Kruse Park Chiropractic Clinic

Accident Information Form

Patient's Name: _____ Date: _____

Your Insurance Information

Name of Policy Holder: _____

Policy Holder's Insurance Company: _____

Insurance Company Address: _____

Insurance Company Phone #: _____ Agent or Claims Contact: _____

Policy Number: _____ Claim Number: _____

Other Insurance: _____

Attorney Information

Attorney Name and Phone #: _____

Attorney Address: _____

THIS FORM MUST BE COMPLETED AND RETURNED TO KPCC WITHIN 72 HOURS OF YOUR FIRST VISIT. ALSO, AN APPLICATION FOR MEDICAL BENEFITS MUST BE FILLED OUT AND FILLED WITH YOUR INSURANCE COMPANY TO ACTIVATE A CLAIM.

Release of Information and Assignment of Benefits

I authorize Kruse Park Chiropractic Clinic to release my records in order to obtain payment on my account for services provided to me. I authorize payment for such services to be paid directly to Kruse Park Chiropractic Clinic. I understand that I am financially responsible for any charges not paid by my insurance carrier or attorney. If I do not file a completed application for medical benefits form with my insurance company, I understand that I will be required to pay cash at the time of service for all care.

Signature:_____ Date:_____

Accident History

Patient Name: _____

Date and time of accident: _____

State how the accident happened:

_____

_____

_____

Where were you sitting? ____ Driver ____Right Front ____Right Rear ____Left Rear ____Other
Whose vehicle were you in? _____

Where were you facing on impact?_____

Were you aware of the impending impact?_____

Did you lose consciousness?_____ If so, how long?_____

Did your head hit the headrest?_____

Did the airbag deploy: ___ on the driver's side ___ on the passenger's side ___ not at all?

Were you cut or bruised from the accident? Please describe. _____

_____

Have you experienced any of these since the accident? Please check any that apply

	Yes	No
Headache		
Ache/pain in lower back		
Ache/pain in mid-back		
Ache/pain in neck/shoulder		
Ache/pain in jaw		
Dizziness		
Trouble sleeping		

What were your immediate symptoms? _____

_____

What are your current symptoms?_____

_____

Have you received any care for your injuries? If so, who was the provider?_____

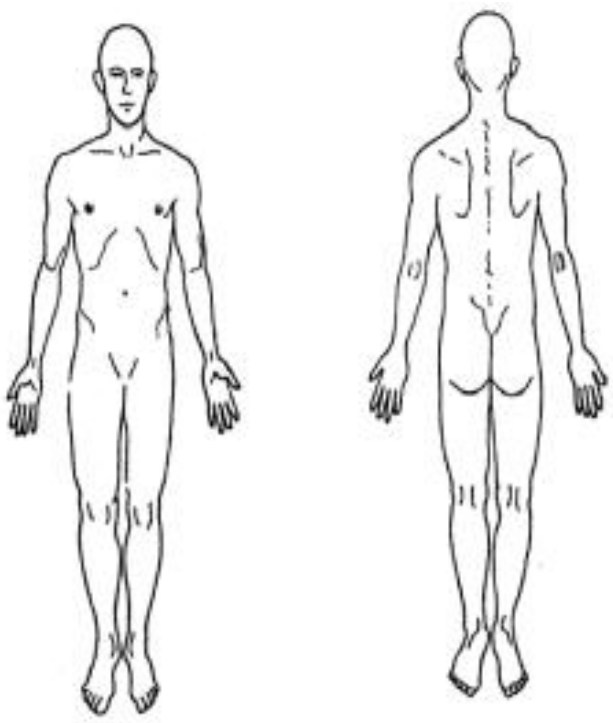
_____

What type of care did you receive and for how long?_____

_____

Pain Chart

Ache	Burning	Numbness
>>>>>	xxxxx	=====
Stabbing	Pins/Needles	Throbbing
/////	00000	~~~~~~



Symptom Rating Scale

What is your symptom intensity RIGHT NOW?

0	1	2	3	4	5	6	7	8	9	10
0 = No Symptoms						10 = Unbearable Symptoms				

What is your TYPICAL or AVERAGE symptom intensity?

0	1	2	3	4	5	6	7	8	9	10
0 = No Symptoms						10 = Unbearable Symptoms				

What is your symptom intensity at its WORST?

0	1	2	3	4	5	6	7	8	9	10
0 = No Symptoms						10 = Unbearable Symptoms				

Doctor's Signature:_____ Date: _____

Kruse Park Chiropractic Clinic
3990 Collins Way, Suite 201 • Lake Oswego, OR 97035 • Phone: 503-635-1236 • Fax: 503-697-4741
Web: www.kruseparkchiro.com

PRIVACY POLICY

We are required by federal and state law to maintain the privacy of your health information. We are also required to give you this policy outlining our privacy practices.

We reserve the right to change this policy at any time, provided the applicable law allows the changes. These changes may apply to health information that was created or received before the changes were made. Before we make a significant change in our privacy practices, we will make the new policy available on request.

You may request a copy of this policy at any time. If you have questions, concerns or complaints about this policy or our privacy practices, please contact Dr. Illingworth at Kpccservice@kruseparkchiro.com

USE AND DISCLOSURE OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment and healthcare operations. Examples include:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing care to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your healthcare information in connection with our healthcare operations. Examples of healthcare operations include provider training, licensing or credentialing activities and quality assessment.

Your Authorization: In addition to the above uses of your healthcare information, you may give us written authorization to release your healthcare information to anyone at any time. You may also revoke this authorization at any time. Revocation of authorization would not affect any information that was released while the authorization was in effect. Unless you give written authorization, we cannot release your healthcare information for any reason other than those described above.

Your family and friends: Your healthcare information will not be released to your family and friends unless we have your specific permission.

Persons Involved in Care: We may use or disclose health information to notify, or assist in the notification of a family member, your personal representative or another person responsible for your care, of your location and/or general condition, if necessary. If you are able to authorize this contact, you will have the opportunity to do so. We will use our professional judgment and our experience with common practice to make reasonable decisions regarding your best interest in allowing a person to pick up your x-rays, supplies or records for you.

Marketing: We will not use your healthcare information for marketing purposes without your written authorization. Required by law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse or neglect, domestic violence or a victim of other crimes. This disclosure will be to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

Appointment Reminders: We may use or disclose your healthcare information to provide you with appointment reminders (such as cards, phone messages or letters).

PATIENT RIGHTS

Access: You have the right to look at or gain access to your healthcare records. If you wish to have copies of your records, you must make that request in writing. You will be charged a minimum of $25.00 for these copies.

Amendment: You have the right to request that your health records be amended. This request must be in writing, along with an explanation for the amendment. All requests for an amendment must be approved by the treating physician and will be clearly marked in the file as a patient requested amendment.

Restrictions: You have the right to place additional restrictions on the use or disclosure of your health information. We may not be required to agree with the request for additional restrictions.

Disclosure accounting: You have the right to ask for a list of all instances of disclosure of your records, other than those disclosures for treatment, payment, healthcare operations or certain other purposes, after April 14, 2003.

QUESITONS AND COMPLAINTS

If you have questions, concerns or complaints regarding the handling of your healthcare information, please contact Dr. Bronwyn Illingworth, DC.
Telephone: 503-635-1236

Thank you,

the KPCC team

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