

Atlas Spinal Care, P.C.

MOTOR VEHICLE ACCIDENT INTAKE

16500 SE 15th Street, Suite 160

(360) 718 - 7944

Vancouver, WA 98683

Fax (360) 718 - 7931

Patient Information

Patient Name: _____ If a Minor, Responsible Party: _____

Address: _____ City _____ State _____ Zip _____

Birth Date ___/___/___ Age _____ Male ___ Female ___ Social Sec. # ___/___/___

Occupation _____ Employer _____

Marital Status: _____ # of children _____ Email: _____

Home # _____ Work # _____ Cell # _____ Best way to contact: _____

Emergency Contact: Name: _____ Relationship: _____

Home # _____ Cell # _____

Who may we thank for referring you? _____

Billing Information

DATE OF ACCIDENT ___/___/___

Time of Day _____ am/pm

Vehicle you were in Year: _____ Make: _____ Model: _____

Name of driver: _____

YOUR Insurance company: _____ Phone # _____

Has a **PERSONAL INJURY (PIP)** claim been filed? ___ Yes ___ No If yes, claim# _____

Name of Adjuster: _____

Other Vehicle Year: _____ Make: _____ Model: _____

Name of driver: _____

OTHER DRIVER'S Insurance company: _____ Phone # _____

Has a claim been filed? ___ Yes ___ No If yes, claim #: _____

Name of Adjuster: _____

Is an attorney representing you? ___ Yes ___ No Name: _____ Phone# _____

Health History

What other treatments have you had for your current complaints?

Chiropractic Physical Therapy Neurologist Medication Surgery Orthopedic

Other: _____

Name of Doctor(s) who have treated you for this condition? _____

Date of last: Physical Exam: _____ Spinal X-ray: _____ MRI: _____ CT Scan: _____

List any allergies you currently have (food, medication, etc): _____

List any medications you are currently taking: _____

List any vitamins/herbs/minerals you are currently taking: _____

Previous surgeries & dates: _____

Broken bones & dates: _____

Falls/Injuries & dates: _____

Female Patients Are you pregnant? Yes No Beginning of last menstrual cycle: _____

Circle any of the following conditions you have had or are currently experiencing:

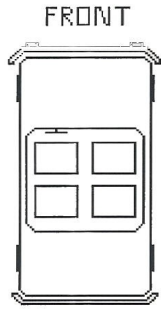
Earache	Epilepsy/Seizures	Anxiety/Depression	Arm/Shoulder Pain	Arthritis
Asthma	Bladder Problems	Cancer	Chronic Fatigue	Deafness
Diabetes-Type 1/Type 2	Digestion Problems	Ear Ringing	High Blood Pressure	Headaches
Heart Disease	Hepatitis	Herniated Disc	Insomnia	Kidney Problems
Leg Pain	Neck Pain	Mid-Back Pain	Migraines	
Low Back Pain	Osteoporosis	Poor Circulation	Prostate Issues	
Rheumatoid Arthritis	Scoliosis	Shingles	Sinus Infection	

Stressors:

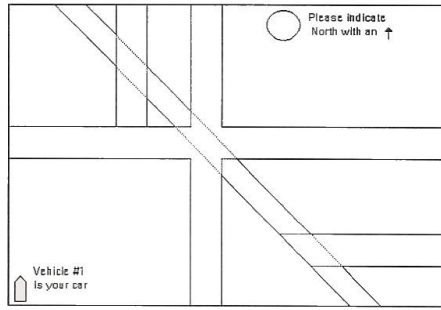
Smoking Packs/Day _____
Alcohol Drink/Week _____
Caffeine Cups/Day _____
High Stress Level Reason _____

Exercise:

_____ None _____ Moderate
_____ Heavy _____ # of days/week



Shade areas of impact



Describe how accident occurred: _____

Location of accident: _____ City: _____ State: _____

Was accident investigated by law enforcement? Yes No If so, which agency: City / County / Sheriff / State Police

Case #: _____ Did you complete a State Accident form? Yes No (if so, please provide copy of report)

Accident Environmental Conditions

- Circle what applies:**
- A) The weather was: Clear / Cloudy / Foggy
 - B) The road conditions were: Dry / Wet / Icy / Snow Covered
 - C) The road surface was: Concrete / Asphalt / Dirt / Gravel
 - D) At the time of the accident, it was: Raining / Drizzling / Snowing / Hail / Dry

Mechanics of Accident

Your position in the car Driver Front passenger Right rear Left rear Other: _____

Were you wearing a seatbelt? Yes No Were you wearing a shoulder harness? Yes No

Did an airbag deploy at your position? Yes No Was there a headrest on your seat? Yes No

Were you aware an accident was about to occur? Yes No Did you brace for impact? Yes No

At the time of the accident, were you: looking forward looking right looking left

At the time of the accident, were you Stopped Moving Forward Moving Backwards

Did you have a: Traffic light; color? _____ Stop sign Yield sign No traffic control

This was a: Head-on collision Rear-end collision T-Bone collision One car collision

Car/Bicycle collision Car/pedestrian collision

Accident Symptoms & Complaints

What is your major symptom/problem? _____

Have you had this problem before? _____ Has the accident made the symptoms worse? _____

Is this problem getting progressively worse? _____

Have you experienced any of the following symptoms after the accident: **(circle what applies)**

Loss of consciousness / Dizziness / Confusion / Tingling in arms or legs / Disorientation / Headaches

Numbness in arms or legs / Neck pain / Neck stiffness / Low back pain / Low back stiffness / Blurred vision /

Warm spots in your body / Cold spots in your body

Have you had difficulty with any of the following daily activities since the accident?

Sleeping / Sitting / Walking / Eating / Reading / Concentrating / Bowel movements

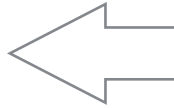
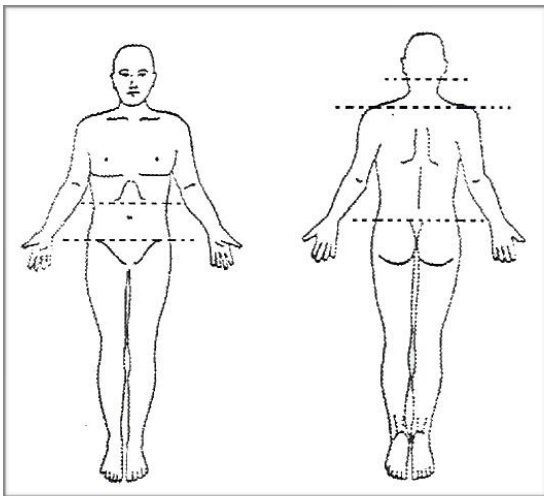
What makes your condition better? _____ What makes your condition worse? _____

Do your accident symptoms interfere with: Work ___ Sleep ___ Daily Routine ___ Recreation ___

Activities/Movements that are painful to perform: Sitting ___ Standing ___ Walking ___ Bending ___

Lying Down ___ Driving ___ Reading ___ Other: _____

Circle the severity of your pain (no pain) 1 2 3 4 5 6 7 8 9 10 (severe pain)



Please note on the diagrams any areas of contusions, bruising, cuts, lacerations or scrapes

Did you receive any injuries, bruises or cuts as a result of the use of seat belts, shoulder harness, headrest or airbag deployment? ___ Yes ___ No

If yes, please describe: _____

The statements made on this form are accurate to the best of my knowledge and I agree to be examined at Atlas Spinal Care for treatment of my symptoms.

Patient Signature _____ **Date** _____

FUNCTIONAL LOSS PATIENT QUESTIONNAIRE

Patient's Name _____ Date _____

	Left	Right		Left	Right
Neck movement limited	_____	_____	Numb face	_____	_____
Shoulder movement limited	_____	_____	Numb neck	_____	_____
Elbow movement limited	_____	_____	Numb upper arm	_____	_____
Wrist movement limited	_____	_____	Numb lower arm	_____	_____
Hand movement limited	_____	_____	Numb hand	_____	_____
Finger movement limited	_____	_____	Numb upper back	_____	_____
Upper back movement limited	_____	_____	Numb lower back	_____	_____
Lower back movement limited	_____	_____	Numb hip	_____	_____
Hip movement limited	_____	_____			
Numb upper leg	_____	_____			
Knee movement limited	_____	_____			
Numb lower leg	_____	_____			
Ankle movement limited	_____	_____			
Numb foot	_____	_____			
Foot movement limited	_____	_____			

	Moderate	Severe	Mild
Neck weakness	_____	_____	_____
Shoulder weakness	_____	_____	_____
Upper arm weakness	_____	_____	_____
Lower arm weakness	_____	_____	_____
Wrist/Hand grip weakness	_____	_____	_____
Upper back weakness	_____	_____	_____
Lower back weakness	_____	_____	_____
Hip weakness	_____	_____	_____
Upper leg weakness	_____	_____	_____
Lower leg weakness	_____	_____	_____
Ankle/foot weakness	_____	_____	_____

Circle the following activities that are difficult:

Walking / Running / Standing / Sitting / Bending / Kneeling / Crawling / Stooping / Lifting / Twisting
Pushing / Pulling / Tying Shoe Laces / Grooming finger nails / Grooming toe nails / Climbing up stairs
Climbing down stairs / Putting on pants / Putting on shoes/socks / Buttoning shirts/pants / Lifting one arm
Lifting both arms / Hand coordination / Balancing while standing / Sleeping / Dizziness / Sleeping-pain in neck
Sleeping-pain in arm / Sleeping-pain in upper back / Sleeping-pain in lower back / Sleeping-pain in hip
Sleeping-pain in upper leg / Sleeping-pain in lower leg / Sleeping-pain in foot / Fatigue / Memory / Speaking
Hearing / Headaches / Migraines / Forgetful of numbers / Forgetful of tasks / Forgetful of names /
Breathing / Bowel movements / Sexual desire / Sexual ability

In your words, please describe how your life has been affected since the accident. Please be very descriptive in your explanation and use complete sentences:

Social: Dancing, sports, gardening, hobbies, family activities:

Work: Changes in performing your job, changes in jobs:

Atlas Spinal Care, P.C.

INFORMED CONSENT FOR CHIROPRACTIC CARE

Washington State Law requires that chiropractic patients be provided with the following information prior to being treated.

Chiropractic examination and therapeutic procedures (including spinal adjustments, muscle therapy, exercise and traction) are considered safe and effective methods of care. Occasionally, however, complications may arise. Any procedure intended to help may have complications. While the chances of experiencing complications are small, it is the practice of this clinic to inform our patients about them. These complications include but are not limited to soreness, inflammation, soft tissue injury, dizziness and temporary worsening of symptoms. More serious complications are extremely rare.

Alternatives to chiropractic care include but are not limited to medical treatment, physical therapy, acupuncture and massage. If you have any questions, please feel free to discuss them with the doctor.

I have read, or have had read to me, the above consent. By signing below I agree to the above and allow the doctor or associates, affiliated with *Atlas Spinal Care* to perform such. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment. I also understand that there is no guarantee or warranty for a specific cure or result.

Patient Name (Printed) _____

Patient Signature _____ Date: _____

(Or Patient Representative)

(Indicate relationship if signing for patient)

Pregnancy Release:

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

Patient Signature _____ Date: _____

Atlas Spinal Care, P.C.

OFFICE POLICIES

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

Please do not wear strong perfumes/colognes. We see many patients with allergies or respiratory problems. Strong scents can impair their progress.

Continued cancellations or missed appointments may result in being released from care. If you need to re-schedule an appointment, please call within 24 hours of your scheduled appointment.

Children are welcome in the clinic. You are responsible for your children's actions at all times. Our staff will assist you with your well-behaved children.

We may schedule you for multiple appointments. This will help insure convenient appointment times for you as well as provide you with the highest level of care possible. If you need to spend extra time discussing your health concerns with your doctor, please let our staff know so we may schedule your next appointment accordingly. Please notify your doctor of **any** changes in your health status regardless of the significance.

FINANCIAL POLICIES

We accept the following forms of payment: Cash, Personal Checks, Debit Cards, Visa, Discover, American Express and Master Card. There will be a 3% service fee for all payments made on a credit or debit card over \$1,000.

Payment is expected at the time of your visit. We will bill your primary insurance company for Initial Intensive Care as a courtesy to you. The patient is always responsible for the payment of their care. We reserve the right to file a lien in the event of non-payment.

Insurance coverage is never guaranteed. If there are any problems between the insurance company and the patient, the latter may file a grievance directly with your insurance company. Your signature below assigns 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.

The office manager may approve account balances. Active monthly payments are required. Accounts with balances 30 days past due may be charged a service fee of 12% per year compounded monthly.

Any account where no payment has been received for sixty days may be sent to a third party collection agency. Any additional collection fees will be the responsibility of the patient. NSF checks or rejected credit card payments will be charged a service fee of \$35 per occurrence.

We do offer a *time of service discount* when services are paid in full at the time of the visit; however this discounted rate is no longer available once we are asked to bill any insurance.

In some cases, we may have a contract with your insurance company governing how we handle your account. This contract may prevent us from offering you our *time of service* discount. Please ask us if you have any questions.

Feel free to ask us any financial questions you may have. Our intent is to provide you with the highest level of service as well as care

Your insurance company determines benefits when they receive our billings. Any statements made by our staff regarding your coverage in no way guarantees that your care here will be covered by your insurance company and you will be responsible for your account regardless of insurance

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

Patient or guardian: _____

Date: ____/____/____

Atlas Spinal Care, P.C.

USE YOUR PIP BENEFITS OPEN YOUR PIP CLAIM IMMEDIATELY AFTER AN ACCIDENT

What is PIP?

Personal Injury Protection is coverage under your auto insurance policy that will pay your medical bills, wage loss and household services immediately after your accident

Facts about PIP Benefits

- PIP is no-fault; it does not matter who caused the accident, you are covered
- PIP does not have a deductible or co-payment
- PIP must be included in your policy unless you **rejected it** in writing
- BY LAW your insurance company cannot raise your rates or cancel your policy for using PIP

What if I excluded PIP on my insurance?

If PIP is excluded on your policy, we can bill your personal health insurance if you have chiropractic and/or massage coverage. You may need to contact your health insurance carrier to provide proof of no PIP coverage

Can you bill the other driver's insurance (3rd Party) ?

We cannot bill the 3rd party insurance carrier. If you do not have PIP or health insurance, you may want to consult with an attorney to protect your rights.

What if my PIP is exhausted?

We can bill your Health insurance if PIP is exhausted. If you do not have Health insurance, we will need to start collecting payment at each time of service. You may want to consult with an attorney to protect your rights.

Closed Claim

When a claim is closed, but not settled, our policy is to collect \$10.00 per month to keep communication open between your attorney, you and our office.

In order to minimize your account balance, as well as cover our up-front expenses in providing care and maintaining your account, it is our policy that we receive a payment at the time of service for massage therapy. All charges will be posted to your account at our standard minimum fee. The deposit amounts required will be:

Massage \$40.00

Payments will be applied to your account and will be reflected in any billing ledger provided to you or your attorney by request. Accounts with balances over 30 days due have a finance charge of 1% per month that may be added. All remaining account balances will be due and payable in full upon settlement of your case or at a time when it becomes apparent that a settlement may not be reached.

Patient Signature _____ Date _____

*Some information provided by Graham Lundberg & Peschel Attorneys At Law

The Rivermead Post-Concussion Symptoms Questionnaire*

After a head injury or accident some people experience symptoms which can cause worry or nuisance. We would like to know if you now suffer from any of the symptoms given below. As many of these symptoms occur normally, we would like you to compare yourself now with before the accident. For each one, please circle the number closest to your answer.

- 0 = Not experienced at all
- 1 = No more of a problem
- 2 = A mild problem
- 3 = A moderate problem
- 4 = A severe problem

Compared with before the accident, do you now (i.e., over the last 24 hours) suffer from:

Headaches.....	0	1	2	3	4
Feelings of Dizziness	0	1	2	3	4
Nausea and/or Vomiting	0	1	2	3	4
Noise Sensitivity, easily upset by loud noise	0	1	2	3	4
Sleep Disturbance.....	0	1	2	3	4
Fatigue, tiring more easily	0	1	2	3	4
Being Irritable, easily angered	0	1	2	3	4
Feeling Depressed or Tearful	0	1	2	3	4
Feeling Frustrated or Impatient	0	1	2	3	4
Forgetfulness, poor memory	0	1	2	3	4
Poor Concentration	0	1	2	3	4
Taking Longer to Think	0	1	2	3	4
Blurred Vision	0	1	2	3	4
Light Sensitivity, Easily upset by bright light.....	0	1	2	3	4
Double Vision	0	1	2	3	4
Restlessness	0	1	2	3	4

Are you experiencing any other difficulties?

- | | | | | | |
|----------|---|---|---|---|---|
| 1. _____ | 0 | 1 | 2 | 3 | 4 |
| 2. _____ | 0 | 1 | 2 | 3 | 4 |

*King, N., Crawford, S., Wenden, F., Moss, N., and Wade, D. (1995) J. Neurology 242: 587-592