

# 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 MEDICAL INTAKE FORM

### PATIENT INFORMATION

Patient Name: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/20\_\_\_\_

DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ Sex: Male Female Marital Status: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Telephone: \_\_\_\_\_ Email: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

SSN: \_\_\_\_\_ Work Phone: \_\_\_\_\_

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

### MVA/WC INSURANCE INFORMATION

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

Type of Accident: Auto Work

Insurance Co: \_\_\_\_\_ Policy No: \_\_\_\_\_

Claim No.: \_\_\_\_\_ Date of Injury: \_\_\_\_\_ Time: \_\_\_\_\_ AM/PM

Adjuster Name: \_\_\_\_\_ Adjuster Tel: \_\_\_\_\_

### NATURE OF ACCIDENT

1. Weather:  Rain  Clear  \_\_\_\_\_

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:

\_\_\_\_\_  
\_\_\_\_\_

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10. What are your PRESENT complaints and symptoms?

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11. Where you taken to the hospital? \_\_\_\_\_

12. Have you ever been treated by another doctor since the accident?  Yes  No

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

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## CHECK SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT:

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

Symptoms Other Than Above:

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13. When did your symptoms begin?: \_\_\_\_\_ / \_\_\_\_\_ / 20\_\_\_\_ or \_\_\_\_\_

14. Did you hae any of these symptoms before the accident?  Yes  No

15. Since the injury occurred, are your symptoms:  Same  Worse  Improving

16. 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

17. Do you notice any activity restrictions as a result from this injury?  Yes  No

If yes, please describe, in detail:

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18. 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:

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19. Has an attorney been retained?  Yes  No

If yes, Please provide your attorney's name, telephone, and address:

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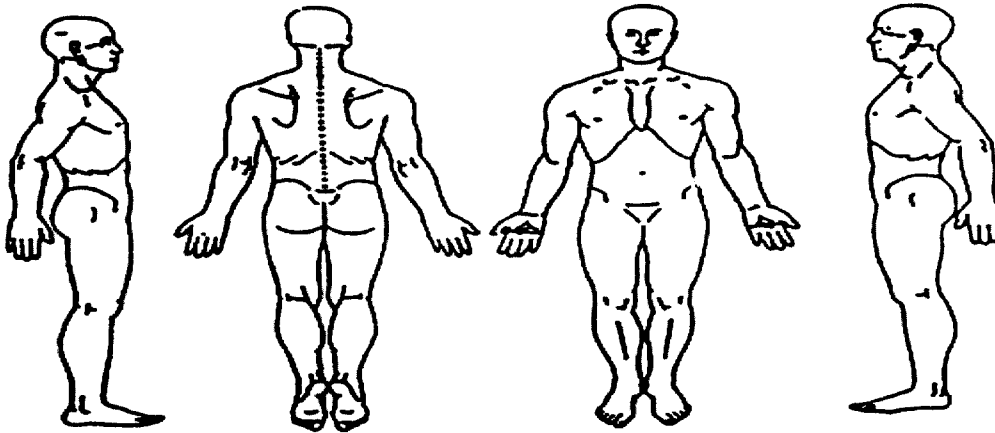
20. Other pertinent information: (medications, operations, pregnancy, etc.)

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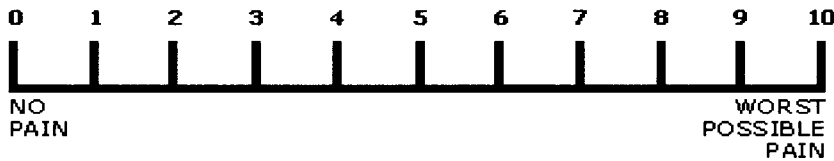
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21. Please mark an X on the areas affected as a result of your injury:



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



### 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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## FINANCIAL POLICY

Thank you for choosing **Body Sage Orthopedic Massage & Chiropractic Wellness** as your provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered we have been advised to develop this payment policy. Please read it, ask any questions you have, and sign in the space provided. A copy will be furnished upon your request.

1. **Insurance:** We participate in most insurance plans. We can verify and check on your insurance benefits for you prior to receiving care, but it is your responsibility to know your insurance benefits. However, insurance companies will never allow that a quote of coverage is a guarantee of benefits. If you have a copay, coinsurance or unmet deductible, you will be responsible for payment at time of service. We will require a deposit of \$80.00 until your insurance is verified. We will bill your insurance for services rendered in the office. After the receipt of Explanation of Benefits (EOB) from your insurance carrier, we can apply the deposit to your co-pays or refund the balance. **Patient Initials** \_\_\_\_\_
2. **Time of Service Discount (TOS):** We offer a time of service discount to our patients that have high deductibles. No health insurance or just prefer to pay cash. Payment is due in full at the time services are rendered. Please note that we will not bill your insurance or go back and bill at a later date once a TOS discount is given.
3. **Non-Covered Services:** Please be aware that some and perhaps all of the services you receive may not be covered or not considered reasonable or necessary by your insurance. You must pay for these services in full at the time of visit.
4. **Proof of Insurance:** All patients must complete our patient information forms before seeing a therapist or the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner you may be responsible for the balance of a claim.
5. **Claim Submission:** We will submit your claims and assist you in any way we reasonably can to help you get your claims paid. Your insurance company may need you to supply certain information directly, but it is your responsibility to comply with their requests. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company, and we are not a party to that contract.
6. **Coverage Changes:** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim within 90 days, the balance will automatically be billed to you.
7. **Personal Injury/Workers' Compensation:** Most Personal Injury and Workers' Compensation claims are covered 100%. However, it is your responsibility to provide our office with the documentation necessary to prove a valid claim, as well as the name(s) of any claims adjuster/attorney, etc. handling the case, claim numbers, and mailing address to send bills. Failure to provide the documentation needed will result in the immediate conversion of your case to cash, and all payment will be due on receipt. **Patient Initials** \_\_\_\_\_

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8. **Non-payment:** If your account is over 90 days past due you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted, unless otherwise negotiated with Body Sage Massage. Please be aware that if a balance remains unpaid we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.
9. **Missed Appointments:** Our policy is to charge \$50.00 for missed appointments not canceled within a 24 hour period to your appointment time. This also includes same day re-scheduled appointments. These charges will be your responsibility and billed directly to you.

Please help us to serve you better by keeping your regularly scheduled appointment. Our practice is committed to providing the best treatment to our patients. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy for Body Sage Massage Orthopedic Massage & Chiropractic Wellness and agree to abide by its guidelines. I also understand that I am ultimately financially responsible for all services not paid by insurance or other third party. Should there be a balance due at the end of my treatment plan, I will receive an invoice and pay it promptly, or contact the office to make payment arrangements.

**Patient/Guardian Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

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## **Health Information Privacy and Accountability Act (HIPAA)**

In accordance with the Health Information Privacy and Accountability Act (HIPAA), all healthcare providers are required by law to maintain the privacy of your health information and provide you a description of their privacy practices. This notice identifies your rights regarding this center's use of your Protected Health Information. This notice also describes how your health information may be used and disclosed, and how you can access this information. Please review it carefully.

Each time you visit a hospital, physician, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatments, a plan for future care or treatment, and billing-related information. This notice applies to all of the records of your care generated by Body Sage Orthopedic Massage & Chiropractic Wellness. Your health information will be used and disclosed to provide treatment or services. The doctor who is involved in your care and who prescribed medical massage will disclose your health information to us, and we will disclose health information about you to that doctor.

For example, a doctor treating you may know of conditions you have that require special care, avoidance of certain therapies, or expectations for healing that your medical massage therapist needs to know about, while your medical massage therapist will share all findings with the prescribing doctor. We will use and disclose health information about the treatment and services you receive from us so that we can bill and receive payment. We will also tell your insurance company about the treatment you are going to receive to determine whether your plan will cover it.

Information about your treatment and services may also be disclosed to your attorney if such attorney is involved in litigation regarding the medical necessity of medical massage and the liability of payment for medical massage. Although your health record is the physical property of Body Sage Orthopedic Massage & Chiropractic Wellness, you have the right to inspect and, upon written request, obtain a copy (for a fee) of your health information, which usually includes prescriptions and medical and billing records.

If you believe the health information we have about you is incorrect or incomplete, and this office still maintains your information, you may submit a written request to amend your records. Our disclosure of your health information is limited to this office, the physician who prescribed physical medicine, your insurance company, your attorney, you and anyone you authorized in writing to receive information from us. If the patient is a minor or has a legal guardian, a parent or guardian is required to read this notice and sign for the patient. The minor patient's health information will be disclosed to the parents or guardian.

If you believe your privacy rights have been violated, you may file a written complaint to:  
**Office of Civil Rights; U.S. Department of Health & Human Services** at 200 Independence Avenue S.W. Room 509f, HHH Building, Washington D.C. 20201. You will not be penalized for filing a complaint.

By signing this form, you hereby acknowledge that Body Sage Orthopedic Massage & Chiropractic Wellness may release your Protected Health Information to carry out payment processing and treatment operations. I have read and understood the Notice of Privacy Practices of Body Sage Orthopedic Massage & Chiropractic Wellness.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_