-MOTOR VEHICLE ACCIDENT REPORT-

Name:_____ Nickname:_____ Date of Birth:_____

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

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

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

Employer:_____ Occupation:_____ Referred by:_____

Emergency Contact:_____ Relationship: _____ Phone #:_____

AUTOMOBILE INSURANCE INFORMATION:

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

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

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

PRIVATE MEDICAL INSURANCE:

Insurance Company:_____ Subscriber Name:_____

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

How would you like us to handle your health insurance? Please initial one option:

☐ Option 1 – I Do Not Have Health Insurance or I Do Not Want You to Bill My Health Insurance.

☐ Option 2 – I Want You to File My Health Insurance and/or Help Verify My Benefits. I Agree to Pay my Co-pay, Co-insurance, or Amounts Towards My Deductible.

☐ Option 3 – I Want You to File My Health Insurance, But I'll Pay in-Full at the Time of Service or Pre-pay. If Insurance Pays, you will Give Me a Refund.

ATTORNEY INFORMATION:

Name of Attorney:_____ Name of Firm: _____

Phone #:_____ Attorney Address:_____

3RD PARTY INSURANCE (AT FAULT PARTY) INFORMATION:

At Fault Name(s): _____

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 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 and penalty 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: _____

Provide a detailed description (including street location and what you were doing at the time of the collision):

_____

_____

_____

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

Weather at time of impact: _____

Road conditions: DRY WET ICY OTHER: _____

Were you wearing a seatbelt: YES NO

Did you experience a flash of light: YES NO

Damage to car: TOTALED MODERATE MINIMAL

NONE UNKNOWN

Visibility: GOOD FAIR POOR

Body & head positions at time of impact (i.e. Looking to the right):_____

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

Did you lose consciousness: 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)

POST-COLLISION:

Your reaction to collision: SHAKEN UPSET CONFUSED DISORIENTED DIZZY NORMAL OTHER: _____

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

If you sought care, how did you get there: _____

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:

Who: _____ Specialty: _____ When: _____

Also: _____ Specialty: _____ When: _____

TREATMENT POST-COLLISION:

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

Did you receive: X-RAYS CATSCAN MRI Part of Body: _____

List prescribed medications:

Drug: _____ Reason: _____

Drug: _____ Reason: _____

Doctor's recommendations: _____

Patient's Name: Today's Date:

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

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

SOCIAL HISTORY:

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

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

Type of work: LIGHT / HEAVY / MENTAL / PHYSICAL Do you smoke? YES NO Years: _____

Hours of sleep/night: _____ Number of children: _____ Number of individuals in household: _____

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

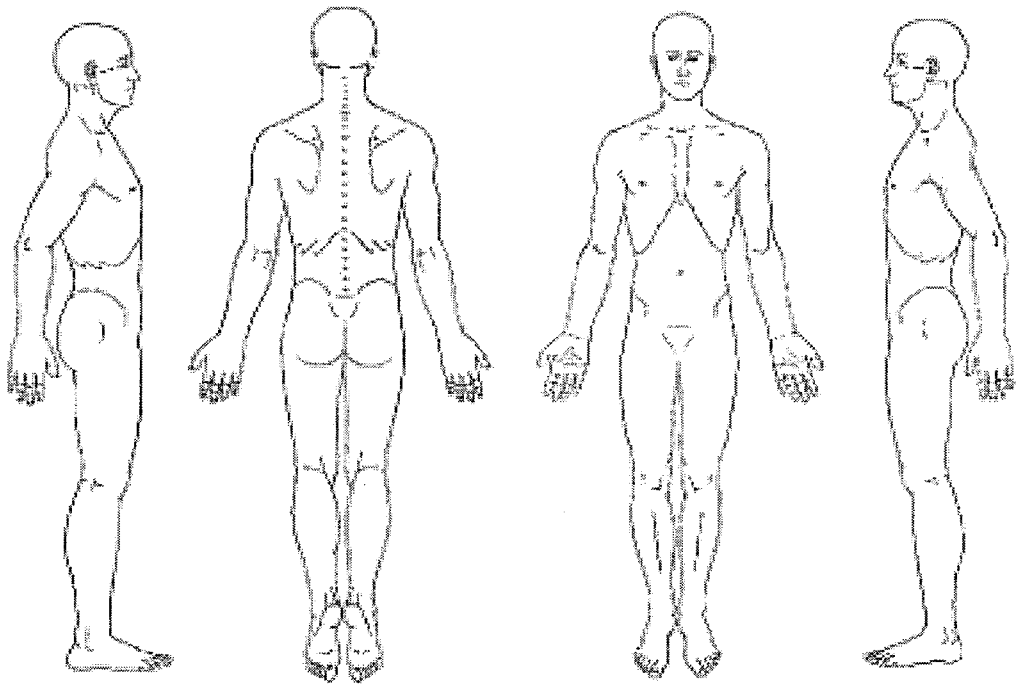
Any prior Physical , Mental, or Emotional handicaps? Describe: _____

Indicate any Pain that has Occurred since Collision: rate pain 1-10 (10 being the worst). Use the indicated marks to show areas where you are experiencing:

Pain= X X X

Numbness= / / /

Tingling= + + +



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

BOURNEMOUTH QUESTIONNAIRE

Patient Name _____ Date _____

Instructions: The following scales have been designed to find out about your neck or back pain and how it is affecting you. Please answer ALL the scales and mark the ONE number on EACH scale that best describes how you feel.

1. Over the past week, on average, how would you rate your neck or back pain?

(No pain) _____ **(Worst pain possible)**

0 1 2 3 4 5 6 7 8 9 10

2. Over the past week, how much has your back pain interfered with your daily activities (housework, washing, dressing, walking, climbing stairs, getting in/out of bed/chair)?

(No interference) **(Unable to carry out activity)**

_____

0 1 2 3 4 5 6 7 8 9 10

3. Over the past week, how much has your back pain interfered with your ability to take part in recreational, social, and family activities?

(No interference) **(Unable to carry out activity)**

_____

0 1 2 3 4 5 6 7 8 9 10

4. Over the past week, how anxious (tense, uptight, irritable, difficulty in concentrating/relaxing) have you been feeling?

(Not at all anxious) **(Extremely anxious)**

_____

0 1 2 3 4 5 6 7 8 9 10

5. Over the past week, how depressed (down-in-the-dumps, sad, in low spirits, pessimistic, unhappy) have you been feeling?

(Not at all depressed) **(Extremely depressed)**

_____

0 1 2 3 4 5 6 7 8 9 10

6. Over the past week, how have you felt your work (both inside and outside the home) has affected (or would affect) your back pain?

(Have made it no worse) **(Have made it much worse)**

_____

0 1 2 3 4 5 6 7 8 9 10

7. Over the past week, how much have you been able to control (reduce/help) your back pain on your own?

(Completely control of it) **(No control whatsoever)**

_____

0 1 2 3 4 5 6 7 8 9 10

OTHER COMMENTS:

_____

_____

_____

Score: _____

Mark S. Jyringi, DC, PS, Jeremiah Tibbitts, DC & Brian Stuck, DC
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., Jeremiah Tibbitts, D.C., and/or Brian Stuck, 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 car 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 writte 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 supporti your treatment.

You may review **Mark S. Jyringi, D.C., P.S., Jeremiah Tibbitts, D.C., and/or Brian Stuck, 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 yo 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 reque 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., Jeremiah Tibbitts, D.C., and/or Brian Stuck, 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: _____

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

PURPOSE AND CONSIDERATION; TERMS WHICH PAYERS MAY BE REQUIRING. The purpose of this Assignment & UCC Lien is to assist the Office in obtaining Proceeds from various Payers (including without limit my Attorney) for the payment of my Charges. In consideration for receiving / continuing health care at the Office based on terms which Payers may be requiring, as well as on terms set forth in various documents of the Office, I agree to the following and direct all Payers as follows:

DEFINITIONS. In this Assignment & UCC 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, Suite 101A Seattle, WA 98105; "Assignment & UCC Lien Document," "Assignment & UCC Lien," "Assignment & Lien," and other like phrases 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 expense or payments benefits ("Medpay"), personal injury protection ("PIP"), 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 & UCC Lien, any Additional Costs incurred by the Office as defined herein, 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; "Additional Costs" shall include without limit any costs incurred by the Office relating directly or indirectly to (i) any effort or action to collect my Charges either from me or from any Payer, or (ii) any legal or medico-legal action, process, or claim of any nature against, or by, the Office or its employees for any reason relating to the foregoing items, (i)-(ii), of the previous clause ("Medico-Legal Process"). "Medico-Legal Process" shall include without limit civil and administrative proceedings, mediation, arbitration, interpleader actions, cross-claims or counterclaims, requests for reconsideration, independent reviews, and internal appeals. Costs associated with such Medico-Legal Processes shall also include without limit any pre- and post-judgment costs, filing fees, service of process charges, and attorney's fees.

ASSIGNMENT AND UCC LIEN TERMS. (i) Assignment 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 the assignment and lien includes any claims arising out of the collision that occurred on or about _____, irrespective of whether the Charges relate to that collision or not ("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. (ii) UCC Lien Terms: I further intend for this Assignment & UCC 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 ("UCC Lien"), 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. (iii) Other Assignment and UCC Lien Terms: Consistent with the foregoing 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 & UCC 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. I hereby direct (and the Office hereby requests) each attorney to provide immediate notice to the Office regarding any Proceeds received by the attorney, 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 with the Office, attorney, or any other party for any reason, any remedies I may have shall not include instructing my attorney to withhold or delay payment of Proceeds to the Office for any portion of the Charges. 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 TO ALL PAYERS. 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 & UCC Lien, unless otherwise agreed to in writing.

MISCELLANEOUS. Except as provided in this paragraph, this Assignment & UCC 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 & UCC Lien. I agree that each and every provision of this Assignment & UCC Lien is reasonably necessary. However, should any provision of this Assignment & UCC 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 & UCC Lien shall, nevertheless, remain in full force and effect. This Assignment & UCC 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 & UCC 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 & UCC Lien.

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

Patient Name (print): _____

Patient Signature: _____ Date: ___/___/_____

Name of Custodial Parent or Legal Guardian, on Behalf of the Patient (please print):_____

Parent/Guardian Signature: _____ Date: ___/___/_____