# BODY SAGE THERAPIES

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 ______________________________

**CLAIM INFORMATION**

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

Insurer: ______________________________ Claim #: ______________________________

Claim Adjuster: ______________________________ Tel: ______________________________

E-mail: ______________________________ Fax: ______________________________

**ACCIDENT/INJURY INFORMATION**

**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:

   ______________________________________________________________________
   ______________________________________________________________________
   ______________________________________________________________________

# BODY SAGE THERAPIES

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

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

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**:

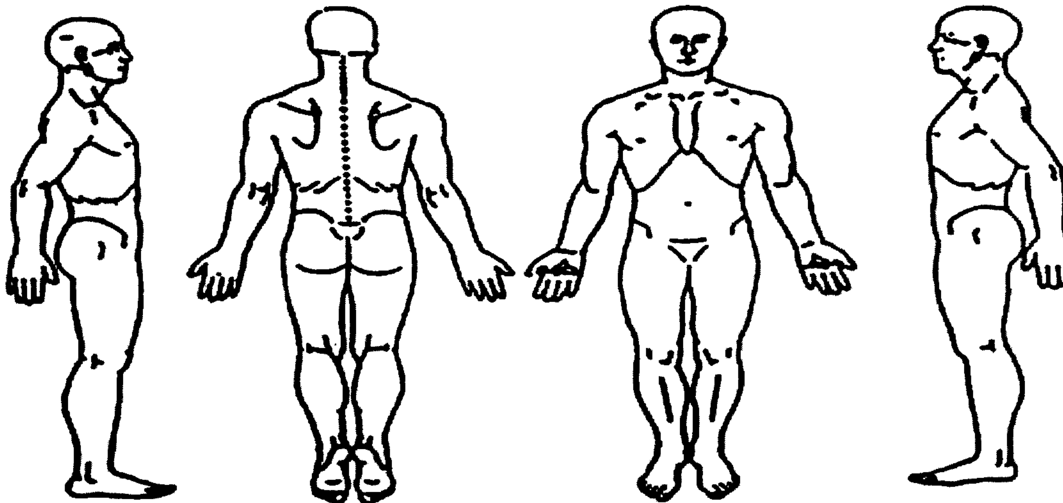
| | | |
|---|---|---|
| □Headache(s) | □Irritability | □Numbness in Toes |
| □Face Flushed | □Feet Cold | □Neck Pain |
| □Chest Pain | □Shortness of Breath | □Buzzing in Ears |
| □Hands Cold | □Neck Stiff | □Dizziness |
| □Fatigue | □Loss of Balance | □Stomach Upset |
| □Sleeping Problems | □Head seems 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: ______________________
    - Are you being compensated for time lost from work? □ Yes □No

**BODY SAGE THERAPIES**
9430 SW Coral Street, Suite 203 Tigard, OR 97223
Tel: (503) 644-1418 Fax: 503 644-1422

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: __________

# BODY SAGE THERAPIES

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

**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 Therapies directly to the treating provider. I understand that I am financially responsible for any balance. I also authorize Body Sage Therapies and my insurance company to release any information required to process my claims.

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

# BODY SAGE THERAPIES

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

## FINANCIAL POLICY

Thank you for choosing **Body Sage Therapies** 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. **Patient Initials** _____
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** ________

**BODY SAGE THERAPIES**
9430 SW Coral Street, Suite 203 Tigard, OR 97223
Tel: (503) 644-1418 Fax: 503 644-1422

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 Therapies**. 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 Therapies** 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**: ______________

# BODY SAGE THERAPIES

9430 SW Coral Street, Suite 203 Tigard, Oregon 97223
Phone (503) 644-1418 Fax (503) 644-1422

## 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 Therapies** in writing. If I choose to do so, my revocation will not affect any action taken by **Body Sage Therapies** before receiving my revocation.

**This authorization will expire on: 12/31/2020 (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____

# BODY SAGE THERAPIES

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

**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:** __________

**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:** ______________________________

Any settlement of this claim without honoring this assignment/lien will cause you to be responsble to this office for payment.