Patient's Name: Today's Date:

-MOTOR VEHICLE ACCIDENT REPORT-

BILLING INFORMATION:

Name:_____ Nickname:_____ Date of Birth:_____

Address:_____ City/State: _____ Zip Code: _____

Social Security #:_____ Home #:_____ Cell #:_____

Marital Status: S / M / W / D / Domestic Partner Spouse's Name:_____

Employer:_____ Occupation:_____

Work Address:_____ Email:_____

Work #:_____ Fax #:_____ Referred by:_____

Emergency Contact:_____ Phone #:_____

AUTOMOBILE INSURANCE INFORMATION:

Insurance Company (PIP):_____ Policy Holder Name:_____

Insurance Company's Address: _____ Insurance Phone #:_____

Policy #:_____ Claim #:_____ Adjuster's Name:_____

I hereby authorize my insurance company to send payments directly to Roosevelt Chiropractic for services rendered to me. I understand that if my bills are over sixty days delinquent they may be sent to a collection agency and may incur interest charges.

PRIVATE MEDICAL INSURANCE:

Insurance Company:_____ Subscriber Name:_____

ID#:_____ Group#:_____ Insurance Phone #:_____

ATTORNEY INFORMATION:

Name of Attorney:_____ Name of Firm: _____

Phone #:_____ Attorney Address:_____

3RD PARTY INSURANCE (AT FAULT PARTY) INFORMATION:

Insurance Company:_____ Policy Holder Name:_____

Insurance Company's Address: _____ Insurance Phone #: _____

Policy #:_____ Claim#:_____ Adjuster's Name:_____

I do not have PIP insurance and want my bills sent to the 3rd party's insurance company (at fault's insurance) upon request. I know that it may take years before a final settlement is reached and reimbursement occurs. Therefore, to protect the doctor, I agree to pay the first visit today and a monthly amount of $100.00 until the balance is paid in full. I ask any future or past attorney I hire to pay the doctor in full before any settlement money is disbursed. If, during treatment, I decide to change to another clinic for treatment of these collision-related injuries, I agree to settle all accounts with Roosevelt Chiropractic within 30 days of my last treatment in this clinic. I understand that any delinquent bills will be sent to a collection agency and will incur interest charges.

Signature:_____ Date:_____

Patient's Name: Today's Date:

MOTOR VEHICLE COLLISION HISTORY:

Date of Collision:_____ Time of Collision:_____ AM/PM

Type of Vehicle you were in: Year:_____ Make:_____ Model:_____

Were you the: Driver / Front Passenger / Right Rear Passenger / Left Rear Passenger / Other*

*If other, please describe: _____

Location of collision (including Street, City & other information you can provide):_____

_____

What was your car doing at time of collision? (i.e. stopped waiting to turn): _____

_____

How was your car hit? (i.e. side, front): _____

Amount of damage to your car: TOTALED MODERATE MINIMAL UNKNOWN

At fault person's name: _____

At fault person's address: _____

Second vehicle involved: Year: _____ Make:_____ Model:_____

Amount of damage to other car: TOTALED MODERATE MINIMAL UNKNOWN

Describe the weather at time of impact:_____ Visibility: GOOD FAIR POOR

Describe the road conditions: DRY WET ICY OTHER _____

What were your body & head positions at time of impact (i.e. body turned right with my head left):_____

_____

Direction your body was thrown: (i.e. forward, side to side):_____

Were you wearing a seatbelt: YES NO If YES, was it a: SHOULDER BELT LAP BELT BOTH

Did the vehicle airbags deploy (if equipped): YES NO Did you lose consciousness: YES NO

Did you experience a flash of light or explosion: YES NO Did you brace for impact: YES NO

Did the police come to the scene: YES NO

Is there a police report on file: YES NO (If YES, please provide copy)

Provide a detailed description of the collision:_____

_____

_____

_____

Patient's Name: Today's Date:

POST-COLLISION:

Your reaction to collision: SHAKEN UPSET CONFUSED DISORIENTED DIZZY NORMAL

Where did you go immediately after the collision: Home / Work / ER / Urgent Care / Hospital / Other_____

If you sought care, where did you go? _____

How did you get there? (Ambulance, I drove, etc.) _____

Type of emergency care: ER BANDAGING BRACING CPR NECK COLLAR SPLINTING OTHER_____

Did you have any cuts or bruises? YES NO If YES, where? _____

Have you seen another healthcare provider for the injuries you received: YES NO If YES, please list below:

Name: _____ Specialty: _____ Date(s): _____

Name: _____ Specialty: _____ Date(s): _____

TREATMENT POST-COLLISION:

Were you admitted to the hospital? YES NO Which hospital? _____

Did you receive: X-RAYS CATSCAN MRI OTHER _____

What parts were tested: (arm, head, lower back, neck) _____

Were you prescribed any medication(s)? YES NO If YES, please list below:

Drug: _____ Reason: _____

Drug: _____ Reason: _____

Doctor's recommendations: _____

Have you had treatment to these areas prior to the collision? YES NO If YES, please describe: _____

_____

SOCIAL HISTORY:

Dominant Hand: RIGHT / LEFT / AMBIDEXTROUS Current Height: _____ Weight: _____

Do you exercise? YES NO What type of exercise? _____ Frequency: _____

Weight prior to collision: _____ Do you think you're overweight? YES NO If YES, how much: _____

Current employer: _____ Occupation: _____ Hours/week: _____

Yearly Income: _____ Education Level: _____ Degree Earned: _____

Type of work: LIGHT / HEAVY / MENTAL / PHYSICAL

Have you smoked cigarettes in the past 12 months? YES NO Frequency: _____ # of Years: _____

Hours of sleep/night: _____ Number of children: _____ Number who live with you: _____

Do you travel internationally? YES NO Frequency: _____

Did you serve in the military? YES NO Did you suffer from war trauma? YES NO Discharged? Type:_____

Any Physical or Mental Handicaps? Describe: _____

Patient's Name: Today's Date:

PRESENT SYMPTOMS LIST:

Head: Pain Scale: (mild) 0 1 2 3 4 5 6 7 8 9 10 (worst) Frequency: _____
Was this here prior to collision? YES NO

Neck: Pain Scale: (mild) 0 1 2 3 4 5 6 7 8 9 10 (worst) Frequency: _____
Was this here prior to collision? YES NO

Chest: Pain Scale: (mild) 0 1 2 3 4 5 6 7 8 9 10 (worst) Frequency: _____
Was this here prior to collision? YES NO

Shoulder: Pain Scale: (mild) 0 1 2 3 4 5 6 7 8 9 10 (worst) Frequency: _____
Was this here prior to collision? YES NO Please circle which side: LEFT RIGHT BOTH

Upper Back: Pain Scale: (mild) 0 1 2 3 4 5 6 7 8 9 10 (worst) Frequency: _____
Was this here prior to collision? YES NO

Mid Back: Pain Scale: (mild) 0 1 2 3 4 5 6 7 8 9 10 (worst) Frequency: _____
Was this here prior to collision? YES NO

Lower Back: Pain Scale: (mild) 0 1 2 3 4 5 6 7 8 9 10 (worst) Frequency: _____
Was this here prior to collision? YES NO

Arm: Pain Scale: (mild) 0 1 2 3 4 5 6 7 8 9 10 (worst) Frequency: _____
Was this here prior to collision? YES NO Please circle which side: LEFT RIGHT BOTH

Hand: Pain Scale: (mild) 0 1 2 3 4 5 6 7 8 9 10 (worst) Frequency: _____
Was this here prior to collision? YES NO Please circle which side: LEFT RIGHT BOTH

Buttocks: Pain Scale: (mild) 0 1 2 3 4 5 6 7 8 9 10 (worst) Frequency: _____
Was this here prior to collision? YES NO Please circle which side: LEFT RIGHT BOTH

Hip/Thigh: Pain Scale: (mild) 0 1 2 3 4 5 6 7 8 9 10 (worst) Frequency: _____
Was this here prior to collision? YES NO Please circle which side: LEFT RIGHT BOTH

Knee: Pain Scale: (mild) 0 1 2 3 4 5 6 7 8 9 10 (worst) Frequency: _____
Was this here prior to collision? YES NO Please circle which side: LEFT RIGHT BOTH

Calf: Pain Scale: (mild) 0 1 2 3 4 5 6 7 8 9 10 (worst) Frequency: _____
Was this here prior to collision? YES NO Please circle which side: LEFT RIGHT BOTH

Shin/Ankle: Pain Scale: (mild) 0 1 2 3 4 5 6 7 8 9 10 (worst) Frequency: _____
Was this here prior to collision? YES NO Please circle which side: LEFT RIGHT BOTH

Foot: Pain Scale: (mild) 0 1 2 3 4 5 6 7 8 9 10 (worst) Frequency: _____
Was this here prior to collision? YES NO Please circle which side: LEFT RIGHT BOTH

Patient's Name: Today's Date:

Do you have or have you had any pain in the following areas? If YES, what is that date of occurrence?

- ☐ Neck: _____
- ☐ Elbow: _____
- ☐ Upper Back: _____
- ☐ Chest: _____
- ☐ Leg: _____
- ☐ Foot: _____
- ☐ Shoulder: _____
- ☐ Wrist: _____
- ☐ Mid Back: _____
- ☐ Hip: _____
- ☐ Knee: _____
- ☐ Other: _____
- ☐ Arm: _____
- ☐ Hand: _____
- ☐ Low Back: _____
- ☐ Pelvis: _____
- ☐ Ankle: _____

Do you experience increased pain at night? YES NO If YES, what areas? _____

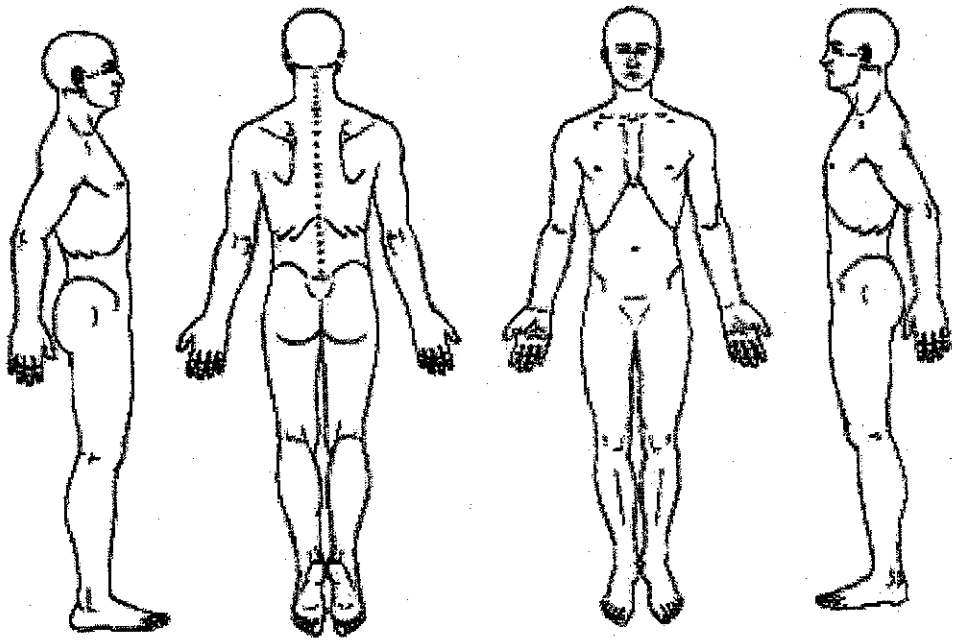
Do you have or have you had any of the following conditions? If YES, what is the date of occurrence?

- ☐ Addison's: _____
- ☐ Bipolar: _____
- ☐ Dizziness: _____
- ☐ Fibromyalgia: _____
- ☐ Hepatitis: _____
- ☐ HIV/AIDS: _____
- ☐ Kidney Infection: _____
- ☐ Numbness: _____
- ☐ Prostatitis: _____
- ☐ Stomach Ulcer: _____
- ☐ Other: _____
- ☐ Asthma: _____
- ☐ Cancer: _____
- ☐ Epilepsy: _____
- ☐ Genital Discharge: _____
  Type: _____
- ☐ Impaired Vision: _____
- ☐ Kidney Stones: _____
  Where: _____
- ☐ Ringing Ears: _____
- ☐ Stroke: _____
- ☐ Arthritis: _____
  Type: _____
- ☐ Fainting: _____
- ☐ Headaches: _____
- ☐ Herpes: _____
- ☐ Insomnia: _____
- ☐ Uncontrolled Bladder: _____
- ☐ Painful Urination: _____
- ☐ Shortness of Breath: _____
- ☐ Tuberculosis: _____

On the pictures below, use the indicated marks to show areas where you are experiencing:
Pain= X X X

Numbness= / / /

Tingling= + + +



ASSIGNMENT, LIEN, AND AUTHORIZATION
FOR DIRECT PAYMENTS BY MY PAYERS TO MARK S. JYRINGI DC, PS, DBA ROOSEVELT CHIROPRACTIC

Purpose. The purpose of this Assignment & Lien is to assist the Office in obtaining Proceeds from various Payers for the payment of my Charges. Accordingly, I agree to the following and direct all Payers as follows:

Definitions. In this Assignment & Lien, the following terms shall have the following meaning: "Office" and "Clinic" shall refer to Mark S. Jyringi, DC, PS, DBA Roosevelt Chiropractic located at 5029 Roosevelt Way NE, Ste 101A, Seattle, WA 98105."Assignment & Lien Document," "Assignment & Lien," and "Assignment" shall refer to this document. "Payer" shall refer to without limit any insurance carrier, health benefit plan administrator and fiduciary, health maintenance organization, preferred and independent provider organization, attorney, adjuster, claims handler, medical examiner, individual reviewer or review entity, at-fault party, individual, and any other entity, which may elect or be obligated to pay or disburse Proceeds, either now or in the future, or which may be involved directly or indirectly in determining the obligation to pay or disburse Proceeds, either now or in the future; "Proceeds" shall include without limit, the proceeds from any settlement, judgment, or verdict, the proceeds from any promise to pay or reimburse, the proceeds relating to "health-care-insurance receivables" and "payment intangibles" as such are defined by the applicable Uniform Commercial Code, and the proceeds relating to the following benefits, plans, or coverages: individual and group health benefits, Medicare and Medicaid, workers' compensation, disability, liability, uninsured and underinsured motorist, no-fault, medical payments benefits, personal injury protection, lost wages, lost services, property damage, errors & omissions, and malpractice; "Charges" shall include without limit the full fees for the Office's goods and services (including without limit treatment, diagnostic services, medical equipment, supplies, supplements, narrative reports, photocopies, pre-authorization requests, no-shows, depositions, and testimony, whether rendered before or after the date of this Assignment & Lien), any Collection Costs incurred by the Office, delinquency penalties and interest to the maximum extent permitted under law or at the annual rate of eighteen percent (18%), whichever is greater, and any other charges incurred by me at the Office; "Collection Costs" shall include without limit any pre- and post judgment court costs, filing fees, service of process charges, attorneys fees, fees or costs associated with requests for reconsideration, independent reviews, appeals, mediation, arbitration, and any other costs of collection incurred by the Office in any effort or action to collect my Charges either from me or from any Payer.

Assignment and Lien Terms. I hereby assign to the Office to the extent permitted by law, but only to the extent of my Charges, all of my claims to, rights to, and interests in, Proceeds, whether resolved or unresolved, including without limit ownership rights, which I may have now or in the future relating directly or indirectly to my Charges, condition, or causes of my condition ("Claims to Proceeds"), including without limit any and all causes of action, receivables, payment intangibles, and remedies that I might have against or with respect to any Payer now or in the future, and the right to prosecute, seek, settle, or otherwise resolve such Claims to Proceeds either in my name or in the Office's name and as the Office otherwise sees fit. I agree that this assignment shall be effective as of the date and time the initial cause of my condition occurred. I further intend for this Assignment & Lien to create a security interest under the applicable Uniform Commercial Code. Accordingly, I hereby grant to the Office a primary, non-contingent security interest in all of my Claims to Proceeds to the extent permitted by law for the purpose of securing payment of my Charges, the attachment and perfection of which shall relate back to, and be effective as of, the date and time that the initial cause of my condition occurred. I further authorize the Office to file the form(s) normally filed with the secretary of state or other governmental agency relating to such security interests, and to make such filings in all relevant jurisdictions as the Office sees fit in its sole discretion. I agree that once payment in-full has been made towards all outstanding Charges to the full extent permitted by law or contract and also as defined by my agreement with the Office, such security interest shall be removed or terminated solely upon my written request sent through the U.S. Postal Service Certified Mail. Consistent with these terms, I hereby direct any and all Payers, to pay the Proceeds directly to, immediately to, and exclusively in the name of, the Office to the full extent of my Charges. To the extent that any law, including without limit a lien statute, purports to limit, reduce, or modify the distribution of Proceeds in any manner inconsistent with this Assignment & Lien including without limit through the reservation of a portion of the Proceeds exclusively to me, I hereby waive such limits, reductions, or modifications. Such waiver shall not adversely affect or prejudice any rights which the Office may have and elect to exercise under said law.

Specific Direction to Any Attorney I Retain, Such as in Accident Cases. In the event that I retain one or more attorneys who receive(s) Proceeds from one or more Payers, I hereby direct (and the Office hereby requests) each attorney to provide immediate notice to the Office regarding such Proceeds, to promptly pay the Office in-full out of such Proceeds, and to provide a full accounting of such Proceeds to the Office. I agree that the purpose of such Proceeds shall be primarily to pay my Charges. If I have a dispute regarding the Charges, any remedies I may have shall not include instructing my attorney to withhold or delay payment of Proceeds to the Office. I further agree to and hereby irrevocably waive any present or future right I may have, whether arising under a "Common Fund Doctrine" or other legal basis, to require the Office to absorb the costs associated with, or otherwise assume responsibility for, any portion of my attorney's fees and costs, or other expenses of obtaining Proceeds.

Disclosure Directives. I hereby direct each and every Payer to immediately release to the Office any Pertinent Information relating to (a) any coverage I may have and (b) any Proceeds Determination by the Payer relating to the Office's Charges. "Pertinent Information" shall include without limit the amount of total coverage available and remaining, as well as the amount of any outstanding claims which the Payer has received from any claimant relating to my condition. "Pertinent Information" shall also include without limit copies of all documents, records, and other information (a) relied upon by the Payer in making a Proceeds Determination, or (b) was submitted, considered, or generated in the course of making a Proceeds Determination without regard to whether such document, record, or other information was relied upon in making the Proceeds Determination. "Proceeds Determination" shall include without limit any determination by the Payer to pay, deny, or delay payment of any Proceeds relating to the Office's Charges, as well as a decision to refer the Charges to an independent review or audit, utilization review, or independent medical exam. I further authorize and direct the Office to release any information relating any services rendered to or for me by the Office to all Payers, including without limit a copy of my Charges and a copy of this Assignment & Lien, unless otherwise agreed to in writing.

Miscellaneous. Except as provided in this paragraph, this Assignment & Lien shall not be modified or revoked without the expressed, written consent of the Office. I hereby revoke, with the Office's consent, the terms of any previously signed documents, but only to the extent those terms conflict with the terms of this Assignment & Lien. I agree that each and every provision of this Assignment & Lien is reasonably necessary. However, should any provision of this Assignment & Lien 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 Assignment & Lien shall, nevertheless, remain in full force and effect. This Assignment & Lien shall be governed under the laws of the state where the Office is located, and is performable in the county where the Office is located. In any action based upon this Assignment & Lien, I hereby consent to personal jurisdiction and venue of any court in said county and waive all objections based on improper jurisdiction, venue, or forum inconvenience. I further waive any statute of limitations which may apply in any action based upon this Assignment & Lien.

I have read, understood, and agree to the terms of this Assignment & Lien.

Patient Name (print): _____ Patient Signature: _____ Date: ___/___/___

Parent/Guardian Name (Print): _____ Parent/Guardian Signature: _____ Date: ___/___/___

Mark S. Jyringi, DC, PS & Jeremiah Tibbitts, DC Roosevelt Chiropractic
5029 Roosevelt Way NE, Ste 101A, Seattle, WA 98105
Phone: (206) 547-4427
Fax: (206) 547-3587

Consent for Purposes of Treatment, Payment and Health Care Operations

I authorize **Mark S. Jyringi, D.C., P.S., and/or Jeremiah Tibbitts, D.C.** to use and disclose the health and medical information of _____for the purposes of Treatment, Payment and Health Care Operations*.

* **Treatment:** Includes activities performed by a health care provider, nurse, office staff and other types of health care professionals providing care to you, coordinating or managing your care with third parties and consultations with and between other healthcare providers. This consent includes treatment provided by any physician who covers my/our practice by telephone, as well as the on-call physician.

* **Payment:** Includes activities involved in determining your eligibility for health plan coverage, billing and receiving payment for your health benefit claims and utilization management activities, which may include review of health care services for medical necessity, justification of charges, pre-certification and pre-authorization.

* **Health Care Operations:** Includes the necessary administrative and business functions of our office.

We are committed to preserving the privacy of your personal health information. We are required by law to have your written consent before we use or disclose to others your medical information for purposes of providing or arranging for your health care, the payment for or reimbursement of the care that we provide to you, and the related administrative activities supporting your treatment.

You may review **Mark S. Jyringi, D.C., P.S., and/or Jeremiah Tibbitts, D.C.** "Notice of Privacy Practices" for additional information about the uses and disclosures of information described in this Consent prior to signing this Consent.

Because we have reserved the right to change our privacy practices in accordance with the law, the terms contained in the Notice may change also. We will offer you a copy of the Notice on your first visit to us after the effective date of the then current Notice. We will also provide you with a detailed Notice of Privacy Practices upon your request which fully explains your rights and our obligations under the law.

As more fully explained in the notice you have the right to request restrictions on how we use and disclose your protected health information for treatment, payment and health care operations purposes. We are not required to agree to your request. If we do agree, we are required to comply with your request unless the information is needed to provide you emergency treatment. Other physicians who provide call coverage for our office are required to use and disclose your protected health information consistent with the Notice. If you have any questions, concerns or complaints about the Notice or your medical information, please contact **Charmaine Strom** at our office at (206) 547-4427.

I understand that I have the right to revoke this consent provided that I do so in writing, except to the extent that **Mark S. Jyringi, D.C., P.S., and/or Jeremiah Tibbitts, D.C.** has already used or disclosed the information in reliance on this Consent.

Patient Printed Name: _____ Date: _____

Signature of Patient: _____ Date: _____

Signature of Parent/Guardian: _____ Date: _____

Mark S. Jyringi, DC, PS, DBA & Jeremiah Tibbitts, DC Roosevelt Chiropractic

5029 Roosevelt Way NE, Suite 101A, Seattle, WA 98105

Phone: 206.547.4427 I Fax: 206.547.3587

- A Little About Chiropractic -

Before beginning treatment, it is our office policy to inform you of what to expect, of possible complications of chiropractic care and of complications of other approaches. Remember that all forms of treatment (including non-treatment!) have associated risks. If you have any questions, please ask the doctor.

What to expect: The treatment at our office will consist of manipulation of the joints and soft tissues, using the hands and/or a mechanical instrument. You may feel joint movement and you may hear joint clicks or other noises. Physical therapy methods, along with therapeutic exercise, may also be used.

Chiropractic Risks: Chiropractic examination and therapy (adjustments, heat, electrotherapy, etc) are considered very safe and effective methods of care. Occasionally, however, complications can arise. Minor, temporary problems, such as soreness and stiffness can occur, especially in the beginning of a treatment plan. Slightly more serious problems are local burns from heat generating physical therapy equipment. More significant problems, such as fracture of weakened bone of sprain/disc injuries are rare. A stroke following neck manipulation is an extremely rare complication, occurring less than 1 per million treatments. Stroke has also been the result of ordinary activities, such as head turning or stargazing.

Other Treatment and Risks:
Medications: Many commonly used medications, such as NSAIDs (e.g. Advil, Aleve or Tylenol), carry risks of tissue damage, including stomach ulcers or kidney damage can occur quickly and may be irreversible. There is a significantly higher risk of developing a serious complication with NSAIDs as opposed to chiropractic treatment. Other medications are habit-forming and may mask pain to allow further tissue damage.

Surgery: Surgery is the treatment choice for less than 1% of back pain patients. Your doctor will screen for surgical "red flags," and will refer you for a surgical opinion if indicated. Clinical results of surgery for mechanical back pain have been disappointment and may expose you to unnecessary hospital and medication risks.

Non-treatment: I understand the potential risks of refusing or neglecting care may include increased pain, scar/adhesion formation, restricted motion, possible nerve damage, increased inflammation and worsening pathology. The aforementioned may complicate treatment making future recovery and rehabilitation more difficult and lengthy.

I have read the above and give my consent to begin chiropractic treatment.

Patient Name: _____ Date: _____

Signature: _____ Relationship to Patient: _____