AUTO ACCIDENT – INSURANCE DATA

Today's Date: _____

Patient Name: _____

Phone #: _____

File #: _____
(to be supplied by the office)

I hereby authorize Dr. _____ to furnish the insurance company/ attorney with reports regarding examination, diagnosis, treatment, prognosis, etc. of myself in regard to the following report.

Patient Signature _____

Date: _____

PATIENT'S INSURANCE COMPANY INFORMATION

Company Name: _____ Phone: _____

P.O. Box/Street Number: _____

City/State/Zip: _____

Claim #: _____

Adjustor's Name: _____ Phone: _____

INSURED'S INSURANCE INFORMATION (if other than patient)

Insured's Name: _____ Phone: _____

Company Name: _____ Phone: _____

P.O. Box/Street Number: _____

City/State/Zip: _____

Policy #: _____

Adjustor's Name: _____ Phone: _____

OTHER DRIVER'S INSURANCE INFORMATION (if another car was involved)

Other Driver's Name: _____ Phone: _____

Company Name: _____ Phone: _____

P.O. Box/Street Number: _____

City/State/Zip: _____

Policy #: _____

Adjustor's Name: _____ Phone: _____

ACCIDENT RELATED QUESTIONS

1. Accident date and time: _____
2. Location: _____
3. Driver of the vehicle in which you were riding: _____
4. Year and Model of Car: _____
5. Road conditions were: Icy_____ Rainy & Wet_____ Dark_____ Other _____
6. Were police called to the scene of the accident? _____
   If so were any citations issued to either party? _____
7. What was approximate damage to your car? _____
8. If you have lost time from your job, indicate dates of time loss: _____

SUNSET CHIROPRACTIC CLINIC
LAURA A. SWINGEN, D.C., P.C.
11507 SW SHILO LANE
PORTLAND, OR 97225
503-643-2225

DOCTOR'S LIEN

Irrevocable Assignment and consent to Disbursement

I do hereby authorize Laura A. Swingen, D.C., to furnish you, my attorney and/or insurance carrier, with a full report of her examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I was involved on _____.

I hereby authorize and direct you, my attorney and/or insurance carrier, to pay directly to said doctor such sums as may be due and owing her for medical service rendered me both by reason of this accident and by reason of any other bills that are due her clinic and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect said doctor. And I hereby further give a Lien on my case to said doctor against any and all proceeds of my settlement, judgment or verdict which may be paid to you, my attorney and/or insurance carrier, or myself, as the result of the injuries for which I have been treated or injuries in connection therewith.

I agree never to rescind this document and that a rescission will not be honored by my attorney and/or insurance carrier. I hereby instruct that in the event another attorney and/or insurance carrier is substituted in this matter, the new attorney and/or insurance carrier honor this lien as inherent to the settlement and enforceable upon the case as if it were executed by the new said party.

I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by her for service rendered me and that this agreement is made solely for said doctor's additional protection and in consideration of her awaiting payment. I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee. I have been advised that if my attorney and/or insurance company does not wish to cooperate in protection of the doctor's interest, the doctor will not await payment but will require me to make payments on a current basis.

_____ _____

Patient's Signature Date

The undersigned being attorney and/or insurance carrier of record for the above patient does hereby agree to observe all terms of the above and agrees to withhold such sums from any settlement, judgment, or verdict, as may be necessary to adequately protect said doctor above named.

_____ _____

Attorney Signature/Insurance Carrier Date

AUTOMOBILE ACCIDENT – PATIENT DATA

Date of Accident _____ Time _____ Location _____

1. Describe the accident in your own words: _____

_____

_____

2. Type of Accident – Answer the following:

A. ☐ Head-on Collision ☐ Left
☐ Rear-end Collision ☐ Right
☐ Broadside Collision ☐ Straight

B. ☐ Front Impact/Patient Rear-ended car in front

C. ☐ Non Collision

3. Describe in your own words what happened to you upon impact: _____

_____

_____

4. Patient Data at the Time of Accident – Answer the following:

A. ☐ Seat Belts/Shoulder Restraints Fastened

B. ☐ Prewarned Accident Was About to Happen, ☐ Bracing for Impact, ☐ Braking

C. Body Position at Time of Impact:
☐ Head Turned Left/Right, ☐ Looking Back, ☐ Head Straight, ☐ Body Straight in Sitting Position,
☐ Body Rotated Left/Right ☐ Other _____

D. Head/Body Hit:
☐ Windshield, ☐ Steering Wheel, ☐ Ceiling, ☐ Headrest, ☐ By Flying Object, ☐ Other _____

E. As a Result of the Accident you were:
☐ Rendered Unconscious, ☐ Dazed/Circumstances Vague, ☐ Hospitalized/Emergency Room
☐ Other _____

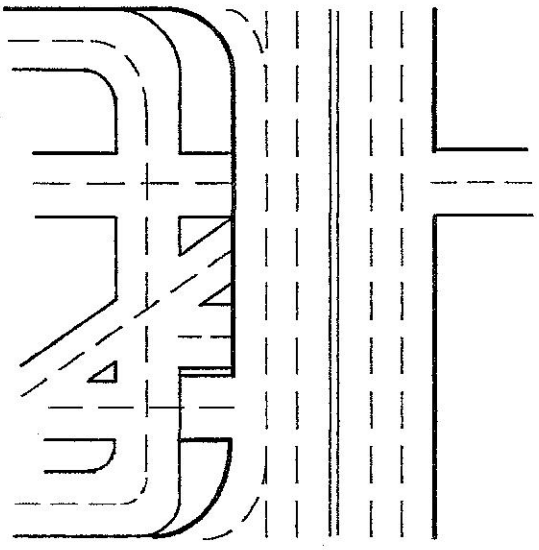
5. Check Symptoms Apparent **Since** the Accident:

☐ Headache
☐ Neck pain/stiffness
☐ Mid back pain
☐ Low back pain
☐ Eyes sensitivie
☐ Dizziness
☐ Fainting
☐ Ringing/buzzing ears
☐ Loss of balance
☐ Loss of smell
☐ Loss of taste
☐ Loss of memory
☐ Fatigue
☐ Fever
☐ Shortness of Breath
☐ Irritability
☐ Depression
☐ Sleeping Problems
☐ Numbness in toes
☐ Numbness in fingers
☐ Cold hands
☐ Cold feet
☐ Diarrhea
☐ Constipation
☐ Chest pain
☐ Nervousness
☐ Cold sweats
☐ Other: _____

_____

_____

6. Indicate on this Diagram What Happened:



Patient Signature _____ Date _____

NOTES: _____

_____

_____

_____

_____

Sunset Chiropractic Clinic 11507 S.W. Shilo Lane, Portland, OR 97225 (503) 643-2225

Patient Billing Policy

Sunset Chiropractic Clinic provides chiropractic and rehabilitative services for acute care, chronic care (usually covered by health insurance) as well as maintenance care (not covered by health insurance). While it is our general policy at Sunset Chiropractic to bill your insurance company as a courtesy to you, we'd like to clarify our billing policy for your information.

For patients that receive chiropractic and rehabilitation services for acute and chronic care, we need to follow a complex set of clinical guidelines & administrative procedures. For example:

- Obtain your insurance information and verify your coverage
- We usually need to provide more intense therapy (i.e. traction, muscle stretching & strengthening, upper & lower extremity adjusting, etc.) which requires you to spend more time with the doctor.
- Complete insurance authorization forms
- Submitting each claim to your insurance company and often re-submitting the claims
- Tracking and posting payments from the insurance company
- Often times waiting weeks, sometimes months to receive reimbursement
- And depending upon the type of insurance, reimbursed a percentage of the billed amount

As a result of the above, the prevailing reasonable and customary rate for the services we provide can range from $ 50 to $ 175 per session. Depending upon your type of insurance, we will be reimbursed a percentage of this amount.

The fees for patients that receive services for maintenance care are $40 to $100. Maintenance care usually begins after the first 12-36 visits and in most cases is not covered by insurance. This type of care usually requires less time, less intense therapy and may provide a discount from our standard fee schedule because there are no administrative costs (example, printing insurance claims, folding and stuffing evelopes, postage fees, etc. that are involved with collecting the fee). Also, we do not have to call insurance company representatives, engage in written correspondence with the insurance company and wait weeks, months or even longer to receive payment.

We often do not know exactly what your insurance company will pay us until we receive payment. Either way, we usually accept their payment after any deductible, co-payment and co-insurance is handled. Please understand that your insurance is an agreement between you and the insurance company and all services rendered to you are ultimately your responsibility. We hope this clarifies our billing policy. If you have any further questions, please don't hestitate to ask.

I have read, agree to, and understand the Sunset Chiropractic billing policy

_____

Patient signature

_____ _____

Patient Name Printed Date

Sunset Chiropractic Clinic . Dr Laura A. Swingen . 11507 S.W. Shilo Lane, Portland, OR 97225 (503) 643 222

SUNSET CHIROPRACTIC CLINIC
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.

Sunset Chiropractic Clinic is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

Disclosure of Your Health Care Information

Treatment
We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations. (example)

> *"On occasion, it may be necessary to seek consultation regarding your condition from other health care providers associated with Sunset Chiropractic Clinic."*
>
> *"It is our policy to provide a substitute health care provider, authorized by Sunset Chiropractic Clinic to provide assessment and/or treatment to our patients, without advanced notice, in the event of your primary health care provider's absence due to vacation, sickness, or other emergency situation."*

Payment
We may disclose your health information to your insurance provider for the purpose of payment or health care operations. (example)

> *"As a courtesy to our patients, we will submit an itemized billing statement to your insurance carrier for the purpose of payment to Sunset Chiropractic Clinic for health care services rendered. If you pay for your health care services personally, we will, as a courtesy, provide an itemized billing to your insurance carrier for the purpose of reimbursement to you. The billing statement contains medical information, including diagnosis, date of injury or condition, and codes which describe the health care services received."*

Workers' Compensation
We may disclose your health information as necessary to comply with State Workers' Compensation Laws.

Emergencies
We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death.

Public Health
As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug

Administration problems with products and reactions to medications, and reporting disease or infection exposure.

Judicial and Administrative Proceedings.
We may disclose your health information in the course of any administrative or judicial proceeding.

Law Enforcement.
We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

Deceased Persons.
We may disclose your health information to coroners or medical examiners.

Organ Donation.
We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.

Research.
We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.

Public Safety.
It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

Specialized Government Agencies.
We may disclose your health information for military, national security, prisoner and government benefits purposes.

Marketing.
We may contact you for marketing purposes or fundraising purposes, as described below: (example)

> *"As a courtesy to our patients, it is our policy to call your home on the evening prior to your scheduled appointment to remind you of your appointment time. If you are not at home, we leave a reminder message on your answering machine or with the person answering the phone. No personal health information will be disclosed during this recording or message other than the date and time of your scheduled appointment along with a request to call our office if you need to cancel or reschedule your appointment."*

> *"It is our practice to participate in charitable events to raise awareness, food donations, gifts, money, etc. During these times, we may send you a letter, post card, invitation or call your home to invite you to participate in the charitable activity. We will provide you with information about the type of activity, the dates and times, and request your participation in such an event. It is not our policy to disclose any personal health information about your condition for the purpose of Sunset Chiropractic Clinic sponsored fund-raising events."*

Change of Ownership.
In the event that Sunset Chiropractic Clinic is sold or merged with another organization, your health information/record will become the property of the new owner.

Your Health Information Rights

- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that Sunset Chiropractic Clinic is not required to agree to the restriction that you requested.
- You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.
- You have the right to inspect and copy your health information.
- You have a right to request that Sunset Chiropractic Clinic amend your protected health information. Please be advised, however, that Sunset Chiropractic Clinic is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s)and information about how you can disagree with the denial.
- You have a right to receive an accounting of disclosures of your protected health information made by Sunset Chiropractic Clinic.
- You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

Changes to this Notice of Privacy Practices
Sunset Chiropractic Clinic reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, Sunset Chiropractic Clinic is required by law to comply with this Notice.

Sunset Chiropractic Clinic is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please contact: Laura Swingen by calling this office at 503-643-2225. If Laura Swingen is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

Complaints
Complaints about your Privacy rights, or how Sunset Chiropractic Clinic has handled your health information should be directed to Laura Swingen by calling this office at 503-643-2225 If Laura Swingen is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201

This notice is effective as of _____/_____/_____

I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide Sunset Chiropractic Clinic with my authorization and consent to use and disclosed my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice

_____
Patient's Name (print)

_____ _____
Patient's Signature Date

_____ _____
Authorized Facility Signature Date