Interurban Chiropractic
Experience the Gonstead Difference

Auto Accident Information and Agreement

You have been in an accident recently and are now taking one of the first steps on the road to recovery. You will be receiving a lot of information as well as questions from everyone – please know we are here to help you.

OPENING THE CLAIM:

1. Contact your auto insurance and open a Personal Injury claim. This is often a different claim number than the one for the damage to property (motor vehicle).
   Do you have Personal Injury Protection (PIP) with your auto insurance? □ **YES** □ **NO**
   Have you opened a Personal Injury claim? □ **YES** □ **NO**

2. If you do not have personal injury coverage with your auto insurance, medical treatment may be covered by your health insurance, with benefits and limitations according to your health insurance plan. *In this situation,* it is best to contact your health insurance customer service and let them know that you do not have personal injury coverage with your auto insurance. This will allow timely processing of your medical claims.
   Do you have regular health insurance? □ **YES** □ **NO**
   Was a copy of your health insurance card provided to our office? □ **YES** □ **NO**

_____ Initial of office employee

AFTER BENEFITS EXHAUST:

1. Your Personal Injury Protection (PIP) has a dollar limit for all medical treatment. Once this dollar limit is met, new payment arrangements need to be established with our office. **At this time your personal health insurance can be billed or you can retain an attorney that will help ensure your medical bills will get paid in the settlement.**

2. **Do you want us to automatically start billing your health insurance once PIP benefits are exhausted?** □ **YES** □ **NO**
   IF YES, make sure we have your current health insurance information is on file at all times. By marking ***yes,*** you understand that all co-pays and deductibles will be billed directly to you.
   IF NO, you understand that we take this as your direct order for us not to bill your health insurance for any balance not paid in full by your auto insurance. If you wish to have us bill your health insurance at a later date we can only bill services that were rendered in the previous 90 days of your request. All prior dates of services cannot be billed due to contractual timely filing limits, and all balances are your responsibility.

Not opening a claim or Third Party:

In the event that you have chosen to not open a claim with your insurance and/or have no health insurance to bill, and the other person is believed to be at fault for the accident, you will need to retain an attorney or pay cash at time of service.

I have read everything above and fully understand my responsibilities financial and other.

_____ _____ _____ _____
Patient or Guardian Signature Date Representative/Guardian Date

13028 Interurban Ave. S., Suite 106 Tukwila, WA 98168
P. 206.957.7950 | F. 206.957.7950
www.interurbanchiropractic.com

Interurban Chiropractic
13028 Interurban Ave S. Suite 106
Tukwila, WA 98168-3340

Auto Accident Patient Information

Name _____ Today's Date _____

Address (No PO Box) _____

City _____ State _____ Zip _____

Cell Phone _____ H. Phone_____ W. Phone_____ (ok to call Y/N)

E-mail _____

Gender_____ Gender Pronoun_____ Date of Birth _____ Marital Status ☐ S ☐ M ☐ D ☐ W ☐ O

Social Security # _____ Referred By _____

Occupation _____Employer _____

DATE OF ACCIDENT _____ **Do you have PIP Coverage?** Yes No Amt _____

Your Auto Insurance Carrier _____ Claim # _____

Agent Name _____ Ph. _____

Auto Insurance Company of Other Driver _____Claim # _____

Agent Name _____ Ph. _____

****Please provide your HEALTH INSURANCE information to the Front Desk****

Other Occupants of Your Vehicle:

Name:_____ Relationship:_____ Age:_____

Name:_____ Relationship:_____ Age:_____

Name:_____ Relationship:_____ Age:_____

Name:_____ Relationship:_____ Age:_____

Would you like to discuss chiropractic care for the other occupants of the vehicle? _____

Patient Name _____ Date _____

AUTO ACCIDENT INFORMATION

Date and time of accident: _____ _____ ☐a.m. ☐p.m.

Were you the: ☐ Driver ☐ Front Passenger ☐Rear Passenger Number of people in accident vehicle? _____

Make and model of the vehicle you were occupying? _____

If a traffic violation was issued, to whom was it issued? _____

Did the police come to the accident site?☐ Yes ☐ No

Was a police report filed? ☐ Yes ☐ No

Were there any witnesses? ☐ Yes ☐ No

Were you wearing a seat belt? ☐ Yes ☐ No

Was this vehicle equipped with airbags? ☐ Yes ☐ No If yes, did it/ they inflate? ☐ Yes ☐ No

In relation to the base of your skull, where was the headrest? ☐ Above ☐ Below ☐ At base of skull

What did your vehicle impact? ☐Another vehicle ☐ Other

If other, please explain: _____

Did any part of your body strike anything in the vehicle? ☐ Yes ☐ No

If yes, please describe: _____

Make and model of the other vehicle(s) involved? _____

Name of the location/ street on which you were traveling? _____

In which direction were you headed? ☐ N ☐ S ☐ E ☐ W

What was the approx. speed of your vehicle? _____

Did the impact to your vehicle come from the: ☐ Front ☐ Rear ☐Right Side ☐ Left Side ☐ Other

During impact, were you facing: ☐ Right ☐ Left ☐Forward

Were you: ☐ aware or ☐surprised by the impact?

If accident vehicle made impact with another vehicle… Direction other vehicle was headed? ☐N ☐ S ☐E ☐ W

Approximate Speed of the other vehicle? _____

In your words, please describe the accident:

PRIOR TO INJURY

List any other Injuries, Traumas, Broken Bones and Surgeries you have had in the past, include dates:

_____

Are you taking any medications or supplements? Please list _____

_____

Do you have any Allergies: _____

Date of last physical exam: _____Height: _____ Weight_____Date of last chiropractic exam: _____

Females: Date of last menses: _____ Is there a possibility you could be pregnant?☐YES ☐NO Please initial: _____

Any previous pregnancies?☐YES☐NO Any associated complications? Please list _____

Level of exercise, alcohol consumption, tobacco use and drug use: _____

Patient Name _____ Date _____

AFTER INJURY

Did accident render you unconscious? ☐ Yes ☐ No

If yes, for how long? _____

Please describe how you felt immediately after the accident: _____

Have you gone to a hospital or seen any other Doctor? ☐Yes ☐ No

When did you go? ☐ Just after accident ☐The next day ☐ 2 days plus

How did you get there? ☐ Ambulance ☐Private transportation

Name of hospital and/ or attending doctor: _____

Was he/she a: ☐D.C. ☐M.D. ☐D.O. ☐ D.D.S.

Describe any treatment you received: _____

Were X-Rays taken? ☐ Yes ☐ No

Was medication prescribed? ☐ Yes ☐ No

Have you been able to work since this injury? ☐Yes ☐No

Are your work activities restricted as a result of this injury? ☐Yes ☐ No

Indicate the symptoms that are a result of this accident:

☐ Dizziness	☐ Difficulty Sleeping	☐ Jaw problems	☐ Nausea
☐ Back pain	☐ Irritability	☐ Arms/shoulder pain	☐ Memory loss
☐ Headache(s)	☐ Fatigue	☐ Lower back pain	☐ Numb hands/ fingers
☐ Blurred vision	☐ Tension	☐ Back stiffness	☐ Buzzing in ear
☐ Neck pain	☐ Neck stiff	☐ Chest pain	☐ Ears ringing
☐ Leg pain	☐ Numb feet/ toes	☐ Stomach upset	☐ Fainting
☐ Loss of Memory	☐ Pins & Needles in Legs	☐ Pins & Needles in Arms	☐ Other (describe below)

_____

Is your condition getting worse? ☐Yes ☐ No ☐ Constant ☐ Comes and goes

Indicate your degree of comfort while performing the following activities:

	Comfortable	Uncomfortable	Painful
Lying on back……	☐	☐	☐
Lying on side.....	☐	☐	☐
Lying on stomach…	☐	☐	☐
Sitting.....	☐	☐	☐
Standing	☐	☐	☐
Stretching.....	☐	☐	☐
Walking.....	☐	☐	☐
Running	☐	☐	☐
Sports	☐	☐	☐
Working	☐	☐	☐
Lifting	☐	☐	☐
Bending	☐	☐	☐
Kneeling……	☐	☐	☐
Pulling……	☐	☐	☐
Reaching	☐	☐	☐

Patient Name _____ Date _____

Recovery

How many hours are in your normal workday? _____

Please indicate on your daily job duties and any activities, which you are occasionally asked to perform

☐ Standing	☐ Driving	☐ Operating equipment
☐ Sitting	☐ Crawling	☐ Typing
☐ Lifting	☐ Bending	☐ Stooping

☐Other _____

What positions can you work in with minimum physical effort and for how long? ☐ N/A

_____

Prior to the injury were you capable of working on an equal basis with others your age? ☐Yes ☐ No ☐ N/A

Do you work with others who can help you with any heavy lifting? ☐Yes ☐ No ☐ N/A

While in recovery, is there any light duty work you could request? ☐Yes ☐ No ☐ N/A

Recreation activities: _____

Have you retained an attorney: ☐ Yes ☐ No

If yes, whom? _____

His/ Her phone #: _____

Address: _____

(Please note: an attorney is required if this is a 3rd party accident & there is no PIP coverage)

- We invite you to discuss with us any questions regarding our services. The best services are based on a friendly, mutual understanding between provider and patient.
- **I understand and agree that all services rendered to me are my financial responsibility and any health or accident insurance policies which I hold are based on a contract between the carrier and myself. I also understand that I am financially responsible for all non-covered services.**
- I authorize the staff to perform any necessary services needed during diagnosis and treatment in accordance with this state's statutes. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature _____ Date ____/____/____

☐Adult patient ☐Parent or Guardian ☐Spouse

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) for other purposes that are permitted or required by law. "Protected Health Information" is information about you, including demographic information that may identify you and that related to your past, present, or future physical or mental health or condition and related care services.

Use and Disclosures of Protected Health Information:
Your protected health information may be used and disclosed by your physician, our staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, pay your health care bills, to support the operations of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your health care information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

We may use or disclose your protected health information in the following situations without your authorization. These situations included as required by law, public health issues, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, and organ donation. Required uses and disclosures under the law, we must make disclosures to you when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES WILL BE MADE ONLY WITH YOUR CONSENT, AUTHORIZATION OR OPPORTUNITY TO OBJECT UNLESS REQUIRED BY LAW.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

_____ _____

Signature of Patient or Representative Date

_____

Printed Name

Interurban Chiropractic Center
Office Policies and Procedures

Symptoms: *Regardless of the reason you came to our office, it is important to understand the difference between symptoms and their cause. As your spine is corrected you will have good days and bad days; it's normal. You will get the best results if you understand that this is a process designed to get you functioning and on the road to wellness. Stay focused on the outcome and you will be pleased with your results.*

Appointments: *A certain number of adjustments in a given time period is necessary to get the best results from your care. While we can't predict the exact number of adjustments you will need, we do know that consistency creates the best results. lt is absolutely necessary that you keep your appointments. If you need to change an appointment, please call in advance to* **reschedule** *so that you can* **stay on target for your wellness plan.** *It is your responsibility to get here, but we will do all that we can to accommodate and help you on the way.*

Re-Examinations: *During your Initial Care, you will receive Re-Examinations to monitor your level of spinal correction. On this visit you will fill out an Update Form and the doctor will conduct a brief exam. Please plan on spending an extra 15 minutes on these days; they will be marked on your calendar.*

Daily Visit Procedure: *Each time you arrive for your adjustment, you will sign in at the front desk, pay any copays or balances owed, and will be directed to an Adjusting Room, or asked to have a seat if the rooms are full. Please, help yourself to our coffee station, read a magazine, or take care of any scheduling. Once you are in the adjusting room, sign in to the computer using your IO digit pin code (your full cell phone number) and have a seat, the doctor will be with your shortly.*

Results: *We are result oriented, however, there are many factors that affect how quickly you respond to your care. Things that you cannot control include, but are not limited to: age, occupation, how long you've had your subluxations etc. Regardless, your body has an incredible ability to heal itself. The recommendations we make will consider these factors along with the current condition of your spine. We will do all that we can to get you to the Maintenance Stage of care as quickly as possible.*

Massage: It *is important to keep your massage appointments and to make sure that arrive on time for them. If you arrive late for a massage, it will cut into your appointment time and the massage wi11 not be extended to compensate. ff you need to cancel or reschedule, 24 business hour notice is REQUIRED to avoid a fee of $95. If this happens more than 2 times you will be required to pay the $95 and a $95 time of service fee as a deposit before scheduling your next massage.* If *you pay the deposit and show up for your massage, you may carry it over as a deposit for the next massage you schedule. If you pay the deposit and miss the appointment, the deposit is not refunded and you will need to pay another $95 to reschedule. X_____(Please initial here)*

Please sign and date below to show that you have read and acknowledged Interurban ChiroRractic's policies and procedures.

X_____ X_____ *Date:* __/__/____

(Printed Name) *(Signature)*

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INFORMED CONSENT

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. When chiropractic care is chosen, it is essential to be working towards the same objectives and expectations, this prevents confusion and disappointment.

WE DO NOT OFFER DIAGNOSIS OR TREATMENT OF DISEASES, BUT RATHER WE WORK TO RESTORE FUNCTION TO THE BODY VIA PROPERLY FUNCTIONING SPINAL JOINTS SUPPORTING OPTIMAL NERVOUS SYSTEM FUNCTION.

Health is a state of optimal function, not merely the absence of disease. Our goal is to find, reduce and correct what is known as subluxation. Subluxation is misalignment of one or more of the vertebrae in the spinal column or bones of pelvis which can cause alteration of nerve function, reducing the body's innate health potential. The doctor will use their hands to correct malfunctioning joints known as subluxation. You may feel and/or hear the movement of the joints which may sound like "popping" your knuckles.

Overall, the risk of complications due to chiropractic care has been described as "rare" and it is considered one of the safest health care options. As with all types of health care interventions, there are some risks, including, but not limited to: fatigue, muscle soreness, muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement. Very rarely fractures, disc injuries, dislocations, strains & sprains may occur.

The association between visits to a chiropractor or a primary care physician and having a stroke is exceedingly rare and is estimated to be related in one in one million to one in two million visits. However, the literature recognizes a correlation between strokes and neck motions including chiropractic adjustments of the cervical spine. The best available scientific evidence supports the understanding that a chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. A dissection or arterial tear may result in the development of a clot that may lead to stroke. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis. Carotid and vertebral artery dissections are rare, with an annual incidence of 2.5 – 4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache.

Also know there are other treatment options available for you as well as getting second opinions. Likely, you've tried many of these approaches already including but not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections & surgery. Lastly, doing nothing could result in your condition worsening.

I have read the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient's Name Printed

SIGNATURE (signature of guardian if minor) Date

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Massage Consent to Treat Form

By signing this form, you have agreed that you understand that all information gathered for this treatment remains confidential, except as required or allowed by law, to facilitate assessment/treatment. You also agree that you understand that the therapist may discuss your case with peers who are under the same confidentiality clause in order to provide the best treatment possible. No other personal information will be disclosed other than that which is directly associated with your care/treatment. Your written consent will be required should any information be released to any third party, e.g. insurance companies, family physician.

Informed Consent to Massage Therapy Treatment:

- I have filled out a complete and updated Patient Health History form and have had an opportunity to ask any questions that I may have to clarify and better understand why an accurate health history is needed.
- The massage therapist has explained to me what the nature and purpose of the proposed assessment/reassessment, treatment and or remedial plans, prior to the commencement of treatment. I understand that results are not guaranteed.
- I am aware that I may discontinue the assessment, reassessment, treatment and remedial exercise plan at any time.
- I further understand and am informed that, as in all health care, the practice of massage therapy involves some risk to treatment, including, but not limited to, muscle strains and soreness. I do not expect the massage therapist to be able to anticipate and explain all risks and complications and I wish to rely on the massage therapist to exercise good judgement during the course of the procedure which the massage therapist feels at the time, based upon the facts then known, and is in my best interest.
- I also confirm that I have the ability to accept or reject this care on my own free will and choice and that I am not a agent of any private, local, provincial or federal agency attempting to gather information without stating.
- I understand the fee structure and accept full responsibility for prompt payment. Being late for the scheduled appointment will result in a shorter treatment and I will be responsible to pay for the scheduled time period. I also understand that a scheduled treatment time includes treatment preparation interview, assessment and documentations required by regulatory body and/ or insurance companies so that I do not expect hands on treatment for the entire schedule time period; however the therapist will try their level best to provide maximum hands on treatment within the time frame.

I, _____ (Print Name) have read the above consent. I have also had an opportunity to ask questions about this consent and by signing below I give my consent to Massage Therapist to proceed with assessment, reassessment, treatment and or remedial exercise plan and share the treatment details with insurance provider if required; I intend this consent to cover the entire course of treatment for my present condition.

Signature: _____ Date: _____