Advanced Back and Neck Pain Clinic
4621 35th Avenue SW Suite B Seattle WA 98126 Phone/Fax: 206-933-8498
Dr. Keshika Nanda & Dr. Christopher Prouty

Date _____

Personal History Form

The following is a confidential questionnaire which will help us determine the best possible course of treatment for you. Please take your time and complete the information accurately. Thank you!

Name _____ S.S.# _____
Address _____City_____State ____ Zip_____
Home phone _____Business phone_____
Cell phone _____ E-mail address_____
Sex: Male Female Birth Date(month/day/year)_____Age_____
Employer_____ Occupation_____
Employment Address _____
In case of emergency contact _____ Phone _____
Referred by _____ **Have you ever been treated by a chiropractor before? Yes No**

Informed Consent

Name:_____

REGARDING: Chiropractic Adjustments, Modalities, and Therapeutic Procedures:

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risk are most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments.

Treatment objectives as well as the risks associated with chiropractic adjustments and, all other procedures provided at Advanced Back and Neck Pain clinic have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor, deems necessary to treat my condition at any time throughout the entire clinical course of my care.

_____ ___/___/___  Witness Initials

Patient or Authorized Person's Signature Date

****Please note there is a front and back to these forms***

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Your personal auto insurance company information (at the time of the accident):

Insurance Company_____
Agent name_____
Phone number_____ Policy No._____
Claim#_____Claim adjuster name & Phone Number_____

Was the vehicle you were registered at the time of the accident? Yes O No
Are you, yourself, licensed to drive? O Yes O No
Are you the legal owner of the vehicle you were in at the time of the accident? O Yes o
please list the name(s) of the legal owner:_____

Other involved partv (if applicable) information:

Name of other party_____
Other party insurance company_____Policy No. _____
Claim No. _____
Have you been in contact with an adjuster from the other party's insurance company regarding this claim? Y/N
If yes, claim adjuster name_____ Phone number_____

Have you retained an attorney? **Y/N**
If so, his/her name_____Phone number_____
Regarding settlement, please check all that apply:

- ☐ I have settled my personal injury claim with this company
- ☐ I have settled the property damage claim
- ☐ I have signed an agreement which will pay my medical expenses for a period of time (explain)

- ☐ I have not signed any agreement and have not settled any portion of my claim

Patient Signature_____Date_____

Doctor Signature_____Date_____

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Accident Details

Your Vehicle Information (year,make, model)_____
Were you the: Driver, Front passenger, rear passenger?_____
If you were the passenger, were you sitting on the: driver's side, passenger side, middle?_____
What was the Estimated Speed of your vehicle at the time of the accident?_____
What type of accident was it? Rear-ended, side-impact, front collision other?_____
The Other Vehicle(s) Information (year, make, model) :_____
The Road Conditions at time of the accident were: (dry, wet, rain, snow, other)?_____
What was the estimated speed of the other vehicle:_____
What type of Headrest does your vehicle have: fixed, adjustable?_____
What position was the headrest in: lowest position, middle position, top position?_____
Was your seatback broken? **Yes** **No**
Did you use a: shoulder/lap belt, lap belt only, carseat, no seatbelt used, other?_____
Did your airbag deploy? **Yes** **No**
If **yes**, did your head strike the airbag?
At the time of the impact, what was your body position: facing forward, looking up, looking down, turned to left, turned to right? _____

Were you aware of the impending collision with the other vehicle? **Yes** **No**

Did you brace for impact? **Yes** **No**
Were your hands on the wheel? **Yes** **No**
If yes: **Left only** **Right only** **Both**
Was your foot on the brake pedal? **Yes** **No**
if yes, was your foot knocked off the brake pedal? **Yes** **No**
Did the collision move your vehicle? **Yes** **No**
If yes, how far_____(ft)
Did any part of your body strike an object in the car? **Yes** **No**
if yes, please explain_____
Did you lose consciousness after the collision? **Yes** **No**
If yes, how long_____
Describe the damage to your vehicle:_____
What dollar amount did the body shop estimate the damage to be?_____
Did the police respond to the accident?_____
Did they file a report? **Yes** **No**
Described the damage to other vehicle(s) involved:_____
Did you file a DMV accident report? **Yes** **No**
Where did you go immediately after the accident?_____
How did you get there?_____
Did you go to the Hospital/UrgentCare/Another Doctor? **Yes** **No**
What Hospital/UrgentCare/Doctor did you go to?_____
What was their diagnoses?_____
What parts had x-rays or testing_____
Any medications given:_____

Immediately after collision symptoms:

Immediately after the accident were you: **Dizzy, nauseous, vomit, confused, disoriented, dazed, other**
_____
Did you feel pain immediately after the collision? **Yes** **No**
If yes, describe:_____
If you didn't feel pain immediately after the collision, how long did it take until you felt pain?

Where did you feel pain?_____
Do you or did you have any cuts, contusions, or bruising after the collision? **Yes** **No**
If yes, describe:_____

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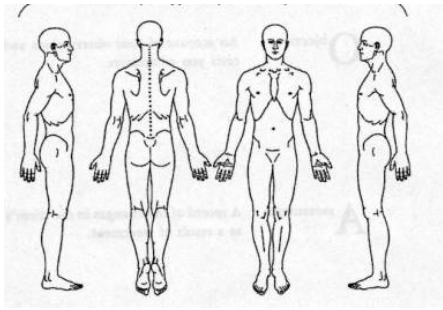
Your Present Symptoms (circle areas of complaint)



Body Part 1:_____

What makes pain worse (activity)_____
What makes pain better_____
Described the type ofpain_____
Does the pain stay or radiate/move to another part of the body?_____
Scale of 0-10 (zero no pain, 10 worst) Rate pain Current_____/10 Average_____/10 Worst_____/10
Is the pain/condition getting better, staying the same, or worse (circle one)
What percentage of waking hours (0-100%)_____
Does your pain vary throughout the day? **Yes** **No**
If varies, explain_____

Body Part 2:_____

What makes pain worse (activity)_____
What makes pain better_____
Described the type of
pain_____
Does the pain stay or radiate/move to another part of the body?_____
Scale of 0-10 (zero no pain, 10 worst) Rate pain Current_____/10 Average_____/10 Worst_____/10
Is the pain/condition getting better, staying the same, or worse (circle one)
What percentage of waking hours (0-100%)_____
Does your pain vary throughout the day? **Yes** **No**
If varies, explain_____

Body Part 3:_____

What makes pain worse (activity)_____
What makes pain better_____
Described the type ofpain_____
Does the pain stay or radiate/move to another part of the body?_____
Scale of 0-10 (zero no pain, 10 worst) Rate pain Current_____/10 Average_____/10 Worst_____/10
Is the pain/condition getting better, staying the same, or worse (circle one)
What percentage of waking hours (0-100%)_____
Does your pain vary throughout the day? **Yes** **No**
If varies, explain_____

Body Part 4:_____

What makes pain worse (activity)_____
What makes pain better_____
Described the type ofpain_____
Does the pain stay or radiate/move to another part of the body?_____
Scale of 0-10 (zero no pain, 10 worst) Rate pain Current_____/10 Average_____/10 Worst_____/10
Is the pain/condition getting better, staying the same, or worse (circle one)
What percentage of waking hours (0-100%)_____
Does your pain vary throughout the day? **Yes** **No**

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If varies, explain_____

If, after the accident, you began to experience the follow symptoms please described:

Weakness of arms or legs_____
Numbness of arms or legs_____
Tingling of arms or legs_____
Pain with swallowing liquids or food? Yes No_____
Changes in vision, sensitivity to light? Yes No_____
Changes in hearing? Yes No_____
Vomiting? Yes No_____
Bowel or Bladder changes? Yes No_____
Any other changes?_____

Your Past Health History:

Do you have any serious illness/chronic disease?_____
Have you been hospitalized?_____
Have you had surgeries?_____
Any previous traumas? **Yes** **No**_____
Any previous auto collisions? **Yes** **No**_____
How many pregnancies have you had?_____
Are you currently taking medications? **Yes** **No**_____
Do you have any allergies? **Yes** **No**_____
Have you had x-rays before? **Yes** **No**_____
Have you seen a chiropractor before? **Yes** **No**_____
When was your last physical?_____
Do you have any prior history of your complaints?_____

Review of Systems: Please circle if you have any of these conditions and explain:

Fever Fatigue night sweats chest pain shortness of breath abdominal pain chronic cough
Rashes unexplained weight loss nausea vomiting diabetes arthritis
Heart disease lung disease musculoskeletal disease

Family Heath History: please circle and explain if your immediate family has/had these conditions:

Anemia Cancer diabetes heart disease lung disease high blood pressure
Epilepsy asthma psychological disorders kidney disease glaucoma

Personal/Social History:

What is your occupation?_____Have you worked since injury? **Yes** **No**
Are you married? Yes No
What ages are your children?_____
Do you exercise regulary prior to injury?_____
What are your hobbies?_____have you been able to do hobbies? **Yes** **No**
Do you drink alcohol? **Yes** **No** if yes, how many drinks per week?_____
Do you use tobacco? **Yes** **No** if yes, how many often per week?_____

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LETTER OF PROTECTION

Patient Name:_____ Accident Date: _____

Attorney Name: _____
Law Firm: _____

I/We ("we") the undersigned patient and attorney, will protect the interests of Columbia Chiropractic PLLC, DBA Advanced Back and Neck Pain clinic ("the Office"), for any/all financials related to the accident listed above, out of the proceeds of any settlement, judgment, or verdict, as well as out of any no-fault proceeds, relating to the accident listed above.
By "interests," we mean any outstanding balance owed to the Office by me, the Patient, for any Charges incurred at the Office relating to this specific accident as defined by the Office's documents.
This letter of protection shall not be modified or revoked without the written consent of the Office. This letter of protection shall not be exclusive of any other security interests or rights, if any, which the Office may have that does not pertain to this particular accident.

_____ _____

Patient's Signature Attorney's Signature

Date: _____ Date: _____

Lien Disclosure

I understand that for treatment provided by Columbia Chiropractic PLLC, DBA Advanced Back and Neck Pain clinic 4621 35th Ave SW Suite B Seattle, WA 98126 related to an automobile collision, primary first party insurance is with the Personal Injury Protection (PIP) Insurance for the car I was driving, riding in as a passenger, or struck by as a pedestrian/bicyclist. I understand and Columbia Chiropractic PLLC, DBA Advanced Back and Neck Pain clinic to bill PIP and authorize the release of any information acquired in the course of my examinations and treatment in accordance with HIPAA privacy regulations.

Should PIP insurance not be available, exhaust or terminate for any reason, I Columbia Chiropractic PLLC, DBA Advanced Back and Neck Pain clinic to bill any applicable health insurance I may have available, subject to any contract Columbia Chiropractic PLLC, DBA Advanced Back and Neck Pain clinic may have with such carrier. I understand and authorize Columbia Chiropractic PLLC, DBA Advanced Back and Neck Pain clinic to bill health insurance, if applicable, and authorize the release of any information acquired in the course of my examination and treatment in accordance with HIPAA privacy regulations.

In the event I do not have PIP or health insurance available for the automobile collision, I authorize Columbia Chiropractic PLLC, DBA Advanced Back and Neck Pain clinic to hold my bills pending final claim resolution and file a medical lien against any applicable third-party insurance settlement pursuant to RCW 60.44.010, et seq. I understand I may then be asked to make minimum monthly payments on any balance owed. I understand and acknowledge that in the event a medical lien is filed, and that if the lien is paid or settled, I will be provided with an original, written Satisfaction of Lien and

I am responsible for filing the Satisfaction of Lien with the County Auditor and for paying the filing fee costs associated with filing any such Satisfaction of Lien. I further understand that payment of any medical lien, in some circumstances, may not fully pay my outstanding final charges due Columbia Chiropractic PLLC, DBA Advanced Back and Neck Pain clinic for treatment provided, and I may be required to make additional payments after satisfaction of the lien.

Dated:_____20/_____
Patient Name (Print)_____
Patient Signature:_____
Date of Injury_____
Parent/Guardian Name (print):_____
Parent/Guardian Signature: _____

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PERSONAL INJURY OFFICE POLICY

If you are injured in a fall, accident, or some other injury where someone else is liable, you may handle your financial obligations for treatment one of several ways.

If you are injured in an auto accident and you were a driver or passenger in a car that has Personal Injury Protection, the insurance carrier will usually pay 100% of your chiropractic care up to your allowed limit. If your balance is paid in full by the insurance company, there will be no out of pocket expense to you. Should the insurance company fail to pay and there were reasonable efforts made to collect, you will then be responsible for payment in full. Per RCW 19.52.020 we will access a 1% interest of balance for each month the account goes unpaid. This fee will start 60 days after you have completed care in our office.

If you are covered by PIP coverage, you must provide Advanced Back and Neck Pain Clinic with the insurance carrier name, address, and policy number within 3 working days of the start of your care or you will be put on a cash basis.

If you have private health insurance but are on an accident or PIP claim, you, the patient, will abide by our office policy as it relates to your private health insurance (SEE OUR CHIROPRACTIC OFFICE FEE STATEMENT). If you have an attorney and private health insurance or PIP coverage, you will assign the insurance benefits for your treatments to be paid directly to Advanced Back and Neck Pain Clinic. This lien will instruct your attorney to pay your remaining balance directly to us out of your settlement.

If you have an attorney and no insurance, then you will sign and instruct your attorney to sign a guarantee of payment on your settlement. We must have the guarantee of payment returned to our clinic within 10 working days, or you will be put on a cash basis. Our office will also file a lien annually for the outstanding balance we have agreed to hold until your claim settles with your attorney. To file and release the lien, your account will be charged a fee of $l46. We will also update the lien annually, in which your account will be charged $73 each time. In addition, we will also require a pre-payment for any medical records or billing requested by an attorney or insurance carrier. Once payment is received, we will then mail the requested information. IF YOU HAVE NO INSURANCE OR ATTORNEY, YOU WILL BE ON A CASH BASIS. NOTE: In all cases, the patient is ultimately responsible for payment for their care. In dealing with your insurance carrier, we will supply billings but it is your responsibility to follow up, necessary to insure payment.

Dated:_____20/_____
Patient Name (Print)_____
Patient Signature:_____

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Advanced Back and Neck Pain Clinic Notice Of Privacy Practice

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your Personal Health Information. In addition, we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as dictated by our office policy, we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. Once you have read this notice, please sign the back page, and return to our front desk receptionist. If you would like a copy of this Notice of Privacy Practice, one can be provided for your records.

PERMITTED DISCLOSURES:

Treatment purposes - discussion with other health care providers involved in your care.
Inadvertent disclosures - open treating area means open discussion. If you need to speak privately to the doctor, please let our staff know so we can place you in a private consultation room.
For payment purposes - to obtain payment from your insurance company or any other collateral source.
For workers compensation purposes - to process a claim or aid in investigation. Emergency - in the event of a medical emergency we may notify a family member. For Public health and safety - in order to prevent or lessen a serious or eminent threat to the health or safety of a person or general public. To Government agencies or Law enforcement - to identify or locate a suspect, fugitive, material witness or missing person. For military, national security, prisoner and government benefits purposes.
Telephone calls or emails and appointment reminders - we may call your home and leave messages regarding a missed appointment or apprize you of changes in practice hours or upcoming events.
Change of ownership- in the event this practice is sold, the new owners would have access to your PHI.
Training purposes- to aid in the training of employees with occasional videotaping or audio taping of patient- doctor and/or patient- staff interactions. Testimonials- written, audio, and/or video testimonials may be shared with others.

YOUR RIGHTS:

To receive an accounting of disclosures.
To receive a paper copy of this Privacy Notice.
To request mailings to an address different than residence.
To request Restrictions on certain uses and disclosures and with whom we release information to, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction.
To inspect your records, with notice in advance.
To request amendments to information. However, like restrictions, we are not required to agree to them. To obtain one copy of your records at no charge, when timely notice is provided (72 hours). X-rays are original records and you are therefore not entitled to them. If you would like us to outsource them to an imaging center, to have copies made, we will be happy to accommodate you. However, you will be responsible for this cost.

COMPLAINTS:

If you wish to make a formal complaint about how we handle your health information, please call Chris at (206) 933-8498. If he is unavailable, you may make an appointment with our receptionist to see him within 72 hours or 3 working days. If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to: DHHS, Office of Civil Rights- 200 Independence Ave. SW, Room 509F HHH Building, Washington DC 20201.

I have received a copy of the Advanced Back and Neck Pain Clinic Patient Privacy Notice to review. I understand my rights as well as the practice's duty to protect my health information, and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this 't Notice of Privacy Practice" at a time in the future and will make the new provisions effective for all information that it maintains past and present.

No Show Fee- As per Clinic Policy $45.00 may be applied to appointments missed, or not cancelled within 24 hours.

I am aware that this "Notice" can be made available to me if needed. At this time, I do not have any questions regarding my rights or any of the information I have received.

Patient's Name _____ DOB _____ **HR#** _____

Patient's Signature _____ Date _____

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