2115 SE 192nd Ave, Suite 108
Camas, WA 98607
(360)833-2868

Auto Accident/ Personal Injury

Name: _____DOB: _____ Date: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____ Email _____

How did you hear about us so we can thank them? _____

Occupation: _____ # Hours per week currently working_____

Have you ever been to an acupuncturist before? Yes/No _____My last visit was_____

Will you be seeking reimbursement from insurance? Y / N Would you like to check your insurance benefits? Y / N

Your position in vehicle: Driver_____ Front Passenger_____ Right rear passenger_____ Left rear passenger_____ Other_____ Please Explain:_____

Involved Party vehicle make: _____ Model:_____ Year:_____

Name of driver: _____

Address of driver:_____
City:_____ State:_____ Zip Code:_____

Involved Party vehicle make: _____ Model:_____ Year:_____

Name of driver: _____

Address of driver:_____

City:_____ State:_____ Zip Code:_____

Has a personal injury protection (PIP) claim been file? Yes:____ No:____

If yes, claim #:_____

Claim's Adjuster Name:_____Phone #_____

Fax #_____

If no PIP, other party insurance company name:_____

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Claim #_____

Claim Adjuster name:_____P#_____

Fax number:_____

How much damage was done to the vehicle: $_____ Have you consulted with an attorney: _____

Is an attorney representing you? _____ If so, please provider contact information below:

Law Office Name:_____

Attorney Name:_____

Law Office Phone number: (_____)_____

Law Office Address:_____City:_____
State:_____ Zip Code:_____

How did you leave the scene of this accident: Drove same vehicle:_____ By ambulance:_____ By fire department:_____

By police:_____ By friend Other:_____
Other:_____

Location of accident:_____

City:_____ County:_____
State:_____

Was this accident investigated by law enforcement:_____

If law enforcement did investigate accident what agency: City police:_____ Country police or sheriff:_____ State police:_____

Case number:_____

Did you complete a state accident form:_____

GENERAL

Weight _____ lbs. Weight 1 year ago _____ lbs. Maximum weight _____ lbs Height _____

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Blood pressure _____ Pulse _____ Temperature _____

When during the day is your energy the best? _____ Worst? _____

PAST MEDICAL HISTORY

__ Allergies __ Cancer __ Diabetes __ Hepatitis __ High blood pressure __ Heart disease

__ Seizures __ Thyroid disease __ Surgeries_____ other significant illnesses_____

__ Accidents or trauma _____

FAMILY HISTORY (check those applicable)

__ Cancer __ Diabetes __ Heart Disease __ High blood pressure __ Stroke __ Epilepsy

__ Mental Illness __ Asthma __ Hay-fever __ Hives __ Anemia __ Kidney Disease

__ Glaucoma __ Tuberculosis __ Thyroid Disease

LIFESTYLE

Do you follow a regular exercise program? _____ If so, please describe:_____

Please describe your average daily diet: _____

Please check any of the following habits that apply. Indicate how much and how often your consume them.

__ Cigarette smoking_____ __ coffee, tea or cola _____

__ Alcoholic beverages _____

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HEALTH HISTORY QUESTIONAIRE

Main problem(s) you would like to address:

_____ _____

_____ _____

To what extent does this problem affect your daily activities (work, sleep, eating, etc.)

_____

How long has it been since you first noticed any symptoms? _____

What kinds of treatment have you tried? _____

Medications taken within the last two months _____

Please put a check next to conditions you have experienced within the last three months. Indicate the length of time you have had this condition:

GENERAL

☐ Poor appetite _____ ☐ Insomnia _____ ☐ Disturbed sleep _____

☐ Localized weakness _____ ☐ Cravings _____ ☐ Strong thirst _____

☐ Weight gain _____ ☐ Weight loss _____ ☐ Changes in appetite _____

☐ Sweating easily _____ ☐ Tremors _____ ☐ Bleeding or bruising easily __

☐ Night sweats _____ ☐ Fever _____ ☐ Chills _____

☐ Sudden energy drop (time of day?) _____ ☐ Poor balance _____

☐ Other unusual or abnormal conditions you have noticed in your general sense of health? _____

_____

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SKIN AND HAIR

☐ Rashes _____ ☐ Ulcerations _____ ☐ Hives _____

☐ Itching _____ ☐ Eczema _____ ☐ Pimples _____

☐ Dandruff _____ ☐ Hair loss _____ ☐ Recent moles _____

☐ Changes in hair or skin texture _____

Any other hair or skin problems? _____

HEAD, EYES, EARS, NOSE, THROAT

☐ Dizziness _____ ☐ Concussions _____ ☐ Migraines _____

☐ Glasses _____ ☐ Spots in front of eyes _____ ☐ Eye pain _____

☐ Poor vision _____ ☐ Night blindness _____ ☐ Color blindness _____

☐ Cataracts _____ ☐ Blurry vision _____ ☐ Earaches _____

☐ Ringing in ears _____ ☐ Poor hearing _____ ☐ Eyestrain _____

☐ Sinus Problems _____ ☐ Recurrent sore throat _____ ☐ Nose bleeds _____

☐ Grinding teeth _____ ☐ Sores on lips or tongue ____ ☐ Facial pain _____

☐ Teeth problems _____ ☐ Headaches (Where? When?)__ ☐ Jaw clicks _____

Any other head or neck problems? _____

CARDIOVASCULAR

☐ Dizziness _____ ☐ Low blood pressure _____ ☐ Chest pain _____

☐ Irregular heartbeat _____ ☐ High blood pressure _____ ☐ Fainting _____

☐ Cold hands or feet _____ ☐ Swelling of hands _____ ☐ Swelling of feet _____

☐ Blood clots _____ ☐ Difficulty in breathing _____ ☐ Phlebitis _____

Any other heart of blood vessel problems? _____

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RESPIRATORY

☐ Cough _____ ☐ Coughing up blood _____ ☐ Asthma _____

☐ Bronchitis _____ ☐ Pain with deep inhalation ___ ☐ Pneumonia _____

☐ Difficulty breathing when lying down _____ ☐ Production of Phlegm (Color?) _____

Any other lung problems? _____

GASTROINTESTINAL

☐ Nausea _____ ☐ Vomiting _____ ☐ Diarrhea _____

☐ Constipation _____ ☐ Gas _____ ☐ Belching _____

☐ Black stools _____ ☐ Blood in stools _____ ☐ Indigestion _____

☐ Bad breath _____ ☐ Rectal pain _____ ☐ Hemorrhoids _____

☐ Abdominal pain or cramps _____ ☐ Chronic laxative use _____

☐ Any other problems with stomach or intestines? _____

GENITO-URINARY

☐ Pain on urination _____ ☐ Frequent urination _____ ☐ Blood in urine _____

☐ Urgency to urinate _____ ☐ Unable to hold urine _____ ☐ Kidney stones _____

☐ Decrease in flow _____ ☐ Impotence _____ ☐ Sores on genitals _____

☐ Do you wake up at night to urinate? _____ If so, how often? _____

Any particular color to your urine? _____

Any other problems with your genital or urinary functions? _____

REPRODUCTIVE AND GYNECOLOGIC

☐ Menstrual clots _____ ☐ Painful menses _____ ☐ Unusual menses

☐ Changes in body/psyche prior to menstruation _____ (heavy or light?) _____

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☐ Irregular menses _____ ☐ Menopause (age?) _____ ☐ Other problems _____

Age at first menses _____ Length of time between menses _____ Duration _____

First day of last menses _____ Number of pregnancies _____ Premature births _____

Miscarriages _____ Abortions _____ Number of births _____

Do you practice birth control? ____ If so, what type? _____ For how long? _____

MUSCULOSKELETAL

☐ Neck pain _____ ☐ Muscle pains _____ ☐ Knee pain _____

☐ Back pain _____ ☐ Muscle weakness _____ ☐ Foot/ankle pain _____

☐ Hand/wrist pains _____ ☐ Shoulder pains _____ ☐ Hip pain _____

Any other joint or bone problems? _____

NEUROPSYCHOLOGICAL

☐ Seizures _____ ☐ Dizziness _____ ☐ Loss of balance _____

☐ Areas of numbness _____ ☐ Poor memory _____ ☐ Lack of coordination _____

☐ Concussion _____ ☐Depression _____ ☐ Anxiety _____

☐ Bad temper _____ ☐ Easily susceptible to stress _____

Have you ever been treated for emotional problems? _____

Have you ever considered or attempted suicide? _____

Any other neurological or psychological problems? _____

COMMENTS

Please tell us of any other problems you would like to discuss: _____

_____

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PERSONAL INJURY FINANCIAL POLICY

This is an agreement between Mind & Body Natural Healing Center and the Patient/Debtor named on this form.

In this agreement the words "you," "your," and "yours" means the Patient/Debtor. The word "account" means the account that has been established in your name to which charges are made and payments are credited. The words "we," "us," and "our" refer to Mind & Body Natural Healing Center.

Charges to Account: Upon reaching an agreement with your insurance company or attorney, charges may be made to your account without payment at time of service during your personal injury claim. We shall have the right to cancel this privilege at any time if circumstances between this office and your attorney or insurance company change. When appointments are not made and kept according to your treatment plan, you may be released from our care due to non-compliance.

Responsibility for Payment: As a courtesy to you, we will gladly submit your charges to your insurance company(ies) and/or your attorney; however, all services rendered by this office are charged directly to you, and ultimately, you are personally responsible for payment of these charges, regardless of any insurance reimbursement or settlement you may or may not receive.

Effective Date: Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in effect. You may receive a copy of this agreement upon request.

Insurance and payments: While you are under care for your personal injury you authorize us to send your records and bills to the appropriate companies. (i.e. auto insurance company or attorney) You authorize your insurance company(s) or attorney to pay benefits directly to Mind & Body Natural Healing Center. If benefits are paid directly to you the patient, payment for your full bill will be expected promptly after your settlement is reached. Any unpaid balance over 120 days post settlement will be transferred to our collections agency. If we refer your account to a collection agency, you agree to pay all of the collection costs that are incurred to you and it will become your responsibility. The insurance company will make the final determination of your eligibility and amount of the settlement. If you disagree with any verification or payment on your behalf, it will be your responsibility to pay your account balance in full. Any discrepancies will be handled between you and your insurance company.

Attorney Liens: If you hire an attorney to represent you in a law suit, it is our policy to have your attorney sign a Doctor's Lien. This will guarantee direct payment to our office for any undid balance upon the settlement of your law suit. We retain the right to first submit all charges to your private and/or auto insurance policy for payment. Further, this office does not discount or reduce the amount of your balance based upon the outcome of your settlement.

Returned Checks: There will be a $10.00 fee assessed for all returned checks.

I have read and understand the financial policy and agree to all terms and conditions stated herein.

Patient's Name/Responsible Party (if not the patient):_____

Signature: _____ Date: _____

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PATIENT HIPAA CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Print Patient Name_____Date_____

Signature of Patient/Guardian_____

Printed Name of Guardian _____

Relationship to Patient _____

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PLEASE READ AND SIGN THE FOLLOWING

Explanation of Insurance Coverage:

Many insurance policies do cover acupuncture care but this office makes no representation that yours does. Insurance policies may vary greatly in terms of deductible and percentage of coverage for acupuncture care. Because of the variance from one insurance policy to another, we require that you, the patient, be personally responsible for the payment of your deductibles, as well as any unpaid balances in this office. We will do our best to verify your insurance coverage, and will bill your insurance in a timely manner.

Assignment of Benefits:

By signing below you assign benefits to Mind & Body Acupuncture & Herb Center. This designation directs your insurance company to send payments directly to this office. If your insurance carrier sends payment to you for services incurred in this office, you agree to send or bring those payments to this office upon receipt. If you pay for your visits in full the assignment need not be signed and the payments will be sent directly to you from the insurance.

Release of Information:

If you're insurance company requires medical reports or records to document your treatment or progress, your signature below authorizes this office to release the medical information necessary to process your claim.

Voluntary Termination of Care:

If you suspend or terminate your care at any time, your portion of all charges for professional services is immediately due and payable to this office. All services rendered by this office are charged directly to you, and you, ultimately will be personally responsible for payment regardless of your insurance coverage.

Cancellation of Appointment(s):

I voluntarily authorize the chiropractor to administer adjustments and/or other treatments of chiropractic medicine for relief of my conditions. I understand that appointment times are reserved especially for me and if for any reason you need to cancel or reschedule we do require a 24 hour notice. If not there will be a $45 fee charged to your account for no show/missed appointments or a $25 fee for same day cancellations. Payment is due prior to future treatments. I also understand that if I miss an appointment and/or cancel an appointment on the same day three times, that my future appointments will be canceled.

Copay-Coinsurance-Deductibles-Returned Checks:

I understand that payment is due at the beginning of each visit, unless otherwise arranged. (If we are not sure of your insurance co-pay or coverage, we ask for full payment until this is determined) There will be a $25.00 fee charged on all returned checks.

I have read and understand the above. Please sign below to authorize insurance payment, if billing medical insurance. I authorize Mind & Body Acupuncture & Herb Center to accept assignment for medical service(s) rendered.We would like to take a moment to welcome you to our office and assure you that you will receive the very best of care available for your condition. In order to familiarize you with the financial policy of this office we would like to explain how your medical bills will be handled.

I have read and agree to the above.

Signature_____

Print Full Name _____Date_____