Confidential Motor Vehicle Accident Intake Form

All information you supply is confidential. We comply with all federal privacy standards.

Today's Date (mm/dd/yyyy) _____ Date of Injury (DOI) _____ Who referred you/how did you find out about us? _____

Previous chiropractic, physical therapy, acupuncture or naturopathic care? ○ Yes ○ No Date of last visit (approx) _____

Your full name _____ Preferred Name _____ Birth date (mm/dd/yyyy) _____ Age _____

Gender (for insurance) ○ Male ○ Female
Gender (if applicable) ○ M2F ○ F2M

○ Single ○ Married ○ Divorced ○ Widowed ○ Separated
Marital Status

Spouse's Name _____ Child's name and age _____ Child's name and age _____ Child's name and age _____

Mailing address _____ E-mail address _____

City _____ State/Province _____ ZIP/Postal Code _____ Cell phone _____ ○ OK to leave Voicemail?

Emergency contact name _____ Relationship _____ Telephone _____

Employment Details

Your occupation _____ Your employer _____ Work Telephone _____

Work address _____ City _____ State/Province _____ ZIP/Postal Code _____

Family (PCP) and/or Specialist Doctor (if applicable)

Primary care physician (Family doctor) _____ Clinic _____ Telephone _____ Fax _____

Specialist _____ Clinic _____ Telephone _____ Fax _____

**If you would prefer us to NOT communicate with your PCP regarding care, mark "No" and initial: ○ No Initials: _____

Preferred Pharmacy _____ Pharmacy Telephone _____

Pharmacy Address _____

INJURY INSURANCE QUESTIONNAIRE

Please Complete All Blanks – All information is Required

IMPORTANT: it is ILLEGAL for your insurance company to increase your premiums for using your PIP policy. This can ONLY be done based on fault. Additionally, the amount of PIP used to cover medical bills and time lost from work (in the case that you are at fault) does not affect how much your premium will be raised.

RCW is official state law. The revised code of Washington (RCW) states, in part:

RCW 46.52.130
(iii) Any policy of insurance may not be canceled, non-renewed, denied, or have the rate increased on the basis of information regarding an accident included in the abstract of a driving record, unless the policyholder was determined to be at fault.

YOUR AUTO INSURANCE INFORMATION

Patient Name: _____ Today's Date: _____

Date of Accident: _____/_____/_____ Time of Accident: _____ □ **AM** □ **PM**

YOUR AUTO Insurance Company: _____

Claim Adjuster: _____ Phone #: _____

Claim #: _____ Policy #: _____

Do you have PIP (personal injury protection)? □ **Yes** □ **No**

A. If YES, are you the insured? □ **Yes** □ **No**
- Limit? □ **$10,000** □ **$35,000** □ **Not Sure** □ **Other**_____
- How many people were in your vehicle? _____ How many cars were involved in the accident? _____

B. If NO, Insured's Name _____ Phone #: _____

Insured's Address: _____

AT-FAULT DRIVER INFORMATION (If it is driver of the other vehicle)

At Fault Driver's Name: _____

At Fault Driver's Address: _____

City, State, Zip: _____

Claim Adjuster: _____ Phone #: _____

Claim #: _____ Policy #: _____

Insurance Information

At-fault driver's insurance company: _____

Insurance Company Address: _____

City, State, Zip: _____

ATTORNEY INFORMATION

Have you retained an Attorney? □ Yes □ No

Attorney Name: _____ Phone #: _____

Attorney Address: _____

Accident (Impact) Details

- Date of Accident: _____/_____/_____
- Where did the accident take place? City _____ Road/Street Name_____
- Were you the?: □ **Driver** □ **Front passenger** □ **Rear passenger** □ **Other** _____
- How many people were in your vehicle? _____
- Your vehicle: Make_____ Model _____Year_____
- Other vehicle: Make_____ Model _____Year_____
- Direction of impact? □ **Front** □ **Rear** □ **Passenger** □ **Driver** □ **Other**_____
- Was the police report filed? □ **Yes** □ **No** If No, why not? _____
- Please describe the accident in your own words: _____

_____

_____

Injury Details

Please check ALL that apply to the injured party:

□ Saw the impact coming and was braced.
□ Did not see the impact coming and was not braced.
□ Was knocked unconscious by the accident.
□ Was wearing a seatbelt. □ Was not wearing a seatbelt.
□ Bruises were left by the seatbelt.
□ Headrest was at head level. □ Headrest was at neck level. □ Headrest was at upper back level.
□ Was looking straight ahead. □ To the left. □ To the right. □ Down □ Behind.
□ Seatback broke from the impact.
□ Car airbags inflated.

For Drivers Only:

□ Foot was on the brake.
□ Both hands were on the wheel. □ Right hand was on the wheel. □ Left hand was on the wheel.

IMPORTANT

- Was there any part of the body that struck or was jammed on the inside the vehicle? □ **Yes** □ **No**
  If yes, explain_____
- Were you taken to hospital? □**Yes** □ **No** In ambulance? □ **Yes** □ **No**

Property Damage Details

Your Vehicle

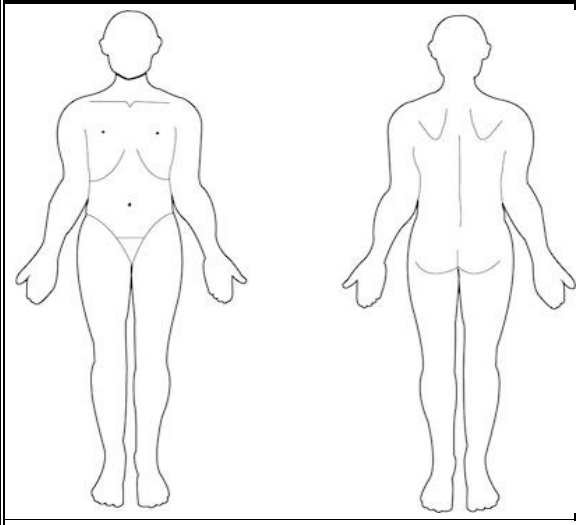
- Estimated cost of damage to your car? $ _____Who gave estimate of damage? _____

Other Vehicle

- Estimated cost of damage to their car? $ _____Who gave estimate of damage? _____

1. Symptom Questionnaire

1. Beside each area/symptom check one circle indicating when the symptoms started.
2. Check the "Have Now" box if you have the symptoms currently.
3. Circle the number indicating the intensity of the symptoms.

SYMPTOM LIST			Right After	Within 3 hrs	Later same day	1-14 Days After	Resolved	Have Now	Inensity Please mark the highest instensity of pain in the respective area in the last 48 hours O = no pain to 10 = Exreme Pain
PAIN / STIFFNESS									
Head			○	○	○	○	□	□	0 1 2 3 4 5 6 7 8 9 10
Jaw			○	○	○	○	□	□	0 1 2 3 4 5 6 7 8 9 10
Neck			○	○	○	○	□	□	0 1 2 3 4 5 6 7 8 9 10
Shoulder	R	L	○	○	○	○	□	□	0 1 2 3 4 5 6 7 8 9 10
Arm	R	L	○	○	○	○	□	□	0 1 2 3 4 5 6 7 8 9 10
Wrist / hand / fingers	R	L	○	○	○	○	□	□	0 1 2 3 4 5 6 7 8 9 10
Upper / middle back			○	○	○	○	□	□	0 1 2 3 4 5 6 7 8 9 10
Chest / Breast			○	○	○	○	□	□	0 1 2 3 4 5 6 7 8 9 10
Rib cage	R	L	○	○	○	○	□	□	0 1 2 3 4 5 6 7 8 9 10
Low back			○	○	○	○	□	□	0 1 2 3 4 5 6 7 8 9 10
Hip	R	L	○	○	○	○	□	□	0 1 2 3 4 5 6 7 8 9 10
Leg / thigh	R	L	○	○	○	○	□	□	0 1 2 3 4 5 6 7 8 9 10
Knee	R	L	○	○	○	○	□	□	0 1 2 3 4 5 6 7 8 9 10
Ankle / foot	R	L	○	○	○	○	□	□	0 1 2 3 4 5 6 7 8 9 10
Other _____			○	○	○	○	□	□	0 1 2 3 4 5 6 7 8 9 10
NUMBNESS / TINGLING									
Arms	R	L	○	○	○	○	□	□	0 1 2 3 4 5 6 7 8 9 10
Wrist / hand / fingers	R	L	○	○	○	○	□	□	0 1 2 3 4 5 6 7 8 9 10
Leg / thigh	R	L	○	○	○	○	□	□	0 1 2 3 4 5 6 7 8 9 10
Foot / toes	R	L	○	○	○	○	□	□	0 1 2 3 4 5 6 7 8 9 10
OTHER:									
Weakness in arms / legs			○	○	○	○	□	□	
Fatigue			○	○	○	○	□	□	
Anxiety			○	○	○	○	□	□	
Sleep Disturbance			○	○	○	○	□	□	
Sensitivity to noise			○	○	○	○	□	□	
Impaired concentration			○	○	○	○	□	□	
Blurred vision			○	○	○	○	□	□	
Irritability			○	○	○	○	□	□	
Difficulty swallowing			○	○	○	○	□	□	
Dizziness			○	○	○	○	□	□	
Forgetfulness			○	○	○	○	□	□	
Tinnitus (ringing in ears)			○	○	○	○	□	□	
Loss of coordination			○	○	○	○	□	□	

Patient Name:_____ **Signature:** _____ **Date:** _____

2. Have you ever suffered from your current symptoms in the past? ○**Yes** ○ **No** If yes, explain:

Year	Cause	Tests done?	Problem resolved completely?
			○**No** ○**Yes**
			○**No** ○**Yes**
			○**No** ○**Yes**

3. Have you received any evaluation and/or treatment for your current condition(s)? ○**Yes** ○ **No** If yes, explain:

Month/Year	Doctor or therapist	Recommended treatment	Outcome (if applicable)

4. Please list any other special diagnostic tests that you have had in the past year

Date	Test Performed	Facility/Clinic/Hospital	Outcome (if applicable)

Examination Note

5. Activities of Daily Living How does this condition currently interfere with your life and ability to function?

	No Affect	Mild Affect	Moderate Affect	Severe Affect		No Affect	Mild Affect	Moderate Affect	Severe Affect
Sitting	○	○	○	○	Grocery shopping	○	○	○	○
Rising out of chair	○	○	○	○	Household chores	○	○	○	○
Standing	○	○	○	○	Lifting objects	○	○	○	○
Walking	○	○	○	○	Reaching overhead	○	○	○	○
Lying down	○	○	○	○	Showering or bathing	○	○	○	○
Bending over	○	○	○	○	Dressing myself	○	○	○	○
Climbing stairs	○	○	○	○	Love life	○	○	○	○
Using a computer	○	○	○	○	Getting to sleep	○	○	○	○
Getting in/out of car	○	○	○	○	Staying asleep	○	○	○	○
Driving car	○	○	○	○	Concentrating	○	○	○	○
Looking over shoulder	○	○	○	○	Gardening/Yard work	○	○	○	○
Caring for family	○	○	○	○	Exercising	○	○	○	○
Work duties	○	○	○	○	Athletics/Recreation	○	○	○	○

Past personal, family and social history Please identify your past health history, including accidents, injuries, illnesses and treatments.

6. Have you ever been hospitalized or had surgery prior to this accident? ○**No** ○**Yes** If yes, describe:

Year	Reason	Surgery	Outcome

7. Have you ever had any <u>past</u> traumas or accidents? (Falls, car accidents, work injury, sports injury, fractures) ○**No** ○**Yes** If yes, describe:

Year	Trauma	Treatment	Outcome

8. Do you take any medications or supplements (including over the counter eg.Tylenol?) ○**No** ○**Yes** If yes, describe:

Name	Reason	x/day	Dose	Since when?

9. Do you have any allergies? ○**No** ○**Yes** If yes, list:

10. Family History

Some health issues are hereditary. Is there a history of illness (cancer, arthritis, heart disease, depression, diabetes, etc.) in your immediate family?

FAMILY

Relative	Age (If living)	Illnesses	Age at death	Cause of death: Natural	Cause of death: Illness
Mother	_____	_____	_____	○	○
Father	_____	_____	_____	○	○
Other: _____	_____	_____	_____	○	○
Other: _____	_____	_____	_____	○	○

11. Social History

SOCIAL

Sleep (check all that apply): ○ Restful sleep ○ Snore heavily ○ Sleep < 6h
○ Difficulty Falling asleep ○ Sleep Face down ○ Sleep 6-8h
○ Wake up frequently ○ Grind teeth at night (bruxism)? ○ Sleep > 8h

How often do you exercise: ○ Don't ○ About 1x/week ○ 2-3x/week ○ > 3x/week ○ Daily

Water intake: ○<33oz(1L) ○ 33-50oz (1-1.5l) ○>50oz(1.5L)

Alcoholic Drinks: ○ Never ○<1/day ○ Daily ○ 6-10/week ○>10/week

Caffeine use: ○ Never ○<1/day ○ Daily ○ 6-10/week ○>10/week Source of caffeine: _____

Tobacco use: ○ No ○<1x/day ○<½ pack/day ○>½ pack/day ○>1 pack/day Type of tobacco: _____

Soft drinks: ○ Never ○<1/day ○ Daily ○ 6-10/week ○>10/week

What vitamins/supplements do you take? ○ Not taking ○ Glucosamine ○ Chondroitin ○ Calcium ○ Multi-Vitamin ○ Fish Oils
○ Pro-biotics ○ Magnesium ○ Greens ○ B Complex ○ Vitamin C ○ Vitamin D ○ Vitamin E
Others: _____

Describe your eating habits: ○ Skip breakfast ○ Two meals per day ○ Three meals per day ○ Snacking between meals

Diet restrictions/intolerances: _____

Rate your fatigue level (0-10): _____ /10

Rate overall stress level (0-10): _____ /10

What are major causes of stress? ○ Work ○ School ○ Economic ○ Family/Relationships

Hobbies: _____

12. Review of systems

Our integrative care focuses on the integrity of all body systems. Please mark the circle beside any condition that you've **HAD** or currently **HAVE**:

a. HEENT	b. Integumentary	c. Respiratory	d. Neurological	e. Digestive	f. Endocrine	g. Genitourinary
○ Blurred Vision	○ Dry Skin	○ Asthma	○ Anxiety	○ Ulcer	○ Thyroid Issues	○ Kidney Stones
○ Floaters in vision	○ Psoriasis	○ Apnea	○ Depression	○ Anorexia/Bulimia	○ Hypoglycemia	○ Prostate Issues
○ Hearing Loss	○ Eczema	○ Shortness of breath	○ Pins and needles	○ Food Sensitivities	○ Immune Disorders	○ Erectile Dysfunction
○ Ringing in ears	○ Acne	○ Emphysema	○ Dizziness	○ Heartburn	○ Low Energy	○ Bedwetting
○ Loss of taste	○ Hair Loss	○ COPD	○ Headaches	○ Constipation	○ Swollen glands	○ PMS Symptoms
○ Loss of smell	○ Rash	○ Allergies	○ Numbness	○ Diarrhea	○ Frequent Infection	○ Infertility
○ Glaucoma	○ Melanoma	○ Pneumonia	○ Multiple Sclerosis	○ Crohn's Disease	○ Polycystic Ovarian Syndrome	○ Urinary Tract infections
○ Ear infections	○ **None**	○ Tuberculosis	○ Parkinson's	○ Irritable Bowel Syndrome	○ Diabetes	○ Yeast Infections
○ Sinusitis		○ **None**	○ Fibromyalgia	○ Ulcerative Colitis	○ Hepatitis	○ Abnormal PAP
○ Nasal Polyps			○ Chronic Pain	○ Celiac	○ Goiter	○ STD's
○ Strep Throat			○ Mood Disorders	○ Diverticulitis/osis	○ **None**	○ Decreased Libido
○ Mononucleosis			○ **None**	○ Gas/Bloating		○ **None**
○ **None**				○ Gall Bladder Disease		
				○ **None**		

h. Constitutional	i. Cardiovascular	j. General
○ Fainting	○ Angina	○ Cancer
○ Low Libido	○ High-cholesterol	○ Epilepsy
○ Poor Appetite	○ High Blood Pressure	○ AIDS/HIV
○ Difficulty losing weight	○ Low Blood Pressure	○ Alcoholism/Drug dependence
○ Weakness	○ Excessive Bruising	○ Gout
○ Sudden Weight Change	○ Poor Circulation	○ Polio
○ Fever	○ Stroke	○ Rheumatic fever
○ Chills	○ Murmurs	○ Scarlet fever
○ Night Sweats	○ A-Fib	○ Typhoid
○ **None**	○ Heart Disease	○ Malaria
	○ **None**	○ Post-Nasal Drip

○ Other:

○ Other:

○ Other:

Erisa Agreement

Assignment of Health Plan Benefits and Rights as well as an appointment and/or designation as my personal representative and an ERISA/PPACA Representative and beneficiary:

I understand and agree that (regardless of whatever health insurance or medical benefits I have), I am ultimately responsible to pay Vida Integrated Health as well as all employees, employers, representatives, and agents thereof, (hereinafter collectively referred to as "Healthcare Provider") the balance due on my account for any professional services rendered and for any supplies, tests, or medications provided. I hereby authorize payment of, and assign my rights to, any health insurance or medical plan benefits directly to Healthcare Provider for any and all medical/healthcare services, supplies, tests, treatments, and/or medications that ***have been*** **or** ***will be*** rendered or provided; as well as designating and appointing Healthcare Provider as my beneficiary under all health insurance or medical plans which I may have benefits under. I hereby authorize the release of any health status, conditions, symptoms or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other remedies necessary in connection with same. I hereby assign directly to Healthcare Provider all rights to payment, benefits, and all other legal rights under, or pursuant to, any health plan (including, but not limited to, any ERISA governed plan/insurance contract, PPACA governed plan/insurance contract) rights that I (or my child, spouse, or dependent) may have under my/our applicable health plan(s) or health insurance policy (ies). I also hereby appoint and designate that Healthcare Provider can act on my/our behalf, as my/our Personal Representative, ERISA Representative, and PPACA Representative as to any claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals and/or legal action (including in my name and on my behalf) to obtain and/or protect benefits and/or payments that are due (or have been previously paid) to either Healthcare Provider, myself, and/or my family members as a result of services rendered by Healthcare Provider, and to pursue any and all remedies to which I/we may be entitled, including the use of legal action against the health plan, the insurer, or any administrator. I hereby also declare that Healthcare Provider is my/our beneficiary regarding my/our health plan as contemplated by both ERISA and PPACA, and that Healthcare Provider can pursue any and all rights that I/we may have under state and/or federal law regarding my/our health plan. This assignment, appointment, and designation will remain in effect unless revoked by me in writing. *It is my intent that the effective date of this document shall relate back to include all services, supplies, test, treatments, or medications that have been previously provided by Healthcare Provider*. A photocopy or scan or this document is to be considered as valid and as enforceable as the original.

_____ _____

Patient Signature Date

_____

Patient Name

Informed Consent

I hereby request and consent to the performance of procedures, which may include, but is not limited to, various modes of physical therapy, massage therapy, acupuncture, trigger point injections, diagnostic x-rays, diagnostic ultrasound, diagnostic lab work including urine, blood, gynecological specimens and body cultures, medical doctor and/or chiropractic manipulations on me (or the patient named below, for whom I am legally responsible) by any licensed clinicians who, now or in the future, treat me while employed by, work or are associated with, or are serving as a replacement or locum, for any Vida Integrated Health clinic, including those working at the center or office listed below or any other office or center.

I have had an opportunity to discuss with the clinicians, and/or with other office or clinic personnel, the nature and purpose of all recommended procedures.

I understand, and am informed that in the practice of medicine, and in the practice of chiropractic, acupuncture, naturopathy and physical therapy, there are some risks to treatments including, but not limited to fractures, disk injuries, strokes, dislocations, sprains and potential exacerbation of symptoms. I do not expect the Vida clinician to be able to anticipate and explain all risks and complications, I wish to rely on the Vida clinician to exercise judgment during the course of the procedures which the Vida clinician deems necessary and, based upon the facts then known, are in my best interest.

I have read, or have had read to me, the above consent. I have also had the opportunity to ask questions about its content, and by signing below, I agree to evaluation and treatment at Vida. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

_____ Date _____

Patient Signature

_____

Patient Name

To be completed by patient's representative if patient is a minor or physically or legally incapacitated

_____ Date _____

Representative Signature

_____

Representitive Name

Records Request Authorization

I understand and authorize all Vida Integrated Health clinics to request health information regarding my condition(s) while under treatment at Vida Integrated Health. Vida Integrated Health may request any of the following, as long as it pertains to the treatment and care rendered at Vida Integrated Health, from the entities that I disclose.

- Records of medical history.
- Examinations.
- Consultations.
- X-Ray reports.
- Laboratory studies.
- Operative and pathology reports.
- Physicians' and nurses' notes.
- Hospital records.
- Diagnoses.
- Prescription or treatment information relating to any disease, injury or other physical condition.

This authorization can be withdrawn by me at any time.

_____ _____

Patient Signature Date

_____

Patient Printed Name

Instruction to Counsel

(Contractual Guarantee of Payment for Health Care Services and Irrevocable Direction and Instruction to Counsel)

I hereby authorize my attorney and/or involved insurance companies to withhold sums, paid as a result of my injuries, from any settlement, arbitration award, judgment or verdict as may be necessary to adequately reemburse Vida Integrated Health. I hereby authorize and direct you, my attorney and/or involved involved insurance companies, to pay directly to Vida Integrated Health such funds as may be due owing for health care services for injuries arising from my motor vehicle accident.

I agree to never rescind this document and that any attempted rescission would not be honored by my attorney.
I fully understand that I am directly and fully responsible to Vida Integrated Health for all health care bills submitted for services rendered to me. Further, this agreement is made solely for Vida Integrated Health's additional protection and in consideration of forbearance on payment: I also understand that such payment is not contingent on any settlement damages or the inclusion of any amount in respect of those bills in the breakdown of any settlement, arbitration award, judgment or verdict.

I specifically request my attorney to acknowledge this agreement by signing below and returning it to Vida Integrated Health. I have been advised that if my attorney does not wish to cooperate in protecting the Vida Integrated Health's interest, Vida Integrated Health will not await payment and will require me to make payments on a current basis.

I fully understand that all past, present and future bills for services rendered by Vida Integrated Health for my treatment are my responsibility for payment. Hereby ratify my agreement to pay all such bills. I also hereby irrevocably agree to have Vida Integrated Health's bill paid from my proceeds of any nature by way of settlement, arbitration award, judgment, verdict, or otherwise that you, my attorney, or that I, might receive. I do hereby irrevocably instruct my legal counsel to pay the doctor in full from any such proceeds of settlement, arbitration award, judgment or verdict or from the enforcement actions thereon. At the time of disbursement, you are to contact Vida Integrated Health to verify the current amount of the accounts receivable balance and pay the doctor prior to disbursing any proceeds to me or any other party at my direction; I also understand that if settlement does not cover Vida Integrated Health's entire bill I am still responsible for the remainder.
I hereby instruct that in the event that another attorney is substituted in this matter, the new attorney shall be bound by and honor this Contractual Guarantee of Payment for Health Care Services and Irrevocable Direction & Instruction to Counsel as inherent in such substitution and enforceable upon the case as if it were executed by him/her.

I agree to pay in full for all services billed by Vida Integrated Health. In addition to this agreement, a lien according to the *Revised Code of Washington* may be filed and enforced and the cost for which will be added to Vida Integrated Health's bill. Further, I understand that interest charges will apply to any and all services rendered to me according to Washington State law and that interest will accrue on the unpaid balance of my account from the date of service at the rate of 1% per month and compounded on a monthly basis.

Signature of Patient: _____ Date: _____

Printed Name: _____

The undersigned, being attorney of record for all above-named patient, does hereby agree to observe all the terms of the above and agrees to withhold such sums from the proceeds of any settlement, arbitration award, judgment or verdict so as to adequately protect the outstanding account of Vida Integrated Health.

Signature of Attorney: _____ Date: _____

WSBA Number: _____

MVA FINANCIAL POLICY

Our office is pleased to accept your accident/injury case provided that the following policies are understood:

For Patients with PIP (Personal Injury Protection)

- We expect you to provide our office with all necessary claim information and fill out applicable forms from your automobile insurance carrier to open your claim.
- We will bill your auto carrier directly for any services you receive in our office.
- Cancellation policy: We require 24 hours' notice if you are unable to keep your appointment for any reason. Any changes made less than 24 hours before your appointment time will incur a charge that is NOT billable to your insurance.
- Costs of supplies and nutritional products are due at the time they are received. If your insurance company later pays for the supplies, we will either credit your account or give you a refund.
- If PIP benefits are exhausted or your insurance company determines that you no longer need ongoing care before your injuries have resolved, our office is then forced to wait until you are ready to settle your claim to receive payment in full. This could take months to years, depending on each individual case. In this instance, please see our policy below regarding Third Party Claims.

IMPORTANT: it is ILLEGAL for your insurance company to increase your premiums for using your PIP policy. This can ONLY be done based on fault. Additionally, the amount of PIP used to cover medical bills and time lost from work (in the case that you are at fault) does not affect how much your premium will be raised.

RCW is official state law. The revised code of Washington (RCW) states, in part:

RCW 46.52.130
(iii) Any policy of insurance may not be canceled, non-renewed, denied, or have the rate increased on the basis of information regarding an accident included in the abstract of a driving record, unless the policyholder was determined to be at fault.

Third Party Pay Claims (For patients with no PIP benefits)

Payment for services may be deferred until the case is settled, provided that the following conditions are satisfied and policies understood.

- That an attorney specializing in personal injury cases is retained to represent you.
- If your claim extends beyond (1) year, you will then begin to pay 5% of the unpaid balance per month until the account is paid in full.
- We will file a medical lien, which is recorded in King, Snohomish County Court, which protects our right to be paid.
- A finance charge of the unpaid balance may be assessed each month.
- Cancellation policy: We require 24 hours' notice if you are unable to keep your appointment for any reason. Any changes made less than 24 hours before your appointment time will incur a charge that is NOT billable to your insurance.

I understand and agree to the above policies

Patient or Guardian Signature: _____ Date: ____/_____/_____

Patient or Guardian Name: _____
(please print)

INSURANCE DIRECTIVE

(HEALTH INSURANCE DIRECTIVE TO DOCTOR AND ATTORNEY/INSURANCE ADJUSTER)

****For patients without PIP or in the case that PIP exausts**

I hereby direct Vida Integrated Health (hereafter PROVIDER):

___ **TO BILL MY HEALTH INSURANCE:**

I have health insurance through _____under ID number _____. I understand that by directing PROVIDER to bill my health insurance, I must pay all co-pays, deductibles and/or charges in excess of stop losses, as applicable, at the time of treatment, without exception.

___ **NOT TO BILL MY HEALTH INSURANCE/L&I:**

I have health insurance through _____ under ID number_____. Because I find it difficult to meet the financial requirements of my health insurance company (including, but not limited to: co-pays, deductibles, limits on number of visits, stop losses, as the case may be), I direct PROVIDER not to bill my health insurance company for the following reasons:_____
_____
_____
_____

Instead, in consideration of my doctor's treatment of me without billing my health Insurance company, I _____ hereby agree to this Third-Party Settlement Directive to Attorney or Insurance Adjuster (Hereafter, "Third Party Directive"):

By signing below, I hereby direct my attorney and/or adjuster to pay PROVIDER directly from any award, judgment or settlement of my motor vehicle accident/personal injury claim of _____ the entire outstanding balance for my treatment related to that injury. I direct my attorney not to bill my health insurance company at any time without the express written consent of PROVIDER.

I agree that once treatment is provided by PROVIDER, this Third-Party Directive may not be rescinded or revoked without the express written consent of PROVIDER. Further, I agree that this directive shall remain in full effect notwithstanding any change of attorney or insurance adjuster or any other circumstance. I understand that I am also personally financially responsible for all charges not covered by this Third-Party Directive. I also understand that I am personally responsible for all of my outstanding medical bills irrespective of the outcome of my motor vehicle accident/personal injury claim. I understand that all fees for professional services rendered are due and payable at the time of service. I agree that this directive does not waive any other remedies or rights of collection by PROVIDER. I also authorize my doctor, my attorney, and/or my insurance company to release any and all information required for the payment of my outstanding medical bills.

_____ _____
Patient Signature Date

_____ _____
Witness Date

HIPAA Agreement

(Notice of Privacy Practices Acknowledgement)

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations, such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed, to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

Patient Signature _____ Date: _____

Patient Name _____

Representative/Gaurdian Signature _____ Date: _____

Representative/Guardian Name _____

Office use only

I attempted to obtain the patient's signature in acknowledgement of this Notice of Privacy Practices Acknowledgement, but was unable to do so, as documented below:

Date:

Initials:

Reason:

HIPAA Agreement
(Patient Copy)

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.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing, and we are required to honor and abide by that written request, except to the extent that we have already taken actions on relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to the requested restriction.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

Patient Copy