HILLCREST
CHIROPRACTIC CLINIC

Patient Information

Today's Date: _____ Date of Birth: _____ Age: _____ M___ F___

First Name: _____ Last Name: _____ MI: ___

Address: _____

City: _____ State: _____ Zip Code: _____ SSN: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email Address: _____

Occupation: _____ Employer: _____

Employer Address: _____

Employer City/State/Zip Code: _____

Insurance Carrier: _____ Carrier Phone #: _____

Carrier Address/City/State/Zip: _____

Policy #: _____ Group #: _____ Claim #: _____

Additional Insurance (Supplemental, from Spouse/Parent, etc) Carrier: _____

Add'l Carrier Address/City/State/Zip: _____

Add'l Carrier Phone: _____ Add'l Carrier Policy #: _____

Physician: _____ Phone: _____

Physician: _____ Phone: _____

Patient's or Authorized Person's Signature: I authorize the release of any medical or other information necessary to process my insurance claim. This is to serve as a long-term authorization card.

Signed: _____ Date: _____

Insured's or Authorized Person's Signature: I authorize payment of medical benefits to Dr. Ryan M. Thomas, Chiropractor, for the services described on the insurance form. This authorization is to apply to all occasions of service until it is revoked in writing.

Signed: _____ Date: _____

Consent to Treatment for a MINOR: I hereby authorize Dr. Thomas to treat and direct treatment for my child who is under the age of eighteen (18) years of age.

Child's Name: _____ Parent's Signature: _____ Date: _____

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Name_____ Date_____

Motor Vehicle Collision Injury Questionnaire

Instructions: Please answer the following questions pertaining to your motor vehicle collision injury to the best of your ability; please make an attempt to answer every question. Write your name and date at the top of each page.

1. Date of collision: _____ 2. Time of collision: _____
3. City of collision: _____ 4. Street of collision: _____
5. Road conditions at time of collision (circle): wet dry icy snowy
6. Did the police respond to the scene of the collision? Yes □ No □
   If yes, was a police report filed? Yes □ No □
7. Please describe what occurred in the collision:_____

   _____

   _____

   _____

8. Was *YOUR* vehicle stopped at the time of impact? Yes □ No □
   If yes, was the driver's foot on the brake? Yes □ No □
9. Was the other car moving at the time of impact? Yes □ No □
10. Was the impact (please circle only one): ***LIGHT*** *(little or no damage)*
    MODERATE *(significant vehicle damage)* ***HEAVY*** *(extreme vehicle damage)*
11. Were you wearing a seat belt? Yes □ No □
12. Was the vehicle equipped with air bags? Yes □ No □ Unknown
    If yes, did the air bags deploy? Yes □ No □
13. List the year, make, and model of the vehicle *YOU* were in:
    Year_____ Make_____ Model_____
14. Owner of the vehicle you were in if other than yourself: _____
15. List the year, make, and model of any other vehicles involved in the collision:

    Year_____ Make_____ Model_____

    Year_____ Make_____ Model_____

    Year_____ Make_____ Model_____

16. Where were *YOU* seated in the vehicle? (circle one)
    Driver Front Passenger Left Rear Center Rear Right Rear
17. What direction was the impact from? (circle one)
    Front Left Side Right Side Rear
18. Did you see the collision coming? Yes □ No □
19. Were you braced for impact? Yes □ No □

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Name_____ Date_____

20. At the moment of impact, where were you looking? (circle one)
Left Straight Right behind Other_____

21. Did any part of your body strike any part of the vehicle? Yes □ No □
If yes, what part of your body was involved? (circle all that apply)
Head Shoulder Elbow Hand Hip Knee Foot
What object did you hit inside the vehicle? (circle all that apply)
Dashboard Windshield Steering wheel Door Other_____

22. Did you lose consciousness upon impact? Yes □ No □ If yes, how long? _____
23. Were you injured by the seat belt? Yes □ No □ If yes, where? _____

24. Did you receive medical treatment at the scene of the collision? Yes □ No □
If yes, from whom? _____
25. Did you go to the hospital? Yes □ No □ If yes, which hospital? _____
When did you go? (circle one) After the collision Next day Other_____
How did you get to the hospital? (circle one) Ambulance Car Other_____
What was done at the hospital? (circle all that apply)
Exam X-ray Medication Other_____
If medication was prescribed, please list type, dose, and last time taken: _____
_____

26. Have you seen any other physician regarding this collision? Yes □ No □
If yes, please list name, address, and phone:_____
_____

27. Are you currently taking any prescription or over the counter medication? Yes □ No □
If yes, please list type, dose, and last time taken: _____
_____

28. Have you ever been injured in a similar manner? Yes □ No □
If yes, please explain: _____
_____
_____
By whom and/or where were you treated? _____

29. Have you ever had any surgeries, procedures, illnesses, or hospitalizations? Yes □ No □
If yes, please list the date and procedures: _____
_____
_____

30. Is there anything else you would like to discuss with the doctor? _____
_____

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Name_____ Date_____

Work Description & Duties

1. Please describe your job: _____

2. In a typical 8 hour workday, How many hours do you…? (circle number of hours for each)
   Sit 0 1 2 3 4 5 6 7 8 hours
   Stand 0 1 2 3 4 5 6 7 8 hours
   Walk 0 1 2 3 4 5 6 7 8 hours

3. On the job, I perform the following activities: (mark all that apply with a 'X')

In terms of an 8 hour workday ***occasionally*** means 0-33%, ***frequently*** means 34-66%, and ***continuously*** means 67-100%.

	Not at all	Occasionally	Frequently	Continuously
Bend/Stoop				
Squat				
Crawl				
Climb				
Reach above				
Crouch				
Kneel				
Push/Pull				
Balance				

4. Relate how you felt **BEFORE** your injury (mark '**B**') compared to how you felt **AFTER** your injury (mark '**A**') when performing the following activities:

	Normal	Limited	Difficult	Painful
Walking				
Sitting				
Standing				
Bending				
Stooping				
Lifting				
Pushing				
Pulling				
Climbing				
Reaching				
Gripping				
Kneeling				
Balancing				

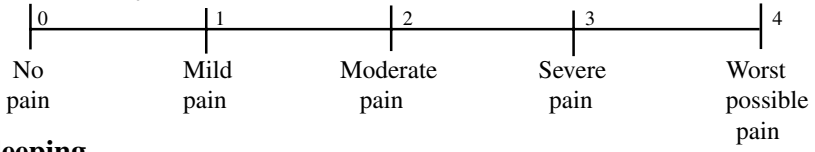
Patient Signature: _____ Date: _____

Functional Rating Index

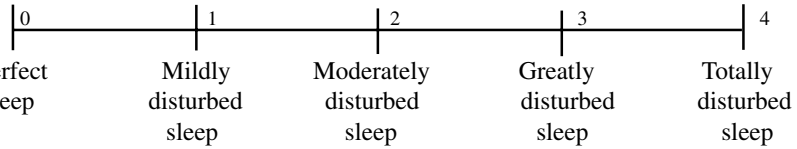
For use with **Neck and/or Back Problems** only.

In order to properly assess your condition, we must understand how much your **neck and/or back problems** have affected your ability to manage everyday activities.
For each item below, **please circle the number which most closely describes your condition right now.**

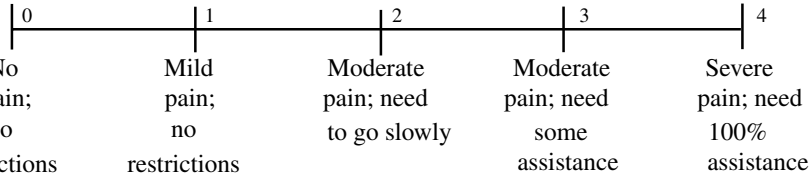
1. Pain Intensity



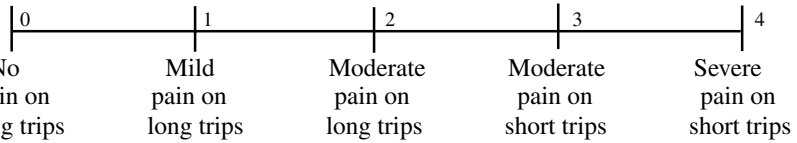
2. Sleeping



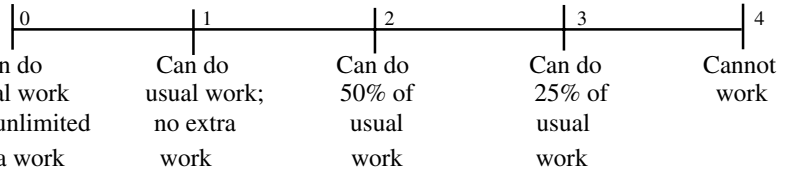
3. Personal Care (washing, dressing, etc.)



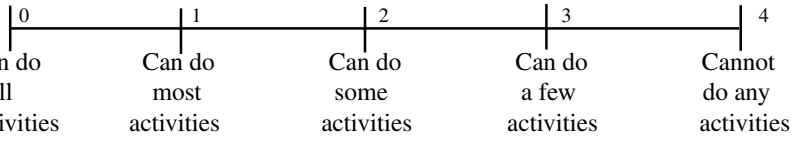
4. Travel (driving, etc.)



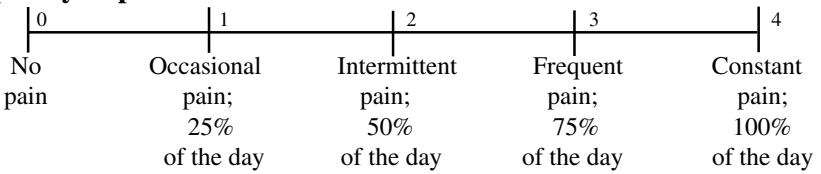
5. Work



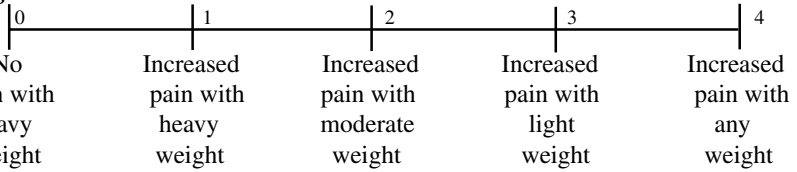
6. Recreation



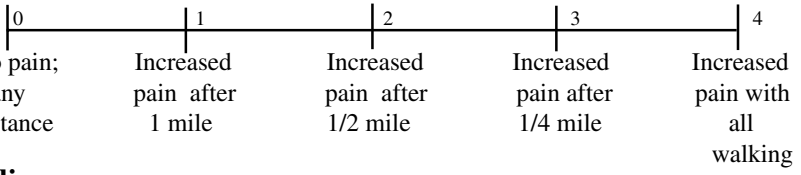
7. Frequency of pain



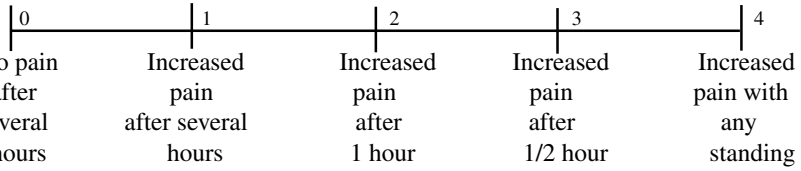
8. Lifting



9. Walking



10. Standing



Name _____
PRINTED

Total Score _____

_____
Signature

_____
Date

Ryan M. Thomas, DC, DABCO, LLC • 329 NE Hood Avenue • Gresham, Oregon 97030 • 503-491-0388

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, [patient's name] acknowledge that I have received, reviewed, understand and agree to the the Notice of Privacy Practices of Hillcrest Chiropractic Clinic, which describes the Practice's policies and procedures regarding the use and disclosure of any of my Protected Health Information created, received or maintained by the Practice.

I, _____, [nombre de los patient's] reconocen que he recibido, repasado, entienden y convienen el aviso de las prácticas de la aislamiento de la clínica del chiropractic de Hillcrest, que describe las políticas y los procedimientos de Practice's con respecto el uso y al acceso de cualquiera de mi información protegida de la salud creada, recibida o mantenida por la práctica.

_____ _____

Date/Firma Signature/Fecha

_____

Print Name

FOR OFFICE USE ONLY IF NOTICE NOT PROVIDED TO PATIENT

The Practice has made a good-faith effort to obtain an acknowledgement of _____ [patient's name]'s receipt of our Notice of Privacy Practices. In spite of these efforts, the Practice has been unable to obtain a signed acknowledgement of receipt for the following reasons (check all that apply):

- ☐ Patient Unavailable
- ☐ Patient Physically Unable
- ☐ Patient Unwilling

In an effort to obtain the patients acknowledgement, the Practice has attempted to provide patient with a Notice of Privacy Practices in the following manner (check all that apply):

- ☐ Personally ☐ Mail ☐ Phone Follow Up
- ☐ Other: _____

_____ _____

Date Signature

_____

Print Name of Physician • Hillcrest Chiropractic Clinic

Hillcrest Chiropractic Clinic
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

Our practice is dedicated, and we are required by applicable federal and state laws, to maintain the privacy of your health information. These laws also require us to provide you with this Notice of our privacy practices, and to inform you of your rights, and our obligations, concerning your health information. We are required to follow the privacy practices described below while this Notice is in effect. This Notice is effective as of April 14, 2003, and will remain in effect until we replace it.

CHANGES TO NOTICE:

We reserve the right to change this Notice and the privacy practices described below at any time in accordance with applicable law. Prior to making significant changes to our privacy practices, we will alter this Notice to reflect the changes, and make the revised Notice available to you on request. Any changes we make to our privacy practices and/or this Notice may be applicable to health information created or received by us prior to the date of the changes.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

PERMITTED USES AND DISCLOSURES OF HEALTH INFORMATION:

A. TREATMENT, PAYMENT, HEALTH CARE OPERATIONS: You should be aware that during the course of our relationship with you we will likely use and disclose health information about you for treatment, payment, and healthcare operations. Examples of these activities are as follows:

> Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.
>
> Payment: We may use and disclose your health information to obtain payment for services we provide to you.
>
> Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, and other business operations.

B. AUTHORIZATIONS: You may specifically authorize us to use your health information for any purpose or to disclose your health information to anyone, by submitting such an authorization in writing. Upon receiving an authorization from you in writing we may use or disclose your health information in accordance with that authorization. You may revoke an authorization at any time by notifying us in writing. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those permitted by this Notice.

C. DISCLOSURES TO FAMILY AND PERSONAL REPRESENTATIVES: We must disclose your health information to you, as described in the Patient Rights section of this Notice. Such disclosures will be made to any of your personal representatives appropriately authorized to have access and control of your health information. We may disclose your health information to a family member, friend or other

person to the extent necessary to help with your healthcare or with payment for your healthcare only if authorized to do so. In the event of your incapacity or in emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare.

D. MARKETING: We will not use your health information for marketing communications without your written authorization.

E. USES OR DISCLOSURES REQUIRED BY LAW: We may use or disclose your health information when we are required to do so by law, including for public health reasons (e.g., disease reporting). In some instances, and in accordance with applicable law, we may be required to disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes.

F. PATIENT AND THIRD PARTY PROTECTION: Only as permitted by law, we may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

G. LAW ENFORCEMENT/NATIONAL SECURITY: Under certain circumstances we may disclose health information relating to members of the Armed Forces to military authorities. Under certain circumstances we may also disclose health information relating to inmates or patients to correctional institutions or law enforcement personnel having lawful custody of those individuals. We may disclose health information in response to judicial proceedings and law enforcement inquiries as permitted by law and to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities.

H. APPOINTMENT REMINDERS: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS:

A. ACCESS TO RECORDS: Upon submission of a written request to us, you have the right to review or receive copies of your health information, with limited exceptions. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may request that we provide copies in a format other than photocopies and we will use the format you request if it is readily available. We will charge you a reasonable cost-based fee relating to the production of such copies. If you request copies, we will charge you **$1.00 per page for the initial 25 pages then $.25 for each page**, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a reasonable cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice if you are interested in receiving a summary of your information instead of copies.

B. ACCOUNTING OF CERTAIN DISCLOSURES. Upon written request, you have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and other activities authorized by you, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

C. RESTRICTIONS AND ALTERNATIVE COMMUNICATIONS: You have the right to request that we place additional restrictions on our use or disclosure of your health information for treatment, payment and healthcare operations purposes. Depending on the circumstances of your request we may, or may not agree to those restrictions. If we do agree to your requested restrictions we must abide by those restrictions, except in emergency treatment scenarios. You have the right to request that we communicate with you about your health information by alternative means or to alternative locations (e.g., at your place of business rather than at your home). Such requests must be made in writing, must specify the alternative

means or location, and must provide satisfactory explanation how payments will be handled under the alternative means or location you request.

D. AMENDMENTS TO RECORDS: You have the right to request that we amend your health information. Such requests must be made in writing, and must explain why the information should be amended. We may deny your request under certain circumstances.

E. ELECTRONIC NOTICES. If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made or any decisions we may make regarding the use, disclosure, or access to your health information you may complain to us using the contact information listed below. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file such a complaint upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Please direct any of your questions or complaints to:

Contact: Ryan M. Thomas DC, LLC

Telephone: 503-491-0388 Fax: 503-491-0784

E-mail: hillcrestchiro@earthlink.net

Address: 329 NE Hood Avenue, Gresham, Oregon 97030