Confidential Intake Form

Please allow our staff to photocopy your driver's license and insurance details. All information you supply is confidential. We comply will all federal privacy standards. Please print clearly in BLACK or BLUE **INK**.

Reason for visit (mark circle)

○ A worsening long-term problem

○ An interest in: ○ Wellness and prevention ○ Annual check-up ○ Other: ____________________________

○ An accident or injury: ○ Work ○ Auto ○ Other:____ Claim #:_________________

Today's Date (mm/dd/yyyy) | Date of Injury (If applicable) | Who referred you/how did you find out about us?

○ No ○ Yes
Previous chiropractic, physical therapy or naturopathic care? Where? Date of last visit (approx)

Your full name | Preferred Name | Gender ○ Male ○ Female

Your Social Security Number | Birth date (mm/dd/yyyy) | Age | Marital Status ○ Single ○ Married ○ Divorced ○ Widowed ○ Separated

Mailing address | Home phone | Spouse's Name

City | State/Province | ZIP/Postal Code | Cell phone | Child's name and age

E-mail address | Child's name and age

Emergency contact | Telephone | Child's name and age

Your occupation | Your employer | Telephone

Work address | City | State/Province | ZIP/Postal Code

Family/Specialist Doctor (if applicable)

Primary care physician (Family doctor) | Clinic | Telephone | Fax

Specialist | Clinic | Telephone | Fax

Josh Bailey, D.C.

PERSONAL INJURY INSURANCE QUESTIONNAIRE (File Financial)

Please Complete All Blanks – All information is Required

Patient Name: ____________________ Today's Date: ____________

Date of Accident: _____/_____/_____ Time of Accident: ____________ □ **AM** □ **PM**

Insurance Company: ____________________

Claim Adjuster: ____________________ Phone #: ____________________

Claim #: ____________________ Policy #: ____________________

Do you have PIP (personal injury protection)? □ **Yes** □ **No**

A. If YES, are you the insured? □ **Yes** □ **No**

- Limit? □ **$10,000** □ **$35,000** □ **Not Sure** □ **Other**____________
- How many people were in your vehicle? _______ How many cars were involved in the accident? _______

B. If NO, Insured's Name ____________________ Phone #: ____________

Insured's Address: ____________________

Personal Information

At Fault Driver's Name: ____________________

At Fault Driver's Address: ____________________

City, State, Zip: ____________________

Claim Adjuster: ____________________ Phone #: ____________________

Claim #: ____________________ Policy #: ____________________

Insurance Information

At-fault driver's insurance company: ____________________

Insurance Company Address: ____________________

City, State, Zip: ____________________

Claim Adjuster: ____________________ Phone #: ____________________

Claim #: ____________________ Policy #: ____________________

Have you retained an Attorney? □ Yes □ No

Attorney Name: ____________________ Phone #: ____________________

Attorney Address: ____________________

PERSONAL INJURY INSURANCE VERIFICATION (For office use only)

Is there an open PIP claim? □ Yes □ No

Verify Claim #: ____________________ DOI: ____________________

Claims Mailing Address: ____________________

Verified by: ____________________ Date: ____________ Spoke To: ____________

Josh Bailey, D.C.

Contractual Guarantee of Payment for Health Care Services and Irrevocable Direction and Instruction to Counsel

I hereby authorize and direct you, my attorney to pay directly to Restart Chiropractic LLC such funds as may be due owing for health care services for injuries arising from my motor vehicle accident. I hereby authorize my attorney and involved insurance companies to withhold sums from any settlement, arbitration award, judgment or verdict as may be necessary to adequately protect said doctor or his office against any and all proceeds of my settlement, arbitration award, judgment, or verdict which may be paid to you, my attorney, or myself as the result of the injuries for which I have been treated.

I agree to never rescind this document and that any attempted rescission with not be honored by my attorney.

I fully understand that I am directly and fully responsible to said doctor and his office for all health care bills submitted by him for services rendered to me. Further, this agreement is made solely for said doctor's additional protection and in consideration of his forbearance on payment: I also understand that such payment is not contingent on any settlement damages or the inclusion of any amount in respect of those bills in the breakdown of any settlement, arbitration award, judgment or verdict.

I specifically request my attorney to acknowledge this agreement by signing below and returning it to the doctor's office. I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment and will require me to make payments on a current basis.

I fully understand that all past, present and future bills for services rendered by Restart Chiropractic LLC for my treatment are my responsibility for payment. Hereby ratify my agreement to pay all such bills. I also hereby irrevocably agree to have the entire doctor's bill paid from my proceeds of any nature by way of settlement, arbitration award, judgment, verdict, or otherwise that you, my attorney, or that I, might receive. I do hereby irrevocably instruct my legal counsel to pay the doctor in full from any such proceeds of settlement, arbitration award, judgment or verdict or from the enforcement actions thereon. At the time of disbursement, you are to contact the doctor's office to verify the current amount of the accounts receivable balance and pay the doctor prior to disbursing any proceeds to me or any other party at my direction; I also understand that if settlement does not cover the doctor's entire bill I am still responsible for the remainder.

I hereby instruct that in the event that another attorney is substituted in this matter, the new attorney shall be bound by and honor this Contractual Guarantee of Payment for Health Care Services and Irrevocable Direction & Instruction to Counsel as inherent in such substitution and enforceable upon the case as if it were executed by him/her.

I instruct you, my legal counsel, not to attempt to negotiate my doctor's bill. He has provided all services billed for and I agree to pay him in full. In addition to this agreement, a lien according to the *Revised Code of Washington* may be filed and enforced and the cost for which will be added to the doctor's bill. Further, I understand that interest charges will apply to any and all services rendered to me according to Washington State law and that interest will accrue on the unpaid balance of my account from the date of service at the rate of 1% per month and compounded on a monthly basis.

Signature of Patient: ________________________________ Date: _________________

Printed Name: _____________________________________

The undersigned, being attorney of record for all above-named patient, does hereby agree to observe all the terms of the above and agrees to withhold such sums from the proceeds of any settlement, arbitration award, judgment or verdict so as to adequately protect the outstanding account of Restart Chiropractic LLC.

Signature of Attorney: __________________________________ Date: ____________

WSBA Number: _____________

Josh Bailey, D.C.

Accident Information (File Chiropractic Hx)

General Information

- Date of Accident: _____/_____/______ Time of Accident_________________ □ **AM** □ **PM**
- Were you the?: □ **Driver** □ **Front passenger** □ **Rear passenger** □ **Other** ________________________
- How many people were in your vehicle? _______
- Your vehicle: Make________________________________ Model ___________________________Year_________
- Which directions were you headed? □ **Northbound** □ **Southbound** □ **Eastbound** □ **Westbound**
- Estimated speed you were traveling ______________ mph
- Your car was: □ **Stopped** □ **Rolling** □ **Speeding up** □ **Slowing down**
- Direction of impact? □ **Front** □ **Rear** □ **Passenger** □ **Driver** □ **Other**__________________________
- Please describe the accident in your own words:____

____

- Other vehicle: Make______________________________ Model ___________________________Year_________
- Other car was: □ **Stopped** □ **Rolling** □ **Speeding up** □ **Slowing down**
- Estimated speed they were traveling? _____ mph
- Where did the accident take place? City _________________ Road/Street Name_________________________
- Visibility: □ **Good** □ **Fair** □ **Poor** Road conditions: □ **Dry** □ **Wet** □ **Icy** □ **Other** ___________________
- Did you anticipate the collision? □ **Yes** □ **No**
- Were you braced for impact? □ **Yes** □ **No**
- Was your foot on the brake? □ **Yes** □ **No (for driver only)**
- Were you wearing a seatbelt? □ **Yes** □ **No**
- Were bruises left by the seatbelt? □**Yes** □ **No**
- In what position was your headrest? □ **Even with head** □ **Even with neck** □ **Even with upper back**
- Were your hands on the steering wheel? □ **No** □ **Yes, both** □ **Yes, right** □ **Yes, left** **(for driver only)**
- At the time of impact which way were you looking? □ **Straight** □ **To the left** □ **Behind you** □ **To the right** □ **Up** □ **Down**
- Were you knocked unconscious by the accident? □ **Yes** □ **No** If Yes, for how long?__________________
- Did your airbags inflate? □ **Yes** □ **No** □ **There were no airbags**
- Did your seatback break from the impact? □ **Yes** □ **No**
- Did any part of your body strike anything **inside** the vehicle? □ **Yes** □ **No**

If yes, explain____

- Was the police report filed? □ **Yes** □ **No** If No, why not?____________________________________
- Were you taken to hospital? □**Yes** □ **No** In ambulance? □ **Yes** □ **No**
- Was your car towed from the scene? □ **Yes** □ **No**

Your Vehicle

- Estimated cost of damage to your car? $ _____________Who gave estimate of damage? __________________

Other Vehicle

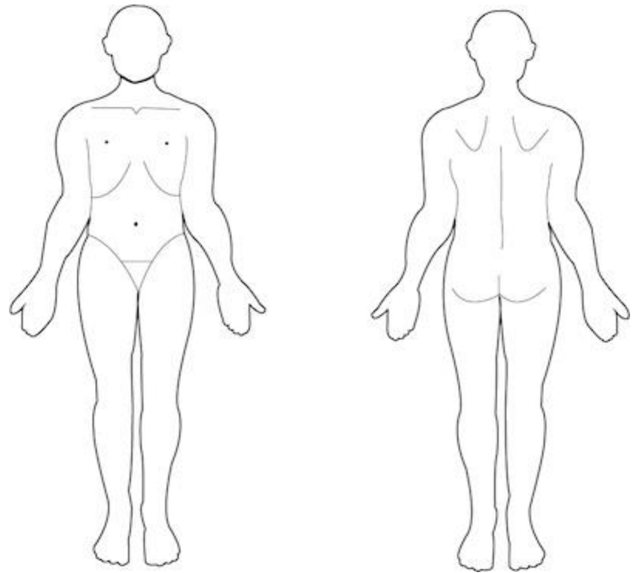
- Estimated cost of damage to their car? $ _____________Who gave estimate of damage? __________________

____
Doctor's Initials

Josh Bailey, D.C.

●1. List your current conditions/complaints

1. ____
2. ____
3. ____
4. ____
5. ____
6. ____



●2.Location (Where does it hurt?)
Mark the area(s) on the illustrations.

●3. Have you received any evaluation and/or treatment for your current condition(s)? ○Yes○ No If yes, explain:

Date: ________________ Doctor or therapist name: ________________________________

Testing done? ○ Yes ○ No Which?: ________________________________

Diagnosis: ________________________________

Treatment/recommendations: ________________________________

Results of treatment?:________________________________

Date: ________________ Doctor or therapist name: ________________________________

Testing done? ○ Yes ○ No Which?: ________________________________

Diagnosis: ________________________________

Treatment/recommendations: ________________________________

Results of treatment?: ________________________________

4. Have you ever suffered from your current symptoms in the past? **○No○Yes** If yes, describe below:

Year	Cause	Tests done?	Problem resolved completely?
			○No ○Yes
			○No ○Yes
			○No ○Yes

5. Please list any other special diagnostic tests that you have had in the past with the year: ________________________

____

●6. Activities of Daily Living How does this condition currently interfere with your life and ability to function?

	No Affect	Mild Affect	Moderate Affect	Severe Affect
Sitting	○	○	○	○
Rising out of chair	○	○	○	○
Standing	○	○	○	○
Walking	○	○	○	○
Lying down	○	○	○	○
Bending over	○	○	○	○
Climbing stairs	○	○	○	○
Using a computer	○	○	○	○
Getting in/out of car	○	○	○	○
Driving car	○	○	○	○
Looking over shoulder	○	○	○	○
Caring for family	○	○	○	○
Work duties	○	○	○	○

	No Affect	Mild Affect	Moderate Affect	Severe Affect
Grocery shopping	○	○	○	○
Household chores	○	○	○	○
Lifting objects	○	○	○	○
Reaching overhead	○	○	○	○
Showering or bathing	○	○	○	○
Dressing myself	○	○	○	○
Love life	○	○	○	○
Getting to sleep	○	○	○	○
Staying asleep	○	○	○	○
Concentrating	○	○	○	○
Gardening/Yard work	○	○	○	○
Exercising/Recreation	○	○	○	○
Athletics	○	○	○	○

____
Doctor's Initials

(Continued from previous page)

Josh Bailey, D.C.

Past personal, family and social history Please identify your past health history, including accidents, injuries, illnesses and treatments.

7. Have you ever been hospitalized or had surgery? ○**No** ○**Yes** If yes, describe:

Year	Reason	Surgery	Outcome

8. Have you ever had any traumas or accidents?(Falls, car accidents, work injury, sports injury, fractures) ○**No** ○**Yes** If yes, describe:

Year	Trauma	Treatment	Outcome

9. Do you take any medications or supplements (including over the counter eg.Tylenol?) ○**No** ○**Yes** If yes, describe:

Name	Reason	x/day	Dose	Since when?

10. Do you have any allergies? ○**No** ○**Yes** If yes, list:

11. Family History

Some health issues are hereditary. Is there a history of illness (cancer, arthritis, heart disease, depression, diabetes, etc.) in your immediate family?

FFAMILY

Relative	Age (If living)	State of Health: Good	State of Health: Poor	Illnesses	Age at death	Cause of death: Normal	Cause of death: Illness
Mother	________	○	○	________	________	○	○
Father	________	○	○	________	________	○	○
Sister 1	________	○	○	________	________	○	○
Sister 2	________	○	○	________	________	○	○
Brother 1	________	○	○	________	________	○	○
Brother 2	________	○	○	________	________	○	○
Other	________	○	○	________	________	○	○

12. Social/Occupational History

SOCIAL

What is your current occupation? ________________________________

Do you rest well at night? ○ Yes ○ No

Do you have trouble falling asleep? ○ Yes ○ No

Do you wake up frequently during the night? ○ Yes ○ No

Do you grind your teeth at night (bruxism)? ○ Yes ○ No

Do you snore heavily? ○ Yes ○ No

How many hours do you sleep at night? ○< 6h ○ 6-8h ○> 8h

Preferred sleep position? ○ Face up ○ Face down ○ Side

Rate your fatigue level (0-10) ________

Approximate age of your mattress and pillow? ________

How often do you exercise?: ○ Don't ○ Occasionally (<1x/week) ○ Frequently (2-3x/week) ○ Daily

Water intake: ○<33oz(1L) ○ 33-50oz (1-1.5l) ○>50oz(1.5L)

SOCIAL

Alcoholic Drinks ○ Never ○<1/day ○ Daily ○ 6-10/week ○>10/week

Caffeine use ○ Never ○<1/day ○ Daily ○ 6-10/week ○>10/week Source of caffeine:________________

Tobacco use ○ No ○<1x/day ○<½ pack/day ○>½ pack/day ○>1 pack/day Type of tobacco: ________________

Soft drinks ○ Never a ○<1/day ○ Daily ○ 6-10/week ○>10/week

What vitamins/supplements do you take? ○ Not taking ○ Glucosamine ○ Chondroitin ○ Calcium ○ Multi-Vitamin ○ Fish Oils ○ Pro-biotics ○ Magnesium ○ Greens ○ B Complex ○ Vitamin C ○ Vitamin D ○ Vitamin E Others: ________________

____
Doctor's Initials

Describe your eating habits: ○ Skip breakfast ○ Two meals per day ○ Three meals per day ○ Snacking between meals

Diet restrictions/intolerances: ________________________________

Rate your overall stress level (0-10): ________ What are your major causes of stress? ○ Work ○ Economic ○ Family/Kids/Relationships

Hobbies: ________________________________

(Continued from previous page)

13. Review of systems

Our integrative care focuses on the integrity of all body systems. Please mark the circle beside any condition that you've **HAD** or currently **HAVE**:

a. HEENT

- ○ Blurred Vision
- ○ Floaters in vision
- ○ Hearing Loss
- ○ Ringing in ears
- ○ Loss of taste
- ○ Loss of smell
- ○ Glaucoma
- ○ Ear infections
- ○ Sinusitis
- ○ Nasal Polyps
- ○ Strep Throat
- ○ Mononucleosis
- ○ **None**

b. Integumentary

- ○ Dry Skin
- ○ Psoriasis
- ○ Eczema
- ○ Acne
- ○ Hair Loss
- ○ Rash
- ○ Melanoma
- ○ **None**

c. Respiratory

- ○ Asthma
- ○ Apnea
- ○ Shortness of breath
- ○ Emphysema
- ○ COPD
- ○ Allergies
- ○ Pneumonia
- ○ Tuberculosis
- ○ **None**

d. Neurological

- ○ Anxiety
- ○ Depression
- ○ Pins and needles
- ○ Dizziness
- ○ Headaches
- ○ Numbness
- ○ Multiple Sclerosis
- ○ Parkinson's
- ○ Fibromyalgia
- ○ Chronic Pain
- ○ Mood Disorders
- ○ **None**

e. Digestive

- ○ Ulcer
- ○ Anorexia/Bulimia
- ○ Food Sensitivities
- ○ Heartburn
- ○ Constipation
- ○ Diarrhea
- ○ Crohn's Disease
- ○ Irritable Bowel Syndrome
- ○ Ulcerative Colitis
- ○ Celiac
- ○ diverticulitis/osis
- ○ Gas/Bloating
- ○ Gall Bladder disease
- ○ **None**

f. Endocrine

- ○ Thyroid Issues
- ○ Hypoglycemia
- ○ Immune Disorders
- ○ Low Energy
- ○ Swollen glands
- ○ Frequent Infection
- ○ Polycystic Ovarian Syndrome
- ○ Diabetes
- ○ Hepatitis
- ○ Goiter
- ○ **None**

g. Genitourinary

- ○Kidney Stones
- ○Prostate Issues
- ○Erectile Dysfunction
- ○Bedwetting
- ○PMS Symptoms
- ○Infertility
- ○ Urinary Tract infections
- ○ Yeast Infections
- ○ Abnormal PAP
- ○ STD's
- ○ Decreased Libido
- ○**None**

h. Constitutional

- ○ Fainting
- ○ Low Libido
- ○ Poor Appetite
- ○ Difficulty losing weight
- ○ Weakness
- ○ Sudden Weight Change
- ○ Fever
- ○ Chills
- ○ Night Sweats
- ○ **None**

i. Cardiovascular

- ○ Angina
- ○ High-cholesterol
- ○ High Blood Pressure
- ○ Low Blood Pressure
- ○ Excessive Bruising
- ○ Poor Circulation
- ○ Stroke
- ○ Murmurs
- ○ A-Fib
- ○ Heart Disease
- ○ **None**

j. General

- ○ Cancer
- ○ Epilepsy
- ○ AIDS
- ○ Alcoholism/Drug dependence
- ○ Gout
- ○ Polio
- ○ Rheumatic fever
- ○ Scarlet fever
- ○ Typhoid
- ○ Malaria
- ○ Post-Nasal Drip

- ○ Other:
- ○ Other:
- ○ Other:

14. What would be the most significant thing that you could do to improve your health? ____________________

____

15. In addition to the main reason for your visit today, what additional health goals do you have? ____________________

____

____
Doctor's Initials

(Continued from previous page)

Post Traumatic Symptom Questionnaire

Pt. Name:______________________________________

PATIENT INSTRUCTIONS: It is ***important*** for this section to be filled out in ***detail***. Look at each symptom listed in the left column and make a **single check mark** or **several check marks** in the appropriate columns for the specific symptom which applies to you. Be certain to indicate when you had the ***beginning*** of any of the following symptoms. Leave the row blank if the symptom listed below does not apply to you.

SYMPTOM LIST (Check all that apply to you)	Right After	Within 3 hrs	Later the same day/night	1-14 Days After	Have Now	Had similar symptoms 1-3 months before	*** DOCTOR's Notes ONLY ***
PAIN / STIFFNESS							
□ Head							
□ Jaw							
□ Neck							
□ Shoulder							
□ Arm							
□ Wrist / hand / fingers							
□ Upper / middle back							
□ Chest / Breast							
□ Rib cage							
□ Low back							
□ Hip							
□ Leg / thigh							
□ Knee							
□ Ankle / foot							
□ Other ____________							
NUMBNESS / TINGLING							
□ Arms							
□ Wrist / hand / fingers							
□ Leg / thigh							
□ Foot / toes							
OTHER:							
□ Weakness in arms / legs							
□ Fatigue							
□ Anxiety							
□ Sleep Disturbance							
□ Sensitivity to noise							
□ Impaired concentration							
□ Blurred vision							
□ Irritability							
□ Difficulty swallowing							
□ Dizziness							
□ Forgetfulness							
□ Tinnitus (ringing in ears)							
□ Loss of coordination							

____
Doctor's Initials

Patient signature: ________________________________ Date: __________

Josh Bailey, D.C.

Our office is pleased to accept your accident/injury case provided that the following policies are understood:

For Patients with PIP (Personal Injury Protection)

- We expect you to provide our office with all necessary claim information and fill out applicable forms from your automobile insurance carrier to open your claim.
- We will bill your auto carrier directly for any services you receive in our office.
- Costs of supplies and nutritional products are due at the time they are received. If your insurance company pays for the supplies, we will either credit your account or give you a refund.
- If PIP benefits are exhausted or your insurance company determines that you no longer need ongoing care before your injuries have resolved, our office is then forced to wait until you are ready to settle your claim to receive payment in full. This could take months to years, depending on each individual case. In this instance, please see our policy below regarding Third Party Claims.

Third Party Pay Claims (For patients with no PIP benefits)

Payment for services may be deferred until the case is settled, provided that the following conditions are satisfied and policies understood.

- That an attorney specializing in personal injury cases is retained to represent you.
- If your claim extends beyond (1) year, you will then begin to pay 5% of the unpaid balance per month until the account is paid in full.
- We will file a medical lien, which is recorded in King, Snohomish County Court, which protects our right to be paid.
- A finance charge of the unpaid balance may be assessed each month.
- You will be required to pay $35.00 for each massage therapy session at the time of services.

I understand and agree to the above policies

Responsible party name: ____ Date: _____________________
(please print)
Signature: ____ C.A. Initials: ____________

(Continued from previous page)

Josh Bailey, D.C.

Acknowledgements

To set clear expectations, improve communications and help you get the best results in the shortest amount of time, please read each statement and initial your agreement.

Informed Consent

I hereby request and consent to the performance of procedures, which may include, but is not limited to, various modes of physical therapy, massage therapy, diagnostic x-rays, diagnostic lab work including urine, blood, gynecological specimens and body cultures, medical doctor and/or chiropractic adjustments on me (or the patient named below, for whom I am legally responsible) by the doctor named below and/or licensed doctors who now or in the future treat me while employed by, work or are associated with, or are serving as back up, for Restart Chiropractic, LLC, including those working at the center or office listed below or any other office or center.

I have had an opportunity to discuss with the doctor named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and/or other procedures.

I understand, and am informed that in the practice of medicine, and in the practice of chiropractic, naturopathy and physical therapy, there are some risks to treatments including, but not limited to fractures, disk injuries, strokes, dislocations, sprains and potential exacerbation of symptoms. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the same time, based upon the facts then known, is in my best interest.

I have read, or have had read to me, the above consent. I have also had the opportunity to ask questions about its content, and by signing below, I agree to the above-named procedure. 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.

To be completed by patient

Patient Name ____________________________________ Signature of Patient ____

Date Signed _____________________________________

To be completed by patient's representative if patient is a minor or physically or legally incapacitated

Representative Name _____________________________ Signature of Representative _________________________________

Date Signed _____________________________________

Josh Bailey, D.C.

(Continued from previous page)

Notice of privacy practices acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (“HIPAA”), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations, such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

Patient Name ____

Representative Name ____

Signature ____

Date____

Office use only

I attempted to obtain the patient’s signature in acknowledgement of this Notice of Privacy Practices Acknowledgement, but was unable to do so, as documented below:

Date:

Initials:

Reason:

HEALTH INSRUANCE DIRECTIVE TO DOCTOR AND ATTORNEY/INSURANCE ADJUSTER

I hereby direct ____ (hereafter PROVIDER):

___ TO BILL MY HEALTH INSURANCE:

I have health insurance through ____under Policy number ______________________________. I understand that by directing PROVIDER to bill my health insurance, I must pay all co-pays, deductibles and/or charges in excess of stop losses, as applicable, at the time of treatment, without exception.

___ NOT TO BILL MY HEALTH INSURANCE/L&I:

I have health insurance through ___________________ under Police/Claim number____________________. Because I find it difficult to meet the financial requirements of my health insurance company (including, but not limited to: co-pays, deductibles, limits on number of visits, stop losses, as the case may be), I direct PROVIDER not to bill my health insurance company.

Instead, in consideration of my doctor’s treatment of me without billing my health insurance/L&I company, I __________________ hereby agree to this Third-Party Settlement Directive to Attorney or Insurance Adjuster (Hereafter, “Third Party Directive”):

By signing below, I hereby direct my attorney and/or adjuster to pay PROVIDER directly from any award, judgment or settlement of my motor vehicle accident/personal injury claim of ______________ the entire outstanding balance for my treatment related to that injury. I direct my attorney not to bill my health insurance company at any time without the express written consent of PROVIDER.

I agree that once treatment is provided by PROVIDER, this Third-Party Directive may not be rescinded or revoked without the express written consent of PROVIDER. Further, I agree that this directive shall remain in full effect notwithstanding any change of attorney or insurance adjuster or any other circumstance. I understand that I am also personally financially responsible for all charges not covered by this Third-Party Directive. I also understand that I am personally responsible for all of my outstanding medical bills irrespective of the outcome of my motor vehicle accident/personal injury claim. I understand that all fees for professional services rendered are due and payable at the time of service. I agree that this directive does not waive any other remedies or rights of collection by PROVIDER. I also authorize my doctor, my attorney, and/or my insurance company to release any and all information required for the payment of my outstanding medical bills.

____ ___________________
Patient Date

____ ___________________
Witness Date

Josh Bailey, D.C.

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.

The Health Insurance Portability & Accountability Act of 1996 (“HIPAA”) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. “HIPAA” provides penalties for covered entities that misuse personal health information.

As required by “HIPAA”, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing, and we are required to honor and abide by that written request, except to the extent that we have already taken actions on relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to the requested restriction.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

Patient Copy

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