VALENTE CHIROPRACTIC

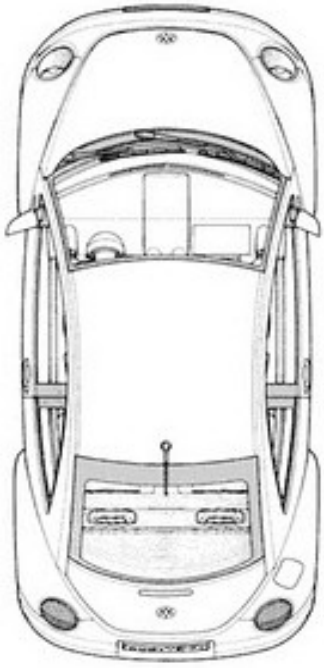
Motor Vehicle Collision Form

Name: _____ **DOB:** _____ **Today's Date:** _____

Report of Accident:

Date of Accident:_____ Time of Accident:_____❑A.M. ❑P.M. City of Accident: _____
Street of Accident that your car was on: _____ Cross Street (intersection): _____
Road conditions at the time of incident: ❑Wet ❑Dry ❑Icy ❑Other _____
Were there any witnesses? ❑Yes ❑No Were you wearing your seat belt? ❑Yes ❑No
Did the police come to the scene of the accident? ❑Yes ❑No Was an accident report filed? ❑Yes ❑No
If a traffic violation was issued, to whom was it issued? _____
Please explain the details of the accident to the best of your knowledge: _____
_____
_____
_____

Indicate where the initial impact struck your vehicle by marking an "X" on the diagram below:



The following questions pertain to you, the patient, and the vehicle you were in:
Number of people in accident vehicle: _____
Were you the: ❑Driver ❑Front Passenger ❑Rear Passenger
Were you ❑aware of the approaching collision ***or*** ❑surprised by impact?
Were you rendered unconscious? ❑Yes ❑No If yes, for how long?_____
Was this vehicle equipped with airbags? ❑Yes ❑No
If yes, did it/they inflate? ❑Yes ❑No
What did your vehicle impact? ❑Another Vehicle ❑Other _____

Vehicle Information & Velocity pertaining to the vehicle you were in:
Vehicle Year: _____ Make:_____ Model: _____
What direction was your vehicle traveling? ❑North ❑South ❑East ❑West
Was your car ❑Moving ***or*** ❑Stopped
If your car was moving:
How fast were you traveling? Approximately _____ MPH
Just before impact, the vehicle you were in was:
❑Slowing down ❑Speeding Up ❑Constant Speed
Did the impact to your vehicle come from the:
❑Front ❑Rear ❑Right Side ❑Left Side ❑Other: _____

The following questions pertain to the other vehicle involved in the accident:
Other Vehicle Year: _____ Make:_____ Model: _____
What direction was the other vehicle traveling? ❑North ❑South ❑East ❑West
Was the other car ❑Moving ***or*** ❑Stopped
If the other car was moving:
How fast was it traveling? Approximately _____ MPH
Just before impact, the other car was:
❑Slowing down ❑Speeding Up ❑Constant Speed

Were there bleeding cuts caused by the accident? ❑Yes ❑No Where: _____
Where there any bruises caused by the accident? ❑Yes ❑No Where:_____
If any part of your body struck anything during the collision please describe what and where: _____
_____
What were the cost of damages to the vehicle you were in? $_____
Which (if any) of the following car parts broke during the accident:
❑Windshield ❑Steering Wheel ❑Front Seat ❑Back Seat ❑Side Window (R/L) ❑Other_____
Was the trunk of your body pointed straight forward at the time of impact? ❑Yes ❑No
If No, which direction was it pointed, and by how much? _____
Was your head pointed straight forward at the time of impact? ❑Yes ❑No
If No, which direction was it turned, and by how much? _____

If you have been involved in previous auto accidents, please list the year of each incident:

_____

Please list any additional information not covered above that we should know about:

_____

_____

_____

Insurance Information:

YOUR INSURANCE INFORMATION:

Do you have PIP (Personal Injury Protection) on your policy: ❑Yes ❑No

Name of Insurance Company:_____
Policy #: _____ Claim #: _____
Insured's Name: _____ DOB: _____
Name of Claim Representative: _____ Telephone #: _____

THE OTHER PARTY'S INSURANCE INFORMATION:

Name of Insurance Company:_____
Policy #: _____ Claim #: _____
Insured's Name: _____ DOB: _____
Name of Claim Representative: _____ Telephone #: _____

Attorney Information:

Name of Attorney/Law Office: _____ Telephone #: _____
Address of Attorney:_____ City: _____ State: _____ Zip:_____

Medical Care:

Have you gone to a Hospital or seen any other Doctor? ❑Yes ❑No
When did you go? ❑Just after accident ❑Next Day Other:_____
Mode of Transportation: ❑Ambulance ❑Privately transported
Name of Hospital and/or Attending Doctor:_____
_____
Was he/she a: ❑D.C. ❑M.D. ❑D.O. ❑D.D.S. ❑P.A.

Were X-Rays taken? ❑Yes ❑No
If yes, what was X-Rayed: _____
_____
Was medication prescribed? ❑Yes ❑No
Describe any treatment you received:
_____

Work:

To evaluate the effect that continuing work will have on your recovery please complete the following:
Have you been able to work since the injury? ❑Yes ❑No

Are your work activities restricted as a result of your injuries sustained? ❑Yes ❑No

How many hours are in your normal work day? _____

What can you do for work with minimum physical effort and for how long? _____❑N/A

Prior to the injury were you capable of working on an equal basis with others your age? ❑Yes ❑No ❑N/A

While in recovery, is there any light duty work you could request? ❑Yes ❑No ❑N/A

Please indicate your daily job duties and any activities in which you are occasionally asked to perform:
❑Standing ❑Sitting
❑Walking ❑Lifting
❑Driving ❑Twisting
❑Crawling ❑Bending
❑Operating equipment ❑Working with arms above head
❑Typing ❑Stooping
❑Other: _____

Patient Signature _____ **Today's Date:**_____

VALENTE
CHIROPRACTIC

Patient Registration

Name: _____ **Date:** _____
Last First Middle

Nickname or Preferred Name: _____

Sex: ☐ Male ☐ Female **Date of Birth:** ___/___/___ **Age:** _____

Address: _____

City _____ **State** _____ **Zip** _____

Social Security # ___ ___ ___-___ ___-___ ___ ___ ___

Driver's License # _____

I would like to be notified of my upcoming appointments by:
☐ Text Message
☐ E-mail Message
☐ No Notification Please

Contact:
Home Phone (_____) _____
Work Phone (_____) _____ EXT
Cell Phone (_____) _____ Carrier: _____
E-mail Address: _____

Whom may we thank for referring you? _____

Marital Status:
☐ Single
☐ Married
☐ Separated
☐ Divorced
☐ Widowed
☐ Partnered for ____ years
Spouse's name:
_____

Race:
☐ American Indian or Alaskan Native
☐ Asian
☐ Black or African American
☐ Native Hawaiian
☐ Other Pacific Islander
☐ White

Ethnicity:
☐ Hispanic or Latino
☐ Not Hispanic or Latino

Preferred Language:
_____

Employment:
☐ Employed (FT)
☐ Employed (PT)
☐ Self-Employed
☐ Unemployed
☐ Homemaker
☐ Active Military
☐ Retired
☐ Disabled
☐ N/A
☐ Full-time Student
☐ Part-time Student
☐ Not a Student

Employer: _____
Occupation: _____
School: _____

IN CASE OF EMERGENCY, CONTACT:
Name _____ Relationship _____
Home # (____) _____ Cell # (____) _____ Work # (____) _____

Accident/Injury Information

Is your condition due to an Auto Accident? ☐ No ☐ Yes Date: _____
Is your condition due to an injury sustained at Work? ☐ No ☐ Yes Date: _____
Is your condition due to another form of accident? ☐ No ☐ Yes Date: _____

If YES please explain: _____

To whom have you made a report of your accident?
☐ L&I ☐ Worker Comp ☐ Employer
☐ Auto Insurance ☐ Other

Attorney Name (if applicable):
_____

VALENTE
CHIROPRACTIC

Patient Current Condition and Pain Form

Name _____ **Date** _____

Complaint/Pain Location(s) (example: neck, upper back, mid-back, low-back, hips, extremities):

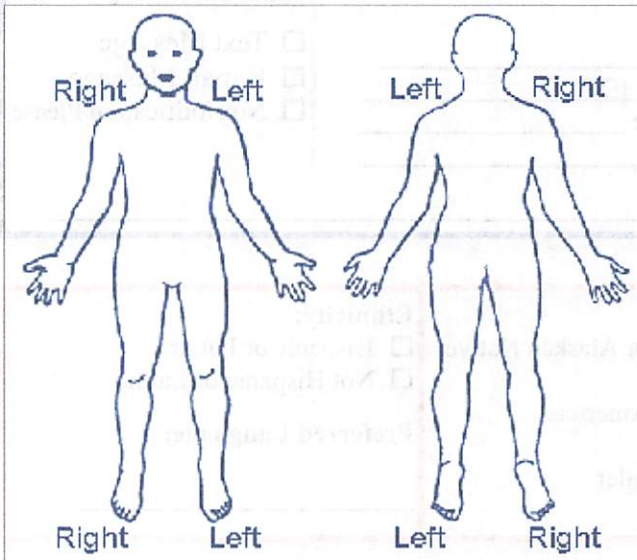
_____

Usual Pain Intensity

No pain 0 1 2 3 4 5 6 7 8 9 10 Severe pain

Today's Pain Intensity

No pain 0 1 2 3 4 5 6 7 8 9 10 Severe pain



Front Back

On the image please indicate where you are experiencing your symptoms.

How would you describe the character of your condition/pain? (please check all that apply)

☐Sharp ☐Dull ☐Tingling ☐Numb
☐Aching ☐Shooting ☐Radiating ☐Burning
☐Throbbing ☐Cramping ☐Stiffness ☐Swelling
☐Other _____

How often do you experience your symptoms?

☐ Constantly (76%-100% of the time)
☐ Frequently (51%-75% of the time)
☐ Occasionally (26%-50% of the time)
☐ Intermittently (0%-25% of the time)

When do you experience your symptoms?

Ex: every day, most days, some days, a few times a year

_____

Does your condition interfere with your.... (please check any that apply)

☐ Sleep ☐ Work ☐ Daily routine ☐ Recreational activities

	Comfortable	Uncomfortable	Painful
Lying down	☐	☐	☐
Sitting	☐	☐	☐
Standing	☐	☐	☐
Stretching	☐	☐	☐
Walking	☐	☐	☐
Running	☐	☐	☐
Bending	☐	☐	☐
Lifting	☐	☐	☐
Kneeling	☐	☐	☐
Pulling	☐	☐	☐
Reaching	☐	☐	☐
Other _____	☐	☐	☐

Additional information / Any recent falls and/or injuries / Prior condition related medical history

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

VALENTE
CHIROPRACTIC

Health History:

It will be assumed that any space left blank indicates that you have NOT had that test, exam, illness, disease, surgery, ect.

A. Date of last:

Physical Exam:	**Medical Doctor:**	**Bone Scan:**	**CT-Scan:**
Chiropractic:	**Chiropractor:**	**Spinal X-Ray:**	**MRI:**
Physical Therapy:	**Physical Therapist:**	**Chest X-Ray:**	**Blood Test:**
Massage Therapy:	**Massage Therapist:**	**Dental X-Ray:**	**Other:**

B. Injuries, traumas, allergies, and illnesses:

Broken Bones/Fractures: _____ Head Injuries: _____

Dislocations: _____ Falls: _____

Please check the box to indicate if you have or have had any of the following:

☐ AID/HIV	☐ Breast Lump	☐ Epilepsy	☐ Herpes	☐ Mumps	☐ Psychiatric Care	☐ Tuberculosis
☐ Alcoholism	☐ Bronchitis	☐ Glaucoma	☐ High Blood Pressure	☐ Osteoporosis	☐ Rheumatoid Arthritis	☐ Tumors, Growths
☐ Allergy shots	☐ Bulimia	☐ Goiter	☐ High Cholesterol	☐ Pacemaker	☐ Rheumatic Fever	☐ Typhoid Fever
☐ Anemia	☐ Cancer	☐ Gonorrhea	☐ Kidney Disease	☐ Parkinson's Disease	☐ Scarlet Fever	☐ Ulcers
☐ Anorexia	☐ Cataracts	☐ Gout	☐ Liver Disease	☐ Pinched Nerve	☐ STD(s)	☐ Vaginal Infections
☐ Appendicitis	☐ Chemical Dependency	☐ Heart Disease	☐ Measles	☐ Pneumonia	☐ Stroke	☐ Whooping Cough
☐ Arthritis	☐ Chicken Pox	☐ Hepatitis	☐ Migraine Headaches	☐ Polio	☐ Suicide Attempt	☐
☐ Asthma	☐ Diabetes	☐ Hernia	☐ Mononucleosis	☐ Prostate Problem	☐ Thyroid Problems	☐
☐ Bleeding Disorders	☐ Emphysema	☐ Herniated Disk	☐ Multiple Sclerosis	☐ Prosthesis	☐ Tonsillitis	☐

Other illness or injury: _____

Allergies (ex: seasonal, peanuts) &/or Medication Allergies (ex: Penicillin, NSAID):

_____ ☐ **NO Known Allergies**

_____

C. Surgeries:

Type of Surgery	Date	Surgeon/Hospital

D. Current Medications: (if certain attributes of your medication(s) are unknown, please write unknown)

Medications or Vitamins/Herbs/Minerals	Dosage (mg)	Frequency	Prescribing Doctor
☐ **NO Current Medications**			

E. Females- Pregnancies and outcomes:

Are you currently pregnant? ☐ No ☐ Yes **Due Date :** _____

Prior pregnancies, dates of delivery, and outcomes: _____

VALENTE
CHIROPRACTIC

2. What previous care/treatment have you received for your condition?

☐ Physical therapy ☐ Chiropractic care ☐ Medication ☐ Surgery ☐ None ☐ Other: _____
Have you ever received Chiropractic Care? ☐ Yes ☐ No If yes, when? _____

3. Family Health History:

Associated health problems of relatives _____

_____

_____

4. Social and Occupational History:

A. Level of Education:

☐ High school ☐ Some college ☐ College graduate ☐ Post graduate studies
☐ Currently attending _____

B. Job description, work schedule, and work activity (eg: sitting, standing, light/heavy labor)**:**

_____

_____

C. Habits:

Do you smoke or use tobacco products?
☐ Current Every Day Smoker ☐ Current Some Day Smoker ☐ Former Smoker ☐ Never Smoker
☐ Other: _____

Do you consume alcohol? ☐ Yes ☐ No
Amount:_____

Do you consume coffee or other caffeinated drinks? ☐ Yes ☐ No
Amount:_____

Are you under a lot of stress? ☐ Yes ☐ No
Reason:_____

D. Recreational activities:

_____

_____

F. Exercise:

Type(s):_____
(e.g: walking, running, aerobic activities, yoga, rock climbing, pool activities, softball, core training, weight lifting)

Frequency:_____
(e.g: 3 times a week, daily, twice daily, rarely, never)

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize Dr. Valente/Valente Chiropractic to provide me with chiropractic care, in accordance with Washington state's statutes.

Signature _____ Date _____

Printed Name: _____

Doctor's Signature _____ Date _____

Patient Motor Vehicle Collision Billing Instructions

Should I not have PIP or Med Pay on my Auto Insurance Policy, or should PIP/MedPay deny coverage for some or all of my charges, or should I exhaust the limits of the PIP/Med Pay with my Auto Insurance Policy:

I, _____, instruct Valente Chiropractic PLLC to bill the following while I'm treating for injuries sustained from the motor vehicle collision that occurred on _____:

Option 1 : Bill Health Insurance

_____ ❑ Bill my health insurance carrier:
Health Insurance Name: _____
Member ID Number: _____

I understand that while billing my health insurance carrier, I will be responsible for paying my deductible, copays, co-insurance, and any non-covered charges as I treat. I understand that by selecting this option, **Valente Chiropractic will not wait until a settlement with a 3rd Party Auto Insurance Company for the collection of my portion of these charges**. I understand that I am responsible for all charges, whether or not paid by insurance.

Option 2 : Wait for Settlement - Lien on 3rd Party Settlement and/or Attorney's Lien

_____ ❑ I would like my charges to be paid upon settlement with a Third Party Auto Insurance Company. I understand that I will be signing a lien to help insure the payment of Valente Chiropractic's charges for services I receive.

Valente Chiropractic agrees to wait until settlement with the 3rd party Auto Insurance Company for collection of my treatment fees, unless it becomes apparent to Valente Chiropractic that no settlement is likely to occur.

Such reasons include, but are not limited to:

- Patient or their attorney stops communication with Valente Chiropractic and/or the 3rd Party Auto Insurance Company
- Patient is found or determined to be at fault for the motor vehicle collision.
- The 3rd Party Auto Insurance Company denies liability and the patient doesn't have an attorney that is working to contest this determination.

I am requesting that my health insurance not be billed. I understand that **my Health Insurance Carrier has a timely filing limit**, and that by requesting that Valente Chiropractic not bill my health insurance carrier, **I WILL NOT BE ABLE TO CHANGE MY MIND AND HAVE VALENTE CHIROPRACTIC RETROACTIVELY BILL MY HEALTH INSURANCE COMPNAY FOR THE SERVICES I RECIEVED, IF THIS TIMELY FILING LIMIT HAS PAST.**

I understand that I am ultimately responsible for the payment of my charges, regardless if they are paid out of a settlement or not. I understand that the 3rd party auto insurance company will not pay Valente Chiropractic's charges as I treat, but rather once a settlement agreement has been made, and that this settlement agreement will need to include payment for my charges at Valente Chiropractic. For this reason, I agree that I and/or my attorney will not settle with the 3rd Party Auto Insurance Company without first obtaining the full and final balance with Valente Chiropractic.

By signing below, I am agreeing that I fully read and understood the billing selection that I made above. I am agreeing that if I had any questions regarding my options, I asked them and was given an satisfactory explanation that addressed the ramifications of each option. I understand that I am considered to be “treating under the motor vehicle collision” per the doctor's judgment and that should I have chosen option 2, I must instruct Valente Chiropractic in writing if I want to begin billing my health insurance. I understand that Valente Chiropractic will not bill out any charges to my health insurance prior to the time the request to bill my health insurance is made.

Patient Signature: _____ Date: _____

LIEN

Authorization and Assignment

Patient's Name:_____ Attorney: _____

Date of Incident:_____ PIP/Med Pay:_____

3rd Party Auto Insurance:_____

- I hereby give a LIEN on my case to Valente Chiropractic PLLC, against any and all proceeds of my settlement, judgment or verdict which may be recovered or paid as the result of the injuries for which I have been treated.
- I authorize and direct my attorney to pay directly to Valente Chiropractic PLLC such sums as may be due and owing for medical services rendered to me both by reason of this incident and by reason of any other bills that are due and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect and fully compensate Valente Chiropractic PLLC.
- I authorize Valente Chiropractic PLLC to release any medical or other information to my attorney or the above listed insurance compan(ies) as the providers and/or staff at Valente Chiropractic PLLC deem necessary.
- In the event that I do not have an attorney, I authorize and direct the 3rd party auto insurance company listed above to pay Valente Chiropractic PLLC directly out of my settlement for the amount due for treatment rendered by the providers at Valente Chiropractic PLLC.
- I understand that I am directly and fully responsible to Valente Chiropractic PLLC for all medical bills submitted by them for services rendered to me. I further understand that such payment is not contingent on any recovery made by me.
- I understand that a UCC Financing Statement may be filed in order to perfect this lien. The UCC Financing Statement may include my name, address, claim number, monies owed, the relevant insurance company's name and address, my Assignment and Release, and this form. Copies of the UCC Financing Statement can be obtained from the Washington State Department of Licensing UCC Search.
- I have been advised that if my attorney does not wish to cooperate in protecting Valente Chiropractic PLLC's interest by signing this document, Valente Chiropractic PLLC will not await payment but may declare the entire balance due and payable.

_____ _____

Date Patient's Signature

_____

Patient's Printed Name

The undersigned attorney agrees:

1. To comply with the above “authorization and assignment”;
2. To withhold and pay directly to Valente Chiropractic PLLC from the above listed patient's proceeds from settlement, collection of judgment, PIP, med-pay or other insurance proceeds, the amount of Valente Chiropractic's charges, after contacting Valente Chiropractic PLLC for a current balance;
3. To notify Valente Chiropractic PLLC of any changes in the status of the claim which may preclude payment of Valente Chiropractic PLLC's charges;

_____ _____

Date Attorney's Signature

_____

Attorney's Printed Name

VALENTE
Chiropractic & Massage

Consent to Treatment

- I voluntarily consent to *receive* medical and health care services that may include diagnostic procedures, examination and treatment.
- As with all health care interventions, there are some risks to care including, but not limited to: muscle spasms, aggravation and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from hot or cold therapies such as heat and ice packs, fractures, disc injures. strokes, sprains, strains, and dislocations. With respect to strokes, there is a rare but serious condition known as arterial dissection that involves an abnormal change in the wall of an artery that may cause the development of a thrombus (clot) with potential to lead to a stroke.
- I agree with the current or future recommendation to receive chiropractic care, massage therapy, and manual therapy as it is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care, massage therapy, or manual care from this office.

Assignment of Benefits

- I hereby assign, transfer, and set over to Valente Chiropractic PLLC all of my rights, title, and interest to *my* medical reimbursement benefits under my insurance policy.
- Valente Chiropractic may use my health care information and may disclose such information and insurance companies involved in *my* treatment for the purposes of obtaining payment for services, determining insurance benefits, and/ or determining benefits payable for related services.
- I understand that Valente Chiropractic PLLC may file a UCC lien in order to obtain direct payment from my associated insurance companies. The lien may include my name, address, claim number, monies owed, an insurance company's name and address, and this form. Copies of the UCC lien can be obtained from the Washington State Department of Licensing UCC Search.
  I understand that should I open a claim, change insurances, or should my insurances coverage change that it may be necessary to sign a new assignment and release form.

Financial Responsibility

- I understand that I am financially responsible for all charges whether or not they are covered by insurance.
- I understand a quote of benefits by Valente Chiropractic does not guarantee payment by *my* insurance company or guarantee benefit eligibility.
- A copy of our full financial policy and standard fee schedule is available to any patient, insurance company or third party.

Release of Information

- I hereby authorize the release of medical information necessary to process my charges or insurance claims. This may include intake forms, chart notes, reports, correspondences, billing statements and other information to my attorney(s), health care provider(s), insurance compan(ies) and case manager(s).

Massage Therapy Agreement

Updated: Effective February 1st, 2023

- **I understand that I will be charged and agree to pay a $50 cancellation fee if I do not show up for my massage appointment or do not cancel within 24 hours notice.**
- **I understand that I will be charged and agree to pay a $70 cancellation fee if I do not show up or late cancel over 3 massage appointments.**
- **I understand that I will be charged and agree to pay a $12.50 late fee if I am more than 15 minutes late to my appointment.**

Signature:_____**Date:**_____

HIPAA NOTICE OF PRIVACY PRACTICES
SUMMARY AND DISCLOSURE

Valente Chiropractic
Effective Date: February 9, 2012

Please indicate below if we may discuss your health information, appointment scheduling and/or billing with someone you trust:

☐ **Spouse:** _____ □ Yes, Health Info □Yes, Billing Info □Yes, Scheduling

☐ **Parent/s or Guardian/s:** _____
□ Yes, Health Info □Yes, Billing Info □Yes, Scheduling

☐ **Relative/Friend/Other:** _____ **Indicate Relationship:** _____
□ Yes, Health Information □Yes, Billing Information □Yes, Appointment Scheduling

Acknowledgment of Receipt of this Notice As a patient of Valente Chiropractic, I acknowledge that I have received and seen this notice and understand that I may request a copy of the full HIPAA Notice Privacy Practices for additional information. I understand that Valente Chiropractic respects their legal obligation to keep health information private unless required by law. My signature below indicates that I agree to these conditions.

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have health insurance coverage with_____
Insurance Carrier

Patient Name:_____ Subscriber Name:_____

Member ID:_____ Subscriber Birthdate:_____

Group No:_____ Subscriber Relation:_____

OR

have a claim open with or wish to open/re-open a claim with:

1st Party Auto (Your Auto Insurance) 3rd Party Auto (Other Party's Ins) Workers' Comp / L&I

_____ _____ _____

Claim #_____ Claim #_____ Claim #_____

☐ I have PIP/Med Pay on my policy (**Please call your Auto Insurance if you are not sure**)

☐ By checking this box I am requesting **not to bill my health insurance** at this time. I am aware I will be responsible for all incurred charges until I sign a new assignment and release stating otherwise.

Signature:_____