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

# WC 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 Social Security Number: ______________________________

Occupation: _______________________________________ Years Employed: ____________________________________

Employer at time of injury: _________________________________________________________________________________

Address: ____________________________________________________________________________________________________

City: ____________________________________________________________ State: ________________ Zip: _________________

Supervisor: _____________________________________________________ Phone: ____________________________________

Attorney's Name: ________________________________________________ Phone: ____________________________________

Address: ____________________________________________________________________________________________________

City: ____________________________________________________________ State: ________________ Zip: _________________

Insurance Company: __________________________________________________________________________________________

Address: ____________________________________________________________________________________________________

City: ____________________________________________________________ State: ________________ Zip: _________________

Claim Representative: _______________________________________________ Phone: ____________________________________

**Nature of Accident**

Date and time of injury: Date: ________________________________________ Time: ____________________________________

Was this an auto accident? ☐ Yes ☐ No If yes, state in which accident occurred: ______________________________

Injury reported to employer? ☐ Yes ☐ No

In your own words, please describe accident: ______________________________________________________________

____________________________________________________________________________________________________________

____________________________________________________________________________________________________________

____________________________________________________________________________________________________________

I understand that once I am an authorized Workers' Compensation Patient, I am not to be billed, by you, your staff, or facility, for services, under any circumstances. The only exception is, unless I am required by law to pay a co-pay after reaching MMI, or unless I, or you are notified by the employer/carrier, through legal avenues that you have been de-authorized.

I understand that it is my responsibility to keep all of my appointments with you. I understand also that if I do not, or if I regularly miss appointments, it is then your obligation to notify the employer/carrier and my physician. To regularly or often miss my scheduled appointments is an indication that I may no longer need treatments and can therefore possibly jeopardize my case.

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# WC 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:

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

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# 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

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## 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 ________________

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**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 ________________