



2908 228th AVE S.E. Suite C,
Sammamish, WA 98075
(425) 391-4095

ACCIDENT INFORMATION

Date of Injury: _____

PATIENT INFORMATION & AUTO INSURANCE INFORMATION

Last Name: _____ First: _____ Initial: _____ Home Phone: _____
 Nick Name: _____ Cell Phone: _____
 Address: _____ Work Phone: _____ Ext: _____
 City: _____ State: _____ Zip: _____ Email: _____
 Birth Date: _____ Gender: Male Female Marital Status: S M W D Partnered
 Driver's License #: _____ State: _____ SSN: _____
 Occupation: _____ Employer: _____

Whom may we thank for referring you? (Insurance Phone Book Web Search Drive By Other: _____)

Auto Insurance Company: _____ Insurance Phone: _____
 Claim Number: _____ Policy Number: _____
 Claim Adjuster: _____ Phone #: _____
 Attorney Name (If Applicable): _____ Phone #: _____

OTHER DRIVER & VEHICLE INFORMATION

Last Name: _____ First: _____ Initial: _____ Phone: _____
 Make/Model/Year of Vehicle: _____
 Insurance Company: _____ Insurance Phone: _____
 Claim Number: _____ Policy Number: _____
 Claim Adjuster: _____ Phone #: _____
 Attorney Name (If Applicable): _____ Phone #: _____

PATIENT CONDITION

NO YES Were you knocked unconscious? If yes, how long? _____
 NO YES Did you feel pain immediately after the accident? If No, when did the pain begin? _____
 NO YES Were you examined by a Medical Professional for this condition? _____
 NO YES Were you hospitalized? If yes, where and when: _____
 NO YES Diagnostic Imaging: X-ray Cat Scan MRI Ultrasound Other: _____
 NO YES Have you lost any days of work? Date from: _____ to: _____
 NO YES Have you had previous complaints in the injured area?
 If yes, how long since the previous complaint was symptomatic _____

PATIENT VEHICLE AND ACCIDENT DETAILS

Make/Model/Year of Vehicle: _____

Were you the: Driver Passenger Front Rear

Please briefly describe the accident: _____

What direction as impact from? Front Rear Left Right Other: _____

Placement of hands on the steering wheel? Both hands Only right hand Only Left Hand

Were you: Surprised by the impact **OR** Braced for Impact

NO YES Were you using a safety belt? Lap Shoulder

The head rest was in the: Low Mid-position High

NO YES Equipped with air bags? Did they inflate? NO YES

Was your car: Moving OR Stationary

NO YES Did your car hit another vehicle?

What speed were you traveling? _____

NO YES Were you hit by more than one car?

NO YES Did your car impact a structure? If yes please explain: _____

NO YES Did and part of your body strike anything in the vehicle? If yes please explain: _____

NO YES Was your foot on the brake?

POLICE: Was a report filed? NO YES

Traffic violation issued to: _____

Officer Name: _____

Phone Number: _____

Case #: _____

Signature of Fact, Receipt of Notice Privacy Policies, Acknowledgement of Insurance Assignment and Release:

To the best of my knowledge and ability, I have provided true and complete information. I understand that I am financially responsible for all charges whether or not paid by insurance. By signing below I authorize the doctor, his designated staff and/or insurance company to release any information required for processing insurance claims. I assign any and all appropriate insurance benefits be paid directly to Dr. Bahm/Pine Lake Chiropractic Clinic, P.S. for services rendered.

I have received and reviewed, or had the opportunity to review, and understand and agree to the *Notice of Privacy Practices of Pine Lake Chiropractic Clinic, P.S.*, which describes the Practice's policies and procedure regarding the use and disclosure of any of my Protected Health Information created, received or maintained by the Practice.

X _____
Signature of Patient or Parent/Guardian

Relationship to Patient

Printed Name

Date

Consent for Treatment of Minors or Dependents:

By my signature below, I hereby authorized Pine Lake Chiropractic Clinic, P.S. and their designated staff to administer care to my child or dependent as they deem necessary.

X _____
Signature Parent or Guardian

Date



HIPPA Notice of Privacy Practices

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), commonly know as "HIPAA" is a Federal program that requires all medical records and other individually identifiable health information used or disclosed by us, in any form, whether electrically, on paper or orally, is kept properly confidential. The act gives you, the patient, significant rights and control over your health information. This notice describe certain obligations we have regarding ways in which we may use and disclose health information about you, it also outlines your rights to the health information we keep about you.

We understand that information about you and your health is personal and are committed to your privacy. We create a record of the care and services you receive. We need this record to provide you with quality care and to comply with certain legal requirements. This Notice applies to all of the records of your care generated by this office, whether made by your personal doctor, others working in the office, or associates processing billing and your insurance claims.

We are required by law to:

- Make sure that health information that identifies you is kept private.
- Give you this Notice of our legal duties and privacy practices with respect to health information about you.
- Follow the terms of the Notice that is currently in effect.

A partial list of how we may use and disclose health Information about you:

- For Treatment, payment, health care and business operations of this office.
- As required by Law, Law enforcement, lawsuits and disputes; protect public safety or assist apprehending criminals.
- Military or Veteran's and Workers Compensation.
- Public Health Risks; Coroners, health examiners and funeral directors.
- To government authorities to prevent child abuse or domestic violence; to avert a serious threat to health and safety
- National security and intelligence activities.
- Security Officials for Inmates:
- To government agencies for audits, investigations and other oversight activities.
- For certain limited research purposes.

As our patient, your rights regarding Health Information about you:

- Right to Inspect and copy.
- Right to Amend.
- Right to Request Restrictions.
- Right to Request Confidential Communication.
- Right to Accounting Disclosures.
- Right to a Paper copy of this Notice (full Notice is available upon request)

Changes to this Notice: We reserve the right to change this Notice. We will post a copy of a current notice in our facility with the current effective date on the first page.

Complaints: If you believe that your privacy rights have been violates, you may file a complaint with us. All complaints must be in writing. Please contact the administrator at the location where you were treated to file a complaint.

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I was provided a copy of the Notice of Privacy Practices and have read (or had the opportunity to read if I chose) and understood the Notice. This notice is considered effective dates signed, and shall remain effective for a minimum of 6 years, unless otherwise revoked, in writing, by patient.

Unless you request otherwise, we may use or disclose health information to a family member or other personal representative to the extent necessary to help you with your healthcare or payment for your health care. In addition, we may use your confidential information to remind you of appointments, phone, email, postal service or other method requested by you.

Additional Disclosure Authority: In addition to the allowable disclosures described in the State of Privacy Practices, I hereby specifically authorize disclosure of my protected health care information to persons indicated as follows:

- Any member of my immediate family Spouse ONLY
- Other(s) as specified: _____

X

Signature

Relationship to Patient

Printed Name

Date