/wt. mach. ___ play video games (_____ hrs per day)
___ exercise _____x/wk ___ jog _____x/wk ___ computer use (_____ hrs per day)
___ swim ___ use ellipitical ___ watch television (_____ hrs per day)

Authorization

I certify that I have read and I understand the above information to the best of my knowledge. The questions above have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize this office to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such chiropractic care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to this office benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Patient's Signature ____ Date: ___________________

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ASSIGNMENT OF BENEFITS AND POWER OF ATTORNEY TO CASH CHECKS

I, the undersigned, do hereby authorize payment directly to the office below, the benefits of my coverage, if any, otherwise payable to me for services but not to
exceed the customary charge for those services. If these payments are made out to me I grant unto the office below as attorney the full power and authority in my name
and stead to endorse any and all checks and drafts or money orders. I hereby authorize the doctor to release all information necessary to secure payment of benefits. A
photocopy of this assignment shall be valid
.

Date________________ Patient's Signature____

AUTO AND OTHER ACCIDENTS - NOTICE OF LIEN TO ATTORNEY

I hereby authorize and direct you, my attorney, to pay directly to said doctor such sums as may be due and owing him for medical service rendered me both by reason
of this accident and by reason of any other bills that are due his office and to withhold such sums from any settlement, judgment or verdict as may be necessary to
adequately protect said doctor. And I hereby further give a Lien on my case to said doctor against any and all proceeds of my settlement, judgment or verdict which
may be paid to you, my attorney, or myself, as the result of the injuries for which I have been treated or injuries in connection therewith.

I agree never to rescind this document and that a rescission will not be honored by my attorney. I hereby instruct that in the event another attorney is substituted in this
matter, the new attorney honor this lien as inherent to the settlement and enforceable upon the case as if it were executed by him
I have received a copy of this document

Date_______________ Patient's Signature____

(signature of parent if the patient is a minor)

Doctor's Comments:

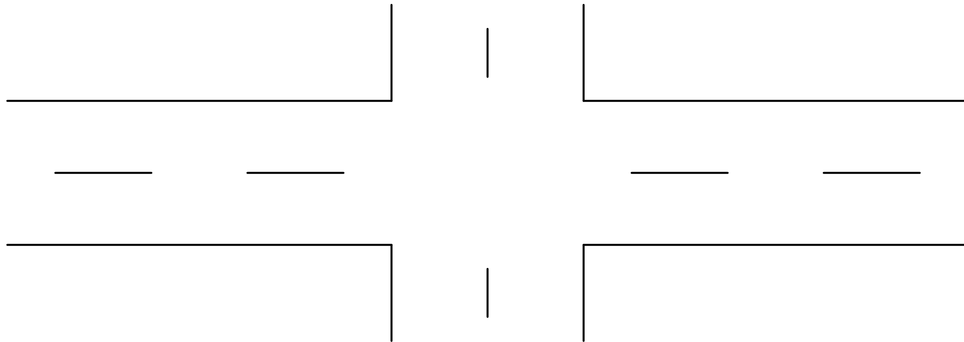
____

____

____

____

____



Absolute Wellness Center
Rick C. White, DC

FINANCIAL POLICY

My primary responsibility is to help my patients' experience better health and I wish to spend my time and energy toward that end. In the interest of maintaining a solid health care practice, I feel it is important to establish a clear financial policy to avoid any misunderstandings.

- Payment is due at the time of your visit unless satisfactory arrangements are made in advance.
- There is a 24 hour cancellation policy. You will be charged a no show fee of $50.00.
- Insurance: As a courtesy we will bill you insurance company. However you are ultimately responsible for your bill. Should your insurance deny coverage we will be happy set up a payment plan so that you may continue your care.
- Some insurance companies do not cover Chiropractic or chiropractic related services please have due diligence and confirm your benefits.
- All ancillary products are paid for at time of service unless other arrangements are made.
- We accept Visa/ Master Card, checks and cash.

Personal Injury/ Auto Insurance

Regardless of who the responsible party is, a claim will be established with your insurance company. Please contact you agent to expedite the claim process. You are still personally responsible for your bill but will not be required to pay as services are rendered. (If our office has not received payment, from your insurance carrier, within 60 days you will be responsible for the balance of the bill.

Workers' Compensation

You are required to complete an accident report on your first visit to establish a claim. You are not personally responsible for the account unless your claim is partially or totally denied by Workers' Compensation Insurance. In such cases payment for services rendered is your responsibility.

I have read and understand the policies as described above. I understand I am responsible for payment of all services provided by Absolute Wellness Center. I agree to make payment in full at time of service, unless other arrangements have been made. I understand that if payment has not been made within 90 days of the date of service and no financial arrangements have been made there will be collection expenses incurred at a rate of 19.8% APR. In addition should this account be turned over to collections I will pay a 40% collection fee.

I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.

Signature: ____ Date: ________________

Absolute Wellness Center

Rick C. White, D.C.
1524 Willamette Street Eugene, Oregon 97401
Phone (541) 484-5777

NOTICE OF USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AS WELL AS HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Uses and Disclosure

The Absolute Wellness Center may collect protected health information from you for the purposes of coordinating treatment, payment or other health care services plan operations. Health care services plan operations including quality management utilization review, claims payment and provider credentialing activities. The Absolute Wellness Center may also collect your protected health information as required by industry or government regulators, such as the U.S. Department of Health and Human Services, and clinical or professional licensing accreditation entities. The Absolute Wellness Center may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. As required, the Absolute Wellness Center may also disclose protected health information to the sponsor of your health plan.

Authorization

Any uses or disclosures other than those described in the “Uses and Disclosure” section above will be made only with your authorization. In the event you authorize the Absolute Wellness Center to use or disclose your protected health information in ways other than those described above, you have the right to revoke that authorization at any time. To revoke such an authorization you must send written notice or revocation to the Absolute Wellness Center at the address listed above.

Statement of Individual Rights

Right To Request Restrictions On Uses and Disclosure of Protected Health Information: You have to right to request restrictions on the use and disclosure of your protected health information. To request a restriction you must submit a written request explaining, in detail, the requested restriction. Upon receipt of such a request, the Absolute Wellness Center will discuss the requested restriction with you. Please note that while you may request a restriction, Absolute Wellness Center has the right to refuse the request. Additionally, as allowed by law, the Absolute Wellness reserves the right to override any such restrictions in emergency health care situations. You may terminate an agreed upon restriction at any time by giving the Absolute Wellness Center a verbal or written request to terminate the restriction. If Absolute Wellness Center unilaterally terminates an agreed upon restriction, the Absolute Wellness Center will inform you of the termination and can share only the information generated after the termination of that restriction.

Right To Receive Confidential Communications: You have the right to receive confidential communications, including the right to direct where communications containing health information sent to you. To verify or specify where you would like such communications sent to you please communicate your preferences to the Absolute Wellness Center.

Right To Inspect And Copy Protected Health Information: You have the right to inspect and copy your protected health information that is maintained by the Absolute Wellness Center. To request, to inspect or

to copy you protected health information, please communicate your request to the Absolute Wellness Center.

Right To Amend Protected Health Information: You have the right to amend your protected health information that is maintained by the Absolute Wellness Center. To amend your protected health information, please communicate your request to the Absolute Wellness Center.

Right To Receive An Accounting of Disclosures Of Protected Health Information: You have a right to receive an accounting of any disclosures of your protected health information that were made for purposes other than coordinating treatment, payment or other health care services plan operations. To request an accounting of any such disclosures, please communicate your request to the Absolute Wellness Center.

Entity Requirements Under Law

The Absolute Wellness Center has a legal requirement to maintain the privacy of your protected health information. The Absolute Wellness Center has a legal requirement to provide you with this notice of his/her duties and privacy practices and to abide by the terms of this notice.

Reservation Of Right To Revise Privacy Practice

The Absolute Wellness Center reserves the right to charge and revise its privacy practices relating to protected health information. If the Absolute Wellness Center changes or revises its privacy practices the Absolute Wellness Center will provide you with a revised notice.

Complaint Procedure

If you believe that your protected health information has been improperly used or disclosed, you may file a complaint with the Absolute Wellness Center. To file such a complaint you should contact the office manager at the telephone number listed above. You also have the right to file a complaint with the Secretary of the U.S. Department of Health and Human Services (DHHS). There are no penalties or other retaliations for filing any complaints regarding the improper use or disclosure of protected health information.

Effective Date & List Of Entities To Whom This Notice Applies

This notice goes into effect on April 14, 2003. This notice applies to Rick White/ Absolute Wellness Center. Absolute Wellness Center will share your protected health information only for the purpose of treatment, payment and health care operations.

____

Patient Name   Patient Signature   Date

Absolute Wellness Center
Rick C. White, D.C.
1524 Willamette St., Suite 100
Eugene, OR 97401
(541) 484-5777

MOTOR VEHICLE ACCIDENT INFORMATION

Patient's Name: ____

Insurance Company: ____

Address: ____

Phone Number: ______________________________________Ext. ___________

Insurance Policy Number: ____

Date of Loss: ____

Claim Number: ____

Lawyer's Name: ____

Address: ____

Phone Number: ______________________________________Ext. ___________