BODY SAGE

Orthopedic Massage & Chiropractic Wellness
9430 SW Coral Street, Suite 203 Tigard, OR 97223
Tel: (503) 644-1418 Fax: 503 644-1422

MVA/WC ACCIDENT INTAKE

Patient Information:

Patient Name: _____ **Date:** ____/____/20____

DOB: ____/____/_____ Age: _____ Sex: □Male □Female Marital Status: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Telephone: _____ Email: _____

Occupation: _____ Employer: _____

How did you hear about Body Sage: □Dr. □Insurance □ Family □Friend □Web □Yellow Pages □ □Social Media □Mailer □ Other _____

Has the accident been reported to the insurance company? □ Yes □No

Insurer: _____ Claim #: _____

Claim Adjuster: _____ Tel: _____

Nature of Accident:

1. D/Injury:____/____/20_____ Time of Day: _____AM/PM Weather: _____
2. Where you: □ Driver □ Passenger □ Front Seat □Back Seat □Middle Back Seat
3. Number of people in your vehicle? _____ Other vehicle? _____
4. What direction where you headed? □North □East □South □West
   On (name of street and/or hwy) _____
5. What direction was the other vehicle headed? □North □East □South □West
6. Were you struck from: □Behind □Front □ Left Side □ Right Side _____
7. Were you knocked unconscious? □Yes □ No If yes, for how long? _____
8. Were police notified? □Yes □ No
9. In your own words, please describe accident:

   _____

   _____
10. Did you have any physical complaints BEFORE THE ACCIDENT? □ Yes □No
    If yes, please describe in detail:

    _____

    _____

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11. Please descibe how you felt:
    - DURING the accident: _____
    - IMMEDIATELY AFTER the accident:_____
    - LATER THAT DAY: _____
    - THE NEXT DAY:_____
12. What are your PRESENT complaints and symptoms?

    _____

    _____
13. Do you have any congenitial (from birth) factors which relate to this problem? □Yes □No
    If yes, please describe: _____
14. Do you have any previous illnesses which relate to this case? □Yes □No
    If yes, please describe: _____
15. Where were you taken after the accident? _____
16. Have you ever been treated by another doctor since the accident? □Yes □No
    If yes, please provide the doctor's name and address:

    _____

CHECK SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT:

□Headache(s)	□Irritability	□Numbness in Toes
□Face Flushed	□Feet Cold	□Neck Pain
□Chest Pain	□Shortness of Breath	□Buzzing in Ears
□Hands Cold	□Neck Stiff	□Dizziness
□Fatigue	□Loss of Balance	□Stomach Upset
□Sleeping Problems	□Head seems Too Heavy	□Depression
□Constipation	□Back Pain	□Pins & Needles in Arms
□Lights Bother Eyes	□Loss of Smell	□Cold Sweats
□Nervousness	□Pins & Needles in Legs	□ Loss of Memory
□Loss of Taste	□Fever	□Tension
□Numbness in Fingers	□Ears Ring	□Fainting

Symptoms Other Than Above:

_____

17. When did your symptoms begin?: _____/_____/20_____ or _____
18. Did you hae any of these symptoms before the accident? □ Yes □No
19. Since the injury occurred, are your symptoms: □ Same □Worse □Improving
20. Have you lost time from work as a result of this accident? ? □ Yes □No
    If yes, please complete the following:
    - Last Day Worked: _____
    - Type of Employment: _____
    - Are you being compensated for time lost from work? □ Yes □No

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21. Do you notice any activity restrictions as a result from this injury? □ Yes □No
    If yes, please describe, in detail:

    _____

    _____

22. Have you ever been involved in an accident before? ? □ Yes □No
    If yes, please describe, include date(s) and type(s) of accidents, as well as injuries received:

    _____

    _____

    _____

23. Has an attorney been retained? □ Yes □No
    If yes, Please provide your attoney's name, telephone, and address:

    _____

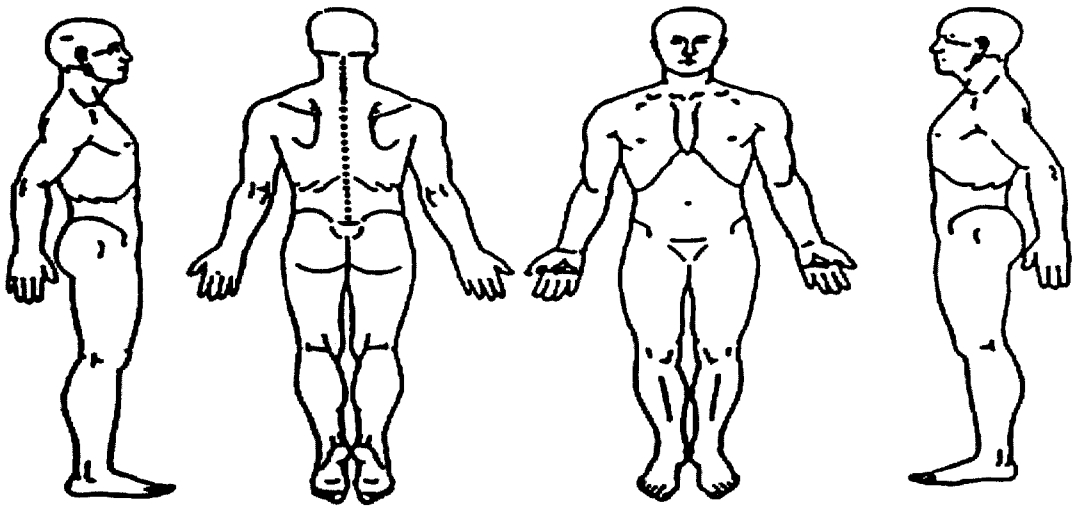
24. Other pertinent information: (medications, operations, pregnancy, etc.)

    _____

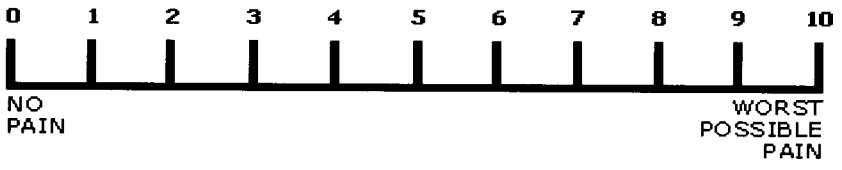
    _____

    _____

25. Please mark an **X** on the areas affected as a result of your injury:



26. Please indicate your current pain level on a scale of 0-10, with 10 being the worst possible pain: _____



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IN CASE OF EMERGENCY

Name of relative or local friend: _____

Relationship to patient: _____ Phone Number: _____

The above information is true to the best of my knowledge. I authorize my insurance company to pay Body Sage Orthopedic Massage and Chiropractic Wellness directly to the treating physician or therapist. I understand that I am financially responsible for any balance. I also authorize Body Sage Orthopedic Massage & Chiropractic Wellness and my insurance company to release any information required to process my claims.

Patient Signature _____ **Date** ____/____/20_____

Signature of Parent of Minor Patient: _____ **Date** ____/____/20_____

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INFORMED CONSENT

The primary treatment used by doctors of chiropractic is the spinal adjustment.

The doctor will use his/her hands or a mechanical device upon your body in such a way as to move your joints. That may cause an audible "pop" or "click." You may feel or sense movement.

As with any health care procedure, there are certain complications which may arise during a chiropractic adjustment. Those complications include: fractures, disc injuries, dislocations, and muscle strain, Horner's syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations.

Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. These complications are extremely rare occurrences.

Fractures are rare occurrences and generally result from some underlying weakness of the bone which we check for during the taking of your history and during the initial examination.

- I have read or have had read to me the above explanation of the chiropractic adjustment and related treatment.
- I have discussed it with the Doctors of Body Sage Orthopedic Massage & Chiropractic Wellness and have had my questions answered to my satisfaction.
- By signing below, I state that I have weighed the risks involved in undergoing treatment recommended. Having been informed of the risks, I hereby give the doctors of Body Sage Orthopedic Massage & Chiropractic Wellness consent to treatment.

_____
Patient name (print)

_____ _____/_____/20_____
Patient Signature **Date**

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CONSENT TO AUTHORIZE DISCLOSURE OF INFORMATION (HIPAA)

Patient's Name: _____

Patient's DOB: ____/____/____ **Patient's Phone Number** _____

I hereby authorize the use and disclosure of individually-identifiable health information related to me as described below:

Specific description of information to be used or disclosed:

A. **Schedule re-schedule, confirm or cancel appointments**
B. **All account financial information, to include all third party information (MVA, WC)**
C. **Making payments, insurance inquiry, account balances or collection inquiry**
D. **Requesting medical records and billing invoices**
E. **Retrieving prescriptions, imaging orders, medication samples or specific written**
F. **doctors' orders**

I authorize the following person to receive my information:
(Please write the name of the person)

NAME: _____ **RELATIONSHIP TO PATIENT:** _____

I understand I may revoke this authorization at any time by notifying Body Sage Orthopedic Massage & Chiropractic Wellness in writing. If I choose to do so, my revocation will not affect any action taken by Body Sage Orthopedic Massage & Chiropractic Wellness before receiving my revocation.

This authorization will expire on: 12/31/2017 (unless revoked sooner by patient/parent representative)

Patient's Signature: _____ **DATE:** ____/____/20____

PATIENT REPRESENTATIVE: (If applicable)

NAME: _____ **RELATIONSHIP TO PATIENT:** _____

DRIVER'S LICENSE # _____ **ISSUING STATE:** _____

Patient's Signature: _____ **DATE:** ____/____/20____

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PATIENT CONSENT AND DOCTOR'S LIEN

Patient: _____ **D/Injury:**____/____/20_____

Insurer: _____ **Claim #:** _____

Consent and Authorization

The undersigned patient ,_____ hereby consents to the examnination, treatment, procedures, and services to be performed by doctor, and or provider _____.

Patient authorizes Provider to release any information needed to process the claims with respect to the examination, treatment, procedures, and services rendered by Provider. The patient further directs that a photocopy of this Claim Agreement and Lien be considered as valid as the original.

Patient further authorizes _____ (name of attorney), ("Attorney") to keep Provider advised of the progress of Patient's court case at reasonable intervals.

Irrevocable Lien

Patient hereby authorizes and directs Attorney to pay Provider directly any sums due for medical services rendered to Patient. Patient directs Attorney to withhold such funds from any settlement, verdict or judgement that is rendered in the said court case. Patient hereby notifies Attorney that Patient is giving Provider a lien on these benefits or settlement proceeds. In consideration for Provider waiting for payment, this lien is irrevocable and can only be satisfied by full payment of all sums due for medical services rendered. Patient authorizes Provider to notify Attorney of this lien at Providers' discretion. Patient understands that any settlement, verdict or judgment proceeds cannot be disbursed to Patient without first satisfying this lien.

Should a dispute arise regarding payment of Provider's charges, Patient authorizes and directs Attorney to hold settlement monies sufficient to satisfy this lien until the dispute can be resolved. Patient acknowledges that it would be a violation of Attorney's ethical duties to disburse the disputed funds prior to resolution of the lien dispute.

Patient understands and agrees that even though this lien has been given. The patient remains personally responsible for payments in full of Provider's fees for all services rendered. Patient is solely responsible for making appropriate arrangements for payment of such fees, including but not limited to insurance benefits. Patient acknowledges that this obligation to pay Provider's fees is not dependent on the outcome of Patient's court case.

Patient understands that such payment is not contingent on any settlement, judgement, or verdict by which I may eventually recover the said fee. If this account is assigned for collection and/or suit, collection costs and/or interest, and/or attorney's fees and/or court costs will be added to the total amount due.

Patient's Signature: _____ **Date:** ____/____/20_____

Patient's Address: _____

City: _____ **State:** _____ **ZipCode:** _____

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Acknowledgement of Attorney

The understanding being attorney of record for the above patient does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgement or verdict as may be necessary to adequately protect said doctor above named. Any settlement of this claim without honoring this assignment/lien will cause you to be responsibel to this office for payment.

Attorney's Name: _____ **Date:** ____/____/20____

Attorney Signature: _____

This office holds an assignment/lien on this case for services rendered. Any settlement of this claim without honoring this assignment/lien will cause you to be responsibel to this office for payment.