

AUTHORIZATION FOR RELEASE OF
X-RAYS AND RECORDS

I authorize any doctor, hospital, employer, insurer, or other person, to whom a signed, original or photocopy of this authorization is delivered, to furnish any information, reports, or copies of records or radiological information, which may be requested to East Vancouver Chiropractic. This authorization shall remain valid for one year from the date signed.

Social Security Number

Date of Birth

Signature

Date Signed

Terms of Acceptance

When a patient seeks chiropractic health care and we accept a patient for such care. It is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understands both the objective and the method that will be used to attain it. It will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxations. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal, physical, mental and social well being, not merely the absence of the disease or infirmity.

Vertebral Subluxations: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

Although, an unexcused absence is missing an appointment without calling 24-hours in advance, emergency absences are excused. However, if it is not an emergency, then you will be charged a **\$30.00 non-refundable fee**. And if you miss 3 appointments that are classified as Unexcused, then you will have to pay for your massages at the time you make the appointments.

We do not offer diagnosis or treat any disease or condition other than vertebral subluxations. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate interference to the expressions of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, _____, have read and fully understand the above statement.

(Print Name)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

(Signature)

(Date)

HIPPA INFORMATION AND CONSENT FORM

The Health Insurance Portability and Accountability Act [HIPAA] provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been *our* proactive for years/ this form in a "friendly" version. A more complete text is posted in the office. What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information [PHI]. These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.
2. It is the policy of this office to remind patients of their appointments. We may not do this by telephone, e-mail, U.S. mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.
3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.
4. You understand and agree to inspection of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.
5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.
6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.
7. We agree to provide patients with access to their records in accordance with state and federal laws.
8. We may change, add, delete or modify any of these provisions to better serve the needs of both the practice and the patient.
9. You have the right to request restrictions into the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to inform your request.

I, _____ date _____ do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

ASSIGNMENT OF PROCEEDS, CONTRACTUAL LIEN, AND AUTHORIZATION

["Agreement"]

I hereby direct any all insurance carriers, attorney, agencies, governmental departments companies, individuals, and/or other legal entities ["payors"], which may elect or be obligated to pay benefits to me for any medical conditions, accidents, injuries, or illnesses, past or future ["conditions"], to pay directly to, and exclusively in the name of, **East Vancouver Chiropractic** ["**East Vancouver Chiropractic**", or "**office**"] such sums as may be owing to **East Vancouver Chiropractic** for charges incurred by me, including, but not limited to charges for treatment, narrative reports, depositions, testimony, and any other charges incurred by me at the Office ["charges"]. I further grant a contractual lien to **East Vancouver Chiropractic** with respect to my charges, applicable to all payers; however, I understand that nothing in this Agreement shall be constructed as an election by **East Vancouver Chiropractic** to claim protection under any statutory lien law. For the purpose of this Agreement, "benefits" shall include, but shall not be limited to proceeds from any settlement, judgment, or verdict, as well as any proceeds relating to commercial health or group insurance, disability benefits, worker's compensation benefits, medical payment benefits. Personal injury protection, lost wages benefits, lost service benefits, no-fault coverage, uninsured motorist coverage, third-party liability distributions, malpractice proceeds, attorney retainer agreements, and any other benefits or proceeds payable to me for the purpose stated herein, regardless of whether such proceeds are related to my charges or not.

I further agree that, in the event a payor refuses to pay **East Vancouver Chiropractic**, I hereby assign, insofar as permitted by law, all of my rights, remedies, and benefits to **East Vancouver Chiropractic** to extent of my charges, as well as any and all causes of action that I might have against such payor, to prosecute such causes of acting either in my name or in the Office's name, and to settle or otherwise resolve such causes of action as the Office sees fit.

In the event that I retain one or more attorneys to represent me in this matter, I will direct each attorney to issue a letter of protection to this office regarding my charges. Upon issuance, I hereby agree that such letter[s] of protection cannot be revoked or modified without the expressed written consent of this office. I further direct each attorney to provide immediate notice of to the Office regarding any funds received by the attorney relating to my accident, to promptly pay such Office, and to provide a full accounting of such funds to the Office upon its request.

I hereby direct all payors to release to **East Vancouver Chiropractic** any information regarding any coverage or benefits which I may have including, but not limited to, the amount of coverage, the amount paid thus far, and the amount of any outstanding claims.

I authorize this Office to release any information regarding my treatment or pertinent to my case[s] to all payor as defined above to facilitate collection under this Agreement. I hereby direct this Office to file a copy of this Agreement, together with any applicable charges, with any or all payors, regardless of whether a claim has been established with said payors. I hereby authorize **East Vancouver Chiropractic** to endorse/sign my name on any and all check listing me as a payee, which is presented to this Office for payment of an account relating to me, my spouse, or any of my dependents. I further authorize **East Vancouver Chiropractic** to apply any credit balances on charges incurred by me to any other outstanding charges still owed by my spouse, my dependents, regardless of whether these other charges are related to my condition or me.

I understand that I remain personally responsible for the total amounts due to **East Vancouver Chiropractic** for their services. This Agreement does not constitute any consideration for this Office to await payments and it may demand payments from me immediately upon rendering services at its option. If this office must take action to collect an outstanding balance on my account, I will be responsible for payment and will reimburse **East Vancouver Chiropractic** for all costs of such collection efforts, including, but not limited to, all court costs and all attorney fees.

This Agreement shall not be modified or revoked without the mutual written consent of **East Vancouver Chiropractic** and myself. I hereby revoke any previously signed authorizations, whether executed at this office or any other office to the extent that the terms of those authorizations conflict with the terms of this agreement.

I agree that each and every provision of this Agreement is reasonably necessary for the protection of the rights and interest of **East Vancouver Chiropractic** and myself. However, should any provision of this Agreement be found to be invalid, illegal, or unenforceable, or for any reason cease to be binding on any party hereto, all other portions and provisions of this Agreement shall, nevertheless, remain in full force and effect.

Patient Name [please print]: _____

Patient Signature: _____ Date: _____

Name of custodial Parent or Legal Guardian [please print]: _____

Parent/Guardian Signature: _____ Date: _____

11. Did the police arrive at the accident?

Yes No

12. How was your vehicle hit?

Rear end Head on Sideswipe

Or did your vehicle hit another vehicle/object?

Rear end Head on Sideswipe

If you were hit from behind, was your vehicle pushed

forward upon impact? Yes No

if yes how much _____

Did your vehicle hit anything else after the initial impact?

Yes No Explain _____

13. Were you at a stop or moving at the time of impact?

Stopped Moving

If you were stopped, was your foot on the brake?

Yes No

If you were moving, were you

increasing speed

decreasing speed

traveling at a steady speed

was the other vehicle moving at the time of impact?

Yes No

If yes was it increasing speed

decreasing speed traveling at a steady speed

14. Where you seated in the vehicle? _____

15. Which way was your head facing upon impact? _____

16. Anything else you want to tell me about the accident

or how you feel _____

17. were you aware of the approaching vehicle or did the impact catch you by surprise? _____

18. Immediately following your accident what is the last thing you remember? _____

what is the next thing you remember? _____

19. Were you wearing a seatbelt? No

lap belt shoulder harness both

20. Is your vehicle equipped with an airbag?

Yes No

did it activate? Yes No

21. Is the top of your head rest:

above your head below your head

Does your head touch the head rest? _____

If no, how far in front of the head rest is your head? _____

22. What were the road conditions?

Wet Dry Icy Oily

23. What type of vehicle were you in? (Make, model, year)

what type of vehicle hit you? (Make, model, year)

24. Did any part of your body come in contact with the

vehicle? Yes No

Explain _____

Did any parts of the vehicle break? Yes No

Explain _____

25. Check all of the following symptoms that you have experienced since the accident:

loss of memory _____

loss of balance _____

visual disturbances _____

hearing difficulties _____

difficulty breathing _____

sleep disturbances _____

Signature _____ date _____

Injury Information

Name _____

Date of injury _____

Date _____

1. How did the accident occur?

Auto on-the-job other _____

2. Was a police report filed?

Yes No

3. Was a work incident report filed?

Yes No

4. Describe how you felt immediately after the accident?

5. Describe any bruises or abrasions as a result of the injury

6. Are your symptoms

getting better

getting worse

no change

What makes them better? _____

Worse? _____

7. Do you feel that you are able to perform your day-to-day business and the same capacity as before your accident?

Yes No

Explain _____

8. Did you return to work on the day of the injury?

Yes No

Have you lost time from work since the injury?

Yes No

9. What are your work responsibilities? _____

Which work activities are affected by this injury? _____

Have your work responsibilities changed as a result of this injury? Yes No

Explain _____

What other daily activities are affected by this injury?

10. Did you go to the emergency room?

Yes No

Were you hospitalized? Yes No

List the health care providers who have treated you for this injury, the type of treatment provided and there diagnosis. _____

Since your accident what is now occurring, that wasn't present before the accident? _____

Signature _____ date _____

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Primary Insurance Company	Group Number	Insurance Id. Number	Co-Pay
Patient's Relationship To Subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other:			

Subscriber Information

Last Name	First Name	Gender	Date Of Birth	Employer
		<input type="checkbox"/> F <input type="checkbox"/> M	/ /	

INSURANCE INFORMATION

Second Insurance Company	Group Number	Insurance Id. Number	Co-Pay
Patient's Relationship To Subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other:			

Subscriber Information

Last Name	First Name	Gender	Date Of Birth	Employer
		<input type="checkbox"/> F <input type="checkbox"/> M	/ /	

FINANCIAL RESPONSIBILITY

(If other than patient)

Last Name	First Name	Middle
Mailing Address	Home Phone	Work Phone
	()	()
City	State	Zip Code
Relationship To Patient		
<input type="checkbox"/> Parent <input type="checkbox"/> Guardian <input type="checkbox"/> Other:		

FINANCIAL AGREEMENT — SIGNATURE REQUIRED

I understand that I am financially responsible for all charges rendered by **East Vancouver Chiropractic Clinic** whether or not they are covered by insurance. I hereby give lifetime authorization for payment of insurance benefits directly to **East Vancouver Chiropractic Clinic** accounts. In the event of default I agree to pay all costs of collection and reasonable attorney's fees. I hereby authorize this healthcare provider to release information necessary to secure payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

I have read the above FINANCIAL AGREEMENT and understand it.

Signature

Date

Parent/Guardian Signature – If patient is a minor

Date

PATIENT REGISTRATION FORM
East Vancouver Chiropractic Clinic
Nicholas M. Peck, D.C.

Patient <input type="checkbox"/> New <input type="checkbox"/> Existing	(Please Print)	Today's Date / /
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PATIENT INFORMATION

Please Print Your Name *As It Appears On Your Insurance Card*

Last Name	First Name	Middle

What Name Do You Prefer To Be Addressed By?	
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Home Address			Mailing Address		
City	State	Zip Code	City	State	Zip Code

Gender	Date Of Birth	Age	Social Security Number	Marital Status (Circle One)
<input type="checkbox"/> F <input type="checkbox"/> M	/ /			Single Married Divorced Separated Widowed

Home Phone	Cell Phone	Email Address	Work Phone	Ext.
()	()		()	

May we leave voicemail messages?	At Your Home:	<input type="checkbox"/> Yes <input type="checkbox"/> No	At Your Work:	<input type="checkbox"/> Yes <input type="checkbox"/> No
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IN CASE OF EMERGENCY

Emergency Contact 1	Home Phone	Work Phone	Ext.	Relationship To Patient
	()	()		

May we communicate with this person about your health?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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Emergency Contact 2	Home Phone	Work Phone	Ext.	Relationship To Patient
	()	()		

May we communicate with this person about your health?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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EMPLOYMENT INFORMATION

Employment Status

<input type="checkbox"/> Full Time	<input type="checkbox"/> Part Time	<input type="checkbox"/> Not Employed	<input type="checkbox"/> Active Military	<input type="checkbox"/> Self Employed	<input type="checkbox"/> Retired	<input type="checkbox"/> Student	<input type="checkbox"/> Other:
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Occupation	Employer	Employer Phone
		()

Employer Address	City	State	Zip Code

PHYSICIAN INFORMATION

Referring Physician	Primary Care Physician

(Continued On Other Side)