Patient Name: _____ **Date:** _____

Auto Accident Mechanism of Injury Form

Date of Collision: _____ Hour of Accident: _____ AM / PM

Location and/or intersection of accident City and/or State:_____

Please describe in detail how the collision happened:_____

_____

_____

What was your position in the car? (Circle) **Driver** / **Front Passenger** / **Left Rear** / **Right Rear**

If "Driver", were your hands on the steering wheel? **Both** / **Left** / **Right**

Did the airbags deploy? **Yes** / **No** Did you strike another vehicle? **Yes** / **No**

Did another vehicle strike your vehicle? **Yes** / **No**

Angle of Impact: **Front** / **Back** / **Left** / **Right** / **Other**: _____

If Second Collision – Angle of 2nd impact: **Front** / **Back** / **Left** / **Right** / **Other**: _____

1) In relation to the back of your head, was your headrest set: **Low** / **Middle** / **High**

2) Were you surprised by the impact? **Yes** / **No**

If "NO", how did you brace? **With Hands** / **With Feet**

3a) Where was your head facing at the time of impact? **Straight Ahead** / **Left** / **Right** / **Behind**

3b) Were you leaning forward at the time of impact? **Yes** / **No**

4) What type and year of vehicle were you in? _____

4a) What was the approximate speed of your vehicle when the accident occurred? _____ mph

5) What type and year of vehicle struck yours?_____

5b) What was the approximate speed of the other vehicle when the accident occurred? _____ mph

6) Were you wearing a seatbelt? **Yes** / **No** What type: **Lap Belt** / **Shoulder Belt** / **Both**

7) Did you feel pain immediately after the accident? **Yes** / **No**

What is the last thing you remember before the collision?_____

What is the next thing you remember after the collision?_____

Did you strike anything in the vehicle at the time of impact? **Yes** / **No** If "YES", specify what part of your body struck what: (i.e. head, chest, chin, shoulder, knee, etc.)

□ Steering Wheel	□ Windshield
□ Dashboard	□ Roof
□ Left Side Door	□ Right Side Door
□ Left Window	□ Right Window
□ Other	

Did your seat break or bend? **Yes** / **No**

ITWH Chiropractic Clinic **Injury Questionnaire** **Dr. Peter Britton, DC**

Patient Name: _____ Date: _____

Have you reported the accident? □**Yes** □**No** If yes, to whom? _____

Do you have auto insurance? □**Yes** □**No** Does your insurance include Personal Injury Protection? □**Yes** □**No** **Not sure**

Did the police come to the accident? □**Yes** □**No** Do you have the police report? □**Yes** □**No** If no, report #: _____

Do you have an attorney? □**Yes** □**No** Name: _____ Phone: _____

Your Auto Insurance Information:

Insurance Company: _____

Phone Number: _____

Name of Insured/Relationship: _____

Name of Patient: _____

Adjuster's Name: _____

Adjuster's Phone: _____

Claim Number: _____

Policy Number: _____

Billing Address: _____

_____

For Office Use Only:

Claim accepted:
□**Yes** □**No**

Confirmation of PIP:
□**Yes** □**No**

Verified with:_____

Date:_____

Initials: _____

The Other Vehicle's Auto Insurance Information:

Insurance Company: _____

Phone Number: _____

Name & Address of Insured _____

Adjuster's Name: _____

Adjuster's Phone: _____

Claim Number: _____

Policy Number: _____

Billing Address: _____

_____

For Office Use Only:
Claim accepted:
□**Yes** □**No**

Verified with:_____

Date:_____

Initials: _____ Has s/he signed anything/rlsd? _____

**Attorney accepts the case:
□**Yes** □**No**
Verified with:_____

Your Personal Health Insurance Company Information:

Name of Insurance Company: _____

Phone Number: _____

Name of Insured/Relationship: _____

Policy Number: _____

Billing Address: _____

□ **I DECLINE TO PROVIDE MY HEALTH INSURANCE INFORMATION**

PLEASE INITIAL IF CHECKED: _____

For Office Use Only:

Incident Report needed:
□**Yes** □**No**

If needed, completed by patient:
□**Yes** □**No**

Patient Name: _____ Date: _____

By signing below, I acknowledge that I understand that it is my responsibility to know what my coverage benefits are through my insurance company and that it is recommended that I call my insurance company to understand the coverage they offer through my insurance plan. I acknowledge and understand that I am responsible for paying my balance if the insurance company does not pay for services rendered. I understand that any benefit information that is given to me by In Touch With Health Chiropractic Clinic, may be incorrect or may change at any time according to my insurance company's discretion.

Signature:_____ Date:_____

ITWH Chiropractic Clinic **Injury Questionnaire** **Dr. Peter Britton, DC**

Patient Name: _____ Date: _____

Address_____ City_____ State _____ Zip Code _____

H. Phone _____W. Phone_____ Cell Phone _____

Email Address: _____

Cell Phone Provider (for text reminders) AT&T Verizon T-Mobil Other_____

Preferred communication for patient reminders (circle) Email / Text

Sex: M F Marital Status: M S D W Date of Birth_____ Age_____

Social Security #_____

Occupation_____ Employer_____

Have you ever received Massage/Chiropractic Care/Acupuncture?
Chiropractic: Yes No If Yes, When?_____
Massage: Yes No If Yes, When? _____
Acupuncture: Yes No If Yes, When? _____
Name of most recent Chiropractor: _____
Name of most recent Massage Therapist: _____
Name of most recent Acupuncturist: _____

1. **Primary complaint**
   _____
   _____

2. **Secondary complaint**
   _____
   _____

3. **Previous interventions, treatments, medications, surgery, or care you've sought for your complaint(s):**

   Please circle: Medical Doctor Physical Therapy Massage Therapy Acupuncture
   Urgent Care Hospital
   Other: _____

4. **Since the Motor Vehicle Collision, have you experienced any of the following:**
   A. Loss of Range of Motion: yes/no
      a. What body parts: _____
   B. Visual Disturbance : yes/no
      □ blurring l/r □ floaters l/r □ vision loss l/r □ hypersensitivity l/r
      % of time: __ % of time: __ % of time: ___ % of time___

   C. Dizziness: yes/no % of time: ____
   D. Anxiety: yes/no % of time: ____
   E. Depression: yes/no % of time: ____
   F. Difficulty Sleeping: yes/no % of time: ____

Patient Name: _____ **Date:** _____

5. Past Health History:

A. Please indicate if you have a history of any of the following:

□ Anticoagulant use □ Bleeding problems □ Bipolar disorder □ Cancer
□ Diabetes □ Heart problems/high blood pressure/chest pain
□ Lung problems/shortness of breath □ Major depression □ Psychiatric disorders
□ Schizophrenia □ Stroke/TIA's □ Other _____
□ None of the above

B. Previous Injury, Trauma or Broken bones:

_____
_____

C. Allergies/Medication Allergies:

_____

□ No Allergies/Medication Allergies

D. Medications/Supplements:

Medication/Supplement Reason for Taking

_____
_____
_____

□ I have a medication list attached

E. Surgeries:

Date Type of Surgery

_____
_____
_____
_____

F. Females/ Pregnancies and outcomes:

Pregnancies/Date of Delivery Outcome

_____
_____

6. Family Health History:

Do you have a family history of? (Please indicate all that apply)

□ Cancer □ Cardiac disease □ Cardiac disease below age 40
□ Diabetes □ Headaches □ Neurological diseases
□ Strokes/TIA □ Psychiatric disease □ Other _____
□ Adopted/Unknown
□ None of the above

Patient Name: _____ Date: _____

Deaths in immediate family:

_____

Cause of parents or sibling's death Age at death

---

7. Social and Occupational History:

A. Job description:

_____

B. Work schedule:

_____

C. Recreational activities:

_____

D. Lifestyle (hobbies, level of exercise, alcohol and drug use, diet):

_____

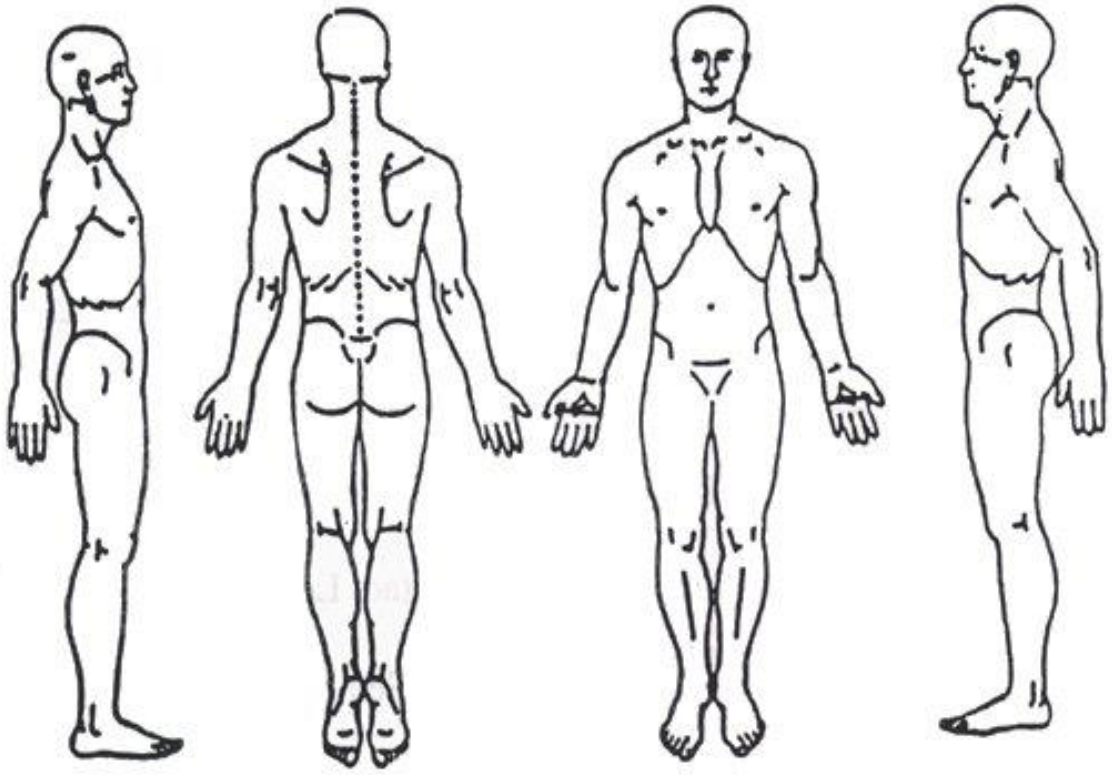
E. Smoking Status (circle one): Every day smoker / Occasional Smoker / Former Smoker / Never Smoked

---

Patient Name: _____ Date: _____

Indicate location of pain/discomfort on the illustration. Use the symbol that best describes the feeling:

XX Sharp/Stabbing **PP** Pins/Needles **DD** Dull/Aching **NN** Numbness



Patient Name: _____ Date: _____

NEW PATIENT HISTORY FORM

Please start at the top of your body and work your way down.

ONE SYMPTOM PER PAGE

Symptom 1 _____

- On a scale from 1-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? _____
    - Was this symptom a result of a motor vehicle collision? Yes/No (circle one)
    - **Did you have this symptom before this motor vehicle collision?** Yes/No
        - If so, what was the intensity (1-10 w/10 the worst) and frequency? ____
- What makes the symptom worse? (circle all that apply):
    - Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): _____
- What makes the symptom better? (circle all that apply):
    - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): _____
- Describe the quality of the symptom (circle all that apply):
    - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging, Other (please describe): _____
- Does the symptom radiate to another part of your body (circle one): yes no
    - If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (circle one)
    - Morning Afternoon Evening Night Unaffected by time of day

Patient Name: _____ Date: _____

ONE SYMPTOM PER PAGE

Symptom 2 _____

- On a scale from 1-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? _____
    - Was this symptom a result of a motor vehicle collision? Yes/No (circle one)
    - **Did you have this symptom before this motor vehicle collision?** Yes/No
        - If so, what was the intensity (1-10 w/10 the worst) and frequency? ____
- What makes the symptom worse? (circle all that apply):
    - Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): _____
- What makes the symptom better? (circle all that apply):
    - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): _____
- Describe the quality of the symptom (circle all that apply):
    - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging, Other (please describe): _____
- Does the symptom radiate to another part of your body (circle one): yes no
    - If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (circle one)
    - Morning Afternoon Evening Night Unaffected by time of day

Patient Name: _____ Date: _____

ONE SYMPTOM PER PAGE

Symptom 3 _____

- On a scale from 1-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? _____
    - Was this symptom a result of a motor vehicle collision? Yes/No (circle one)
    - **Did you have this symptom before this motor vehicle collision?** Yes/No
        - If so, what was the intensity (1-10 w/10 the worst) and frequency? ____
- What makes the symptom worse? (circle all that apply):
    - Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): _____
- What makes the symptom better? (circle all that apply):
    - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): _____
- Describe the quality of the symptom (circle all that apply):
    - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging, Other (please describe): _____
- Does the symptom radiate to another part of your body (circle one): yes no
    - If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (circle one)
    - Morning Afternoon Evening Night Unaffected by time of day

Patient Name: _____ Date: _____

ONE SYMPTOM PER PAGE

Symptom 4 _____

- On a scale from 1-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? _____
    - Was this symptom a result of a motor vehicle collision? Yes/No (circle one)
    - **Did you have this symptom before this motor vehicle collision?** Yes/No
        - If so, what was the intensity (1-10 w/10 the worst) and frequency? ____
- What makes the symptom worse? (circle all that apply):
    - Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): _____
- What makes the symptom better? (circle all that apply):
    - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): _____
- Describe the quality of the symptom (circle all that apply):
    - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging, Other (please describe): _____
- Does the symptom radiate to another part of your body (circle one): yes no
    - If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (circle one)
    - Morning Afternoon Evening Night Unaffected by time of day

Patient Name: _____ Date: _____

ONE SYMPTOM PER PAGE

Symptom 5 _____

- On a scale from 1-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? _____
    - Was this symptom a result of a motor vehicle collision? Yes/No (circle one)
    - **Did you have this symptom before this motor vehicle collision?** Yes/No
        - If so, what was the intensity (1-10 w/10 the worst) and frequency? ____
- What makes the symptom worse? (circle all that apply):
    - Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): _____
- What makes the symptom better? (circle all that apply):
    - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): _____
- Describe the quality of the symptom (circle all that apply):
    - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging, Other (please describe): _____
- Does the symptom radiate to another part of your body (circle one): yes no
    - If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (circle one)

    Morning Afternoon Evening Night Unaffected by time of day

Patient Name: _____ Date: _____

Review of Systems

Have you had any of the following **pulmonary (lung-related)** issues?
□ Asthma/difficulty breathing □ COPD □ Emphysema □ Other _____ □ None of the above

Have you had any of the following **cardiovascular (heart-related)** issues or procedures?
□ Heart surgeries □ Congestive heart failure □ Murmurs or valvular disease □ Heart attacks/MIs □ Heart disease/problems □ Hypertension □ Pacemaker □ Angina/chest pain □ Irregular heartbeat □ Other _____ □ None of the above

Have you had any of the following **neurological (nerve-related)** issues?
□ Visual changes/loss of vision □ One-sided weakness of face or body □ History of seizures □ One-sided decreased feeling in the face or body □ Headaches □ Memory loss □ Tremors □ Vertigo □ Loss of sense of smell □ Strokes/TIAs □ Other _____ □ None of the above

Have you had any of the following **endocrine (glandular/hormonal)** related issues or procedures?
□ Thyroid disease □ Hormone replacement therapy □ Injectable steroid replacements □ Diabetes □ Other _____ □ None of the above

Have you had any of the following **renal (kidney-related)** issues or procedures?
□ Renal calculi/stones □ Hematuria (blood in the urine) □ Incontinence (can't control) □ Bladder Infections □ Difficulty urinating □ Kidney disease □ Dialysis □ Other _____ □ None of the above

Have you had any of the following **gastroenterological (stomach-related)** issues?
□ Nausea □ Difficulty swallowing □ Ulcerative disease □ Frequent abdominal pain □ Hiatal hernia □ Constipation □ Pancreatic disease □ Irritable bowel/colitis □ Hepatitis or liver disease □ Bloody or black tarry stools □ Vomiting blood □ Bowel incontinence □ Gastroesophageal reflux/heartburn □ Other _____ □ None of the above

Have you had any of the following **hematological (blood-related)** issues?
□ Anemia □ Regular anti-inflammatory use (Motrin/Ibuprofen/Naproxen/Naprosyn/Aleve) □ HIV positive □ Abnormal bleeding/bruising □ Sickle-cell anemia □ Enlarged lymph nodes □ Hemophilia □ Hypercoagulation or deep venous thrombosis/history of blood clots □ Anticoagulant therapy □ Regular aspirin use □ Other _____ □ None of the above

Have you had any of the following **dermatological (skin-related)** issues?
□ Significant burns □ Significant rashes □ Skin grafts □ Psoriatic disorders □ Other _____ □ None of the above

Have you had any of the following **musculoskeletal (bone/muscle-related)** issues?
□ Rheumatoid arthritis □ Gout □ Osteoarthritis □ Broken bones □ Spinal fracture □ Spinal surgery □ Joint surgery □ Arthritis (unknown type) □ Scoliosis □ Metal implants □ Other _____ □ None of the above

Have you had any of the following **psychological** issues?
□ Psychiatric diagnosis □ Depression □ Suicidal ideations □ Bipolar disorder □ Homicidal ideations □ Schizophrenia □ Psychiatric hospitalizations □ Other _____ □ None of the above

Is there anything else in your past medical history that you feel is important to your care here? _____

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of Chiropractic to provide me with chiropractic care, in accordance with this state's statutes. If my insurance will be billed, I authorize payment of medical benefits to **In Touch With Health Chiropractic Clinic** for services performed.

Patient or Guardian Signature _____Date_____

Patient Name: _____ **Date:** _____

Loss of Enjoyment/Duties Under Duress Summary

Complete the following summary as it relates to your lifestyle, work environment and activities which you normally would be enjoying, but are currently not enjoying, as a result of the motor vehicle collision. Include all areas which you have had to reduce the time you are capable of experiencing them. Include all instances where you have received lifting, stretching, bending, sitting, standing, walking or other restrictions which affect your participation in any of the following areas:

Work	**Reason for the difficulty (circle)**	**Duration**
Job Description: _____		
□ Lifting	Increased Pain / Anxiety	_____
□ Bending	Increased Pain / Anxiety	_____
□ Sitting	Increased Pain / Anxiety	_____
□ Walking	Increased Pain / Anxiety	_____
□ Computer Duties	Increased Pain / Anxiety	_____
Other: _____	Increased Pain / Anxiety	_____

Studies/School	**Reason for the difficulty (circle)**	**Duration**
□ Lifting	Increased Pain / Anxiety	_____
□ Bending	Increased Pain / Anxiety	_____
□ Sitting	Increased Pain / Anxiety	_____
□ Walking	Increased Pain / Anxiety	_____
□ Computer Duties	Increased Pain / Anxiety	_____
□ Studying	Increased Pain / Anxiety	_____
Other: _____	Increased Pain / Anxiety	_____

Domestic Duties	**Reason for the difficulty (circle)**	**Duration**
□ Vacuuming	Increased Pain / Anxiety	_____
□ Taking Care of Kids	Increased Pain / Anxiety	_____
□ Cleaning	Increased Pain / Anxiety	_____
□ Preparing Meals	Increased Pain / Anxiety	_____
Other: _____	Increased Pain / Anxiety	_____

Household Duties	**Reason for the difficulty (circle)**	**Duration**
□ Yardwork	Increased Pain / Anxiety	_____
□ Transportation	Increased Pain / Anxiety	_____
□ Shopping	Increased Pain / Anxiety	_____
□ Taking Out Trash	Increased Pain / Anxiety	_____
Other: _____	Increased Pain / Anxiety	_____

Sports	**Reason for the difficulty (fill-in)**	**Duration**
□ Social	_____	_____
□ Competitive	_____	_____
□ Regional	_____	_____
Other:	_____	_____

Patient Name: _____ **Date:** _____

In Touch With Health Chiropractic Clinic P.C.
1111 N Northgate Way
Seattle WA 98133
100 W Harrison St. North Tower Suite 140, Unit K
Seattle WA 98119
Tel 206.523.2225
Fax 206.495.9135

AFFIDAVIT OF INJURY

I hereby affirm that I sustained injuries as a result of an incident on _____. No one has offered or given me any money, incentive, remuneration, anything of value, or any other form of inducement for the purpose of treating at this clinic.

No one has made any promises or guarantees with regard to my medical treatment or any other aspect of my case. I understand that I have a choice regarding where I seek treatment for my injuries, and I have chosen, of my own free will, to seek treatment at this clinic.

_____ _____

Signature of patient and/or responsible parties Signature on behalf of Provider

Sworn to and subscribed before me by _____ on
print patient or legal guardian name

_____, 20___.
month

For office use only:

Notary Public in and for:

The State of:

My commission expires:

Patient Name: _____ Date: _____

HIPAA NOTICE OF PRIVACY PRACTICES

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.

This Notice of Privacy describes how we may use and disclose your protected health information (PHI) to carry our treatment, payment or health care operations (TPO) for other purposes that are permitted or required by law. "Protected Health Information" is information about you, including demographic information that may identify you and that related to your past, present, or future physical or mental health or condition and related care services.

Use and Disclosures of Protected Health Information:
Your protected health information may be used and disclosed by your physician, our staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, pay your health care bills, to support the operations of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your health care information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing, and fund raising activities, and conduction or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations included as required by law, public health issues, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, and organ donation. Required uses and disclosures under the law, we must make disclosures to you when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.
OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES WILL BE MADE ONLY WITH YOUR CONSENT, AUTHORIZATION OR OPPORTUNITY TO OBJECT UNLESS REQUIRED BY LAW.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Signature of Patient or
Representative_____Date_____

Printed Name_____

Patient Name: _____ Date: _____

MASSAGE CANCELLATION POLICY

There is **a fee of $45 for each appointment you cancel with less than 24 hours notice or if you show up 15 minutes late for your appointment**. Your health insurance, PIP or 3rd party won't cover for this charge. This timeframe of 24 hours will allow us to fill your scheduled time with another patient who might be waiting for treatment. We appreciate your time, and ask that you respect our time as well. The fee will be collected via cash, check, and VISA or MasterCard card upon your next scheduled visit prior to treatment.

We appreciate your understanding and consideration in this matter and we reserve the right to make exceptions to this policy at any time.

Please sign that you have read and acknowledge our policy regarding massage appointment cancellations.

I agree to abide by In Touch With Health Chiropractic Clinic's policy to provide 24 hours notice when needing to reschedule an appointment. If I am unable to provide 24 hours notice, I agree to pay a fee of $45 for my late cancellation.

Patient Initials: _____ Date: _____

MASSAGE THERAPY CONTRA-INDICATIONS:

*** Note the following conditions could be aggravated by receiving massage. If you have one of the following conditions, please discuss it with your doctor prior to receiving massage therapy. Thank you.**

1. If you are coming down with a cold/flu (any type of fever or infection)

2. Spinal fracture or broken bones

3. Any cancer (must be cancer- free for 5 years or have M.D. ok)

4. Under the influence of strong pain medication

5. High blood pressure (if not under control or M.D. supervision)

6. Acute or current inflammation such as rheumatoid arthritis or gout

7. Acute or current blood clot

8. Pregnant (should be approved by M.D.)

*Please ask your doctor if your condition is safe for massage
I understand these contradictions and approve treatment.

Patient Signature: _____ Date: _____

Patient Name: _____ Date: _____

Financial Policy

Interest

As per RCW 19.52.020 simple interest of 1% monthly will incur if a balance remains unpaid upon settlement of the claim.

Medical Records Fees

Patients are entitled under federal law to have access to their protected health information and we follow all rules, guidelines and exceptions to ensure compliance to patient rights. However, providers also have the right to be compensated for records and our fees are a reasonable cost-based fee for copies including the copying, supplies, labor, and postage of the files and or summaries.

We realize that temporary financial problems may affect timely payment of your account. If this should occur, please contact us for assistance in the management of your account. Our goal is to provide quality care and service. Please let us know immediately if you require any assistance or clarification from anyone within our business.

I have read and understand the above financial policy. I agree to assign insurance benefits to **In Touch With Health** whenever applicable. I also agree, in addition to the amount owed, I also will be responsible for the fee charged by the collection agency for costs of collections if such action becomes necessary.

Patient's Signature: _____ Date: _____

Patient Name: _____ Date: _____

DISCLOSURE REGARDING USE OF MEDICAL LIENS

I understand that for treatment provided by **In Touch with Health Chiropractic** 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 authorize **In Touch with Health Chiropractic** to bill PIP and authorize the release of any information acquired in the course of my examination and treatment in accordance with HIPAA privacy regulations.

Should PIP insurance not be available, exhaust or terminate for any reason, I authorize **In Touch with Health Chiropractic** to bill any applicable health insurance I may have available, subject to any contract **In Touch with Health Chiropractic** may have with such carrier. I understand and authorize **In Touch with Health Chiropractic** 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.

I authorize **In Touch with Health Chiropractic** to 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 to **In Touch with Health Chiropractic** for treatment provided, and I may be required to make additional payments after satisfaction of the lien.

Dated this _____ day of _____, 20_____, at Seattle, Washington.

Signed _____ (patient signature)

Date of Automobile Collision _____

Patient Name: _____ Date: _____

CONSENT TO TREATMENT [Chiropractic]

Health care providers are required to advise patients of the nature of the treatment to be provided, the risks and benefits of the treatment, and any alternatives to the treatment. There are some risks that may be associated with treatment, in particular you should note:

1) While rare, some patients have experienced rib fractures or muscle and ligament sprains or strains following treatment;

2) There have been rare reported cases of disc injuries following cervical and lumbar spinal adjustment although no scientific study has ever demonstrated such injuries are caused, or may be caused, by spinal or soft tissue manipulation or treatment.

3) There have been reported cases of injury to a vertebral artery following osseous spinal manipulation. Vertebral artery injuries have been known to cause a stroke, sometimes with serious neurological impairment, and may, on rare occasion, result in paralysis or death. The possibility of such injuries resulting from cervical spine manipulation is extremely remote;

Osseous and soft tissue manipulation has been the subject of government reports and multi-disciplinary studies conducted over many years and have demonstrated it to be highly effective treatment of spinal conditions including general pain and loss of mobility, headaches and other related symptoms.

Musculoskeletal care contributes to your overall well being. The risk of injuries or complications from treatment is substantially lower than that associated with many medical or other treatments, medications, and procedures given for the same symptoms.

I acknowledge I have discussed the following with my healthcare provider:
a. The condition that the treatment is to address;
b. The nature of the treatment;
c. The risks and benefits of that treatment; and
d. Any alternatives to that treatment.

I have had the opportunity to ask questions and receive answers regarding the treatment.
I consent to the treatments offered or recommended to me by my healthcare provider, including osseous and soft tissue manipulation. I intend this consent to apply to all my present and future care with **In Touch With Health Chiropractic**

Patient signature (or Legal Guardian)	Signature of witness
Print Name	Print Name
Date	Date

Patient Name: _____ Date: _____

CONSENT TO TREAT [Acupuncture]

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist named below and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with or serving as back-up for the acupuncturist named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tiu-Na (Chinese massage), Chinese herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally or in writing. The herbs may be an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxibustion and cupping. I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant.

I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known is in my best interest. I understand that results are not guaranteed.

I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. 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.

Patient signature (or Legal Guardian)	Signature of witness
Print Name	Print Name
Date	Date

Patient Name: _____ Date: _____

AGREEMENT TO HEALTH CARE PROVIDER'S LIEN

Patient Name: _____

Date of Injury: _____

To Attorney: _____

The undersigned patient (hereafter "Patient") of the above named health care provider (hereafter "provider") authorize the clinic to furnish to my attorney above named (hereafter "attorney") with all documents relating to my care for the injury of the above date (hereafter "injury") that are in procession of provider, regardless of where or by whom such documents originated.

I understand and direct my attorney to pay to the provider all such bills as may be due and owing to the provider for treatment relating to my injury. I also specifically direct my attorney to withhold such monies out of any award or settlement that would be otherwise is net payable to me when my claim for injuries resolves.

I acknowledge full responsibility for payment of all bills owing to provider. I also specifically agree that the provider may withhold collection on my account in exchange for my promise to have my attorney pay my bills out of the resolution of my injury claim. I agree that the terms of this document may not be rescinded and I direct my attorney not be bound by any request on my part to rescind the terms herein and I hold my attorney harmless thereon.

This direction to my attorney in no way releases me from my obligation to pay the provider on my bill, and I understand that this obligation to pay is not contingent on my recovering monies free and clear to me from my injury claim. I agree that if the provider is not paid on my account, the provider may take lawful collection efforts as it deems just.

I have been advised by the provider that if my attorney does not wish to sign this agreement, that the provider may declare my entire bill due and owing. If the patient is a minor or incompetent, I represent that I am the legal guardian or legal representative of said patient and that I have lawful authority to execute this document on behalf of said minor or incompetent person.

Date: _____ Patient's Name (printed):_____

Patient's Signature: _____

Acknowledgement of Attorney

The undersigned, being attorney for the above named patient in the claim for injuries of above stated date, agrees to the above terms and agrees to withhold from any settlement, award, judgment, or verdict any monies that would be otherwise net payable to patient in resolution of patient's claim. Attorney's signature is not valid without patient's signature above.

Date: _____ Attorney Name (printed):_____

Attorney Signature: _____

Patient Name: _____ Date: _____

WAIVER OF ATTORNEY/CLIENT PRIVILEGE

In the event that my attorney asks to reduce the final medical bills of Dr. Peter Britton D.C. and In Touch With Health Chiropractic Clinic P.C. for injuries sustained on _____, I hereby authorize my attorney to release a true and complete copy of the financial disbursement sheet that shows the full amount offered or agreed upon at settlement as well as a listing of all attorney fees, lost wages, medical expenses and/or any other payee and amount payable relating to my case.

THIS ASSIGNMENT AND CONTRACTUAL LIEN IS IRREVOCABLE UNLESS BOTH THE PROVIDER AND I AGREE TO REVOKE IT IN WRITING.

By my signature, I acknowledge that I have carefully read and fully understand the above document and acknowledge that it is a valid and irrevocable Waiver of Attorney/Client Privilege.

_____ _____

Signature of patient and/or responsible parties Signature on behalf of Provider

Sworn to and subscribed before me by _____ on

print patient or legal guardian name

_____, 20___.

month and day

For office use only:

Notary Public in and for:

The State of:

My commission expires:

Patient Name: _____ Date: _____

ASSIGNMENT OF PROCEEDS AND CONTRACTUAL LIEN

In consideration for deferred billing and the services rendered and/or to be rendered, I, the undersigned patient and/or responsible party, hereby irrevocably and exclusively assign and transfer to **In Touch With Health Chiropractic Clinic P.C. Dr. Peter Britton D.C.** (herein after "Provider") any and all claims, causes of action, and right to any proceeds and/or benefits that I may have against any other person, entity, and/or insurance company for reimbursement and/or payment of the medical charges incurred by me from Provider up to the full amount of the charges and I grant a contractual lien on proceeds of any settlement and/or judgment in any pending or future legal claim or action.

THIS ASSIGNMENT AND CONTRACTUAL LIEN IS IRREVOCABLE UNLESS BOTH THE PROVIDER AND I AGREE TO REVOKE IT IN WRITING.

I acknowledge that the amount subject to this lien constitutes the ordinary and customary charges by Provider for such services, supplies and/or treatment, and may include administrative charges for costs, expenses and risk of collection typically incurred by Provider. Thus, the amount of the lien may or may not constitute the same charge of such medical services, supplies and/or treatment for similar services to others.

I authorize Provider to establish Personal Injury Protection (PIP), Med Pay and/or Uninsured Motorized (UM) claim on my behalf. I also authorize Provider to prosecute said claim and/or action either in my name or its name, as it sees fit, and further authorize it to comprise, settle, or otherwise resolve said claims as it sees fit. However, Provider shall have no duty whatsoever to prosecute the claim or litigation. Provider shall not be liable for any costs and/or expenses associated with any claims or litigation unless Provider files that litigation. Nothing herein shall prevent me from pursuing any claim or litigation that I otherwise have a right to pursue. However, I will not settle any case or claim involving recovery of Provider's medical bills without the permission of Provider. I understand that whatever amounts Provider does not collect from insurance proceeds (whether it be all or part of what is due), I personally remain responsible and owe and agree to pay the outstanding balance in a current manner. I agree to notify Provider of any payment received by me for medical services from an insurance company or other source, and I hereby instruct my attorney, if any, to likewise notify Provider.

Any and all services rendered under this agreement shall be at the sole discretion of Provider and in no way shall this agreement be construed to obligate Provider to provide any certain services.

INSTRUCTIONS TO INSURANCE COMPANIES: I hereby irrevocably authorize, direct and instruct any and all insurance carriers, attorneys, agencies, governmental departments, companies, individuals and/or other legal entity (herein after referred to as "payers"), which may elect or be obligated to pay, provide or distribute proceeds to me for any medical conditions, accidents, injuries, or illnesses, past, present, or future (herein after referred to as "condition") to **pay directly and exclusively to In Touch With Health Chiropractic Clinic P.C. , Dr. Peter Britton D.C.** such sums as may be outstanding and

1111 N Northgate Way, Seattle WA 98133 **PH: 206.523.2225 FX: 206.495.9135**

owed to said Provider for charges incurred by me at the office relating to my condition, with such payment **to be made by separate check and PAYABLE exclusively in the name of, In Touch With Health Chiropractic Clinic P.C. Attn: Dr. Peter Britton D.C.** and deliver such payment to **1111 North Northgate Way, Seattle, WA, 98133**. Payment directly to me, even if Provider's name is on the check, does not constitute payment to Provider and does not comply with the terms of this instruction. For the purposes of this document, "proceeds" shall include, but not be limited to, monies/proceeds from any settlement judgment, or verdict, as well as any monies/proceeds relating to commercial health or group insurance, attorney retainer agreements, medical payments benefits, personal injury protection, no-fault coverage, uninsured and underinsured motorist coverage, third-party liability insurance, disability benefits, worker's compensation benefits, and any other benefits or proceeds payable to me for the purposes stated herein.

This instruction applies irrespective of whether I have hired an attorney to pursue my other claims. In the event that I retain one or more attorneys to represent my other claims in this matter, I, nevertheless, irrevocably direct any "payer" (auto insurance and/or health insurance) to directly issue full and separate medical payment to **In Touch With Health Chiropractic Clinic P.C.**

INSTRUCTIONS TO ATTORNEYS: In the event that I retain one or more attorneys to represent my other claims in this matter and any settlement proceeds are paid directly to my attorney, I hereby irrevocably instruct my attorney to withhold all such sums and amounts that are outstanding on my account to Provider and remit payment of all such sums fully and directly to Provider contemporaneously with any disbursement of money to me, my attorney, or any other party from said settlement or judgment. I further irrevocably instruct and authorize my attorney to furnish to Provider any documents relating to my insurance settlement and distribution of funds, upon request of Provider, in order that Provider may be made aware of the full settlement disbursement of any recovery I may receive.

AUTHORIZATION TO RELEASE INFORMATION: Provider is authorized to release any information it deems appropriate concerning my physical condition and treatment to all payers as defined above or my attorneys to facilitate collection under this assignment. I further authorize and direct all payers to release to Provider all information regarding any coverage or benefits which I may have including, but not limited to, the amount of the coverage, the amount paid thus far, the amount of settlement, and the amount of any outstanding claims. I hereby authorize and direct Provider to file a copy of this assignment, together with any applicable charges, with any or all payers and seek collection of payments, regardless of whether a claim has been established with said payers.

I also hereby grant to Provider the limited power of attorney to endorse my name upon any checks, drafts, or other negotiable instrument representing payment from any insurance company for treatment and services rendered by the Provider. I agree that any insurance payment representing an amount in excess of the charges for treatment rendered will be credited to my/our account or forwarded to me upon request in writing to Provider.

Patient Name: _____ Date: _____

DEMAND FOR PAYMENT: To any insurance company providing benefits of any kind to me/us for treatment rendered by the Provider, you are hereby tendered a demand to pay in full the bill for services rendered by Provider within 30 days following your receipt of such bill for services to the extent such bills are payable under the terms of the policy. This demand specifically conforms to RCW Chapter 60.44 (RCW 60.44.010, RCW 60.44.020, RCW 60.44.030, RCW 60.44.040, RCW 60.44.050, RCW 60.44.060), RCW Chapter 48.22, RCW 48.22.005(7), providing for attorney fees, penalty, court cost, and interest from judgment, upon violation.

STATUTE OF LIMITATIONS: In further consideration of deferred billing and the services rendered and/or to be rendered, I waive my right to claim any statute of limitations regarding claims for or collection of the amount due for services rendered or to be rendered by Provider, in addition to reasonable cost of collection, including attorney fees and court cost incurred.

This assignment and contract shall not be modified or revoked without the mutual written consent of Provider and myself. I hereby revoke and resend any previously signed authorizations and assignments, whether executed at this office or any other office to the extent that the terms of those authorizations or assignments conflict with the terms of this assignment and contract:

By my signature, I acknowledge that I have carefully read and fully understand the above document and acknowledge that it is a valid and irrevocable Assignment and Contractual Lien.

_____ _____

Signature of patient and/or responsible parties Signature on behalf of Provider

Sworn to and subscribed before me by _____ on
print patient or legal guardian name

_____, 20___.
month and day

For office use only:

Notary Public in and for:

The State of:

My commission expires:

1111 N Northgate Way, Seattle WA 98133 **PH: 206.523.2225 FX: 206.495.9135**

Patient Name: _____ Date: _____

In Touch With Health Chiropractic Clinic P.C.
1111 North Northgate Way
Seattle, Washington, 98133
Tel 206.523.2225
Fax 206.495.9133

VIA Fax and CMRRR

_____
Name of Law Firm

_____
Name of Insurance Company

_____
Address

_____
Address

Re: _____
Patient Name

Dear: _____
Attorney's Name

When any settlement agreement or any payment is made for this case, please issue **a separate check** payable to **In Touch With Health Chiropractic Clinic P.C. Dr. Peter Britton D.C.** for the amount of my outstanding balance with their office and deliver such payment to 1111 North Northgate Way Seattle, Washington, 98133. I have previously agreed to this in writing and signed an irrevocable Assignment of Benefits and Contractual Lien when I began treatment with **In Touch With Health Chiropractic Clinic P.C. Dr. Peter Britton D.C.**

Sincerely,

_____
Signature of patient and/or responsible parties

_____
Date