



MVA DC PATIENT INFORMATION

Patient Claim: _____ Date: _____
 Last Name: _____ First Name: _____ MI: _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Date of Birth: _____ Gender: Male Female
 Marital Status: Single Married Other Spouse's Name: _____
 Home Phone: _____ Cell Phone: _____
 Work Phone: _____ Email: _____
 Employed Full-time Student Part-time Student

Insured
 Patient Relationship to Insured: Self Spouse Child Other _____
 Insured Last Name: _____ First Name: _____ MI: _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Insured's Date of Birth: _____ Gender: Male Female Phone: _____
 Insurance Company: _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Claim Representative: _____ Phone: _____
 Attorney's Name: _____ Phone: _____
 Address: _____
 City: _____ State: _____ Zip: _____

Nature of Accident
 Date and time of accident: Date: _____ Time: _____
 State in which accident occurred: _____
 Were you: Driver Passenger Front Seat Back Seat
 Number of people in your vehicle? _____ Were you wearing seat belts? Yes No
 What direction were you headed? North East South West
 On (name of street) _____
 What direction was other vehicle headed? North East South West
 On (name of street) _____
 Were you struck from: Behind Front Left side Right side
 Approximate speed of your car _____ mph Other car _____ mph
 Were you knocked unconscious? Yes No
 Were police notified? Yes No
 In your own words, please describe accident: _____



MVA DC MEDICAL HISTORY

Patient: _____ Claim: _____

Did you have any physical complaints BEFORE THE ACCIDENT? Yes No If yes, please describe in detail: _____

Please describe how you felt:

DURING the accident: _____

IMMEDIATELY AFTER the accident: _____

LATER THAT DAY: _____

THE NEXT DAY: _____

What are your PRESENT complaints and symptoms? _____

Do you have any congenital (from birth) factors which relate to this problem? Yes No If yes, please describe: _____

Do you have any previous illnesses which relate to this case? Yes No If yes, please describe: _____

Have you ever been involved in an accident before? Yes No If yes, please describe, including date(s) and type(s) of accidents, as well as injury(ies) received: _____

Where were you taken after the accident? _____

Have you been treated by another doctor since the accident? Yes No If yes, please list doctor's name and address: _____

What type of treatment did you receive? _____

Since this injury occurred, are your symptoms: Improving Getting Worse Same

CHECK SYMPTOMS YOU HAVE NOTICED SINCE ACCIDENT:

- | | | | | |
|--|---|--|--|--|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Irritability | <input type="checkbox"/> Numbness in Toes | <input type="checkbox"/> Face Flushed | <input type="checkbox"/> Feet Cold |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Buzzing in Ears | <input type="checkbox"/> Hands Cold |
| <input type="checkbox"/> Neck Stiff | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Stomach Upset |
| <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Head Seems Too Heavy | <input type="checkbox"/> Depression | <input type="checkbox"/> Fainting | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Pins & Needles in Arms | <input type="checkbox"/> Lights Bother Eyes | <input type="checkbox"/> Loss of Smell | <input type="checkbox"/> Cold Sweats |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Pins & Needles in Legs | <input type="checkbox"/> Loss of Memory | <input type="checkbox"/> Loss of Taste | <input type="checkbox"/> Fever |
| <input type="checkbox"/> Tension | <input type="checkbox"/> Numbness in Fingers | <input type="checkbox"/> Ears Ring | <input type="checkbox"/> Diarrhea | |

Symptoms other than above _____

Do you notice any activity restrictions as a result of this injury? Yes No If yes, please describe in detail: _____

Have you lost time from work as a result of this accident? Yes No If yes, please complete the following:

Last day worked: _____ Occupation: _____

Been unable to work since accident

Other pertinent information: _____

 Patient or Authorized Person's Signature Date



RoseSprings Medical
 5215 NE Elam Young Parkway, Suite A
 Hillsboro, Oregon 97124-6498
 Phone 503-693-9101
 Fax 503-693-9123
 EIN 27-0256414

**RELEASE OF RECORDS
 PAYMENT AGREEMENT
 ASSIGNMENT OF BENEFITS**

Patient to sign prior to any medical treatment to be performed.

Patient: _____ Claim: _____

This form may be submitted by fax or copies and be as valid as if it were the original. My attorney, in writing, to RoseSprings Medical and/or my insurance company may in the future, revoke the assignment portion. Revocation of assignment will in no way release me from the payment agreement portion. The payment agreement portion of this instrument may not be revoked in writing or otherwise.

Release of records: I hereby authorize RoseSprings Medical to release medical or any other necessary information or records, pertaining to services received by me or my dependent(s) to my insurance company, or to my attorney, now or in the future, and/or my physician(s), if necessary, for the purposes of billing, payment, or collection of my medically related outstanding debts, administration and evaluation, utilization review and financial audit. This authorization remains valid and effective from the date of this signing until revoked in writing, to both my insurance company and to RoseSprings Medical.

 Patient or Authorized Person's Signature Date

Payment agreement: All charges are due at the time of service, unless other arrangements have been made in advance. All professional services rendered are charged to me and I am responsible for all fees, regardless of insurance coverage. I understand that my insurance coverage is a contract between myself and my insurance company and that RoseSprings Medical is hereby willing to assist me in collecting those payments from my insurance company for my services. I understand I am responsible to RoseSprings Medical for charges not covered by this assignment, including deductibles and co-payment requirements by my insurance company policy, certificate of coverage, or for any unauthorized workers' compensation claims. I will bear the expenses of collection and/or court costs, and reasonable legal fees, should this be required. I understand if my commercial, health, or other insurance has not paid my medical bill within 60 days of my visit(s), for my services received from RoseSprings Medical, I am responsible, and I will then make whatever arrangements are necessary and available to me to pay all unpaid charges.

 Patient or Authorized Person's Signature Date

Assignment of Benefits: I hereby authorize payment of medical benefits to and assign to RoseSprings Medical all money to which I am entitled for medically related expenses received at or through RoseSprings Medical. The payment shall not exceed my total indebtedness for services received through RoseSprings Medical. Any payment that RoseSprings Medical received from the insurance company, beyond my indebtedness shall be refunded to me, when my outstanding bill(s) with them are paid.

 Patient or Authorized Person's Signature Date



DC FEE SCHEDULE

The following table lists some of the most common CPT codes used by RoseSprings Medical and the amounts billed. Other codes may be used and are billed at UCR rates. The amounts billed may be adjusted from time to time.

Code	Description	Unit	Fee
99203	Detailed New Patient Evaluation	session	\$75.00
99204	Comprehensive New Patient Evaluation	session	\$100.00
99205	Complex New Patient Evaluation	session	\$150.00
99211	Focused Established Patient Evaluation	session	\$30.00
99212	Expanded Established Patient Evaluation	session	\$50.00
99213	Detailed Established Patient Evaluation	session	\$70.00
99214	Comprehensive Established Patient Evaluation	session	\$120.00
98940	Chiropractic Manipulative Treatment Spinal 1-2 Regions	session	\$50.00
98941	Chiropractic Manipulative Treatment Spinal 3-4 Regions	session	\$65.00

Patient or Authorized Person's Signature

Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

This document is to be signed by a person legally responsible for the patient's medical decisions relative to the treatment situation.

I acknowledge that RoseSprings Medical has provided me with a copy of its Notice of Privacy Practices that describes how medical information about me may be used and disclosed, and how I can access this information. I understand that if I have questions or complaints I may contact:

Region X, Office for Civil Rights
 US Department of Health and Human Services
 2201 Sixth Avenue, Suite 900
 Seattle, WA 98121-1831
 1-866-627-7748
 TDD (206) 615-2296

I also understand that I am entitled to receive updates upon request if RoseSprings Medical amends or changes its Notice of Privacy Practices in a material way.

Signature

Date

Printed Name

Relationship to Patient

This section is to be completed by practitioner when unable to obtain written acknowledgement from the patient.

I made a good faith effort to obtain a written acknowledgment of receipt of the Notice of Privacy Practices from the above-named patient, but was unable to because:

- Patient declined to sign this Written Acknowledgment.
- Other (specify): _____

Practitioner Printed Name

License Number

Practitioner Signature

Date