Salem Naturopathic Clinic, P.C.
1305 Broadway Street NE • Salem, OR 97301 • ph. 503 364-1441 • fax 503 364-9924

Motor Vehicle Accident Intake Form

Patient Information: Today's Date: ___/___/_____

Name: _____

(Current patients of Salem Naturopathic Clinic may skip ahead to Auto Insurance Claim Information unless there have been changes to the following demographic information)

Mailing Address: _____City: _____ State: _____ Zip: _____

Gender: _____ Age: _____ Date of Birth: ___/ ___/ _____

Phone- (Cell): _____(Home): _____(Work): _____

Email: _____

Would you like to receive appointment reminders by text and/or email? Text: ___ Email: ___ No Reminders: ___

Emergency Contact Name: _____ Phone #: _____

Relation to You: _____ May we discuss billing and/or treatment with this person? Yes: ___ No: ___

Name of Primary Care Provider: _____

May we update your Primary Care Provider regarding your treatment in our office? Yes: ___ No: ___

Whom may we thank for your referral today? _____

Auto Insurance Claim Information:

Date of Accident: ___/ ___/ _____ Time of Accident: _____ AM: ___ PM: ___

In which state did the accident occur? _____

Your Auto Insurance Company: _____ Auto Insurance Policy #: _____

Auto Insurance Mailing Address: _____City/State/Zip: _____

Auto Insurance Company Phone #: _____Claim #: _____

Claim Adjuster's Name: _____

Claim Adjuster's Phone #: _____ Fax #: _____

Are there Personal Injury Protection (PIP) benefits available with your insurance company? Yes: ___ No: ___

Have you retained an attorney? Yes: ___ No: ___

Attorney's Name: _____ Phone #: _____

Motor Vehicle Accident History:

Please describe the accident in your own words:

_____

_____

_____

_____

Home Care Remedies Since Injury:

Rest:____ Details:_____

Ice/Heat:___ Details:_____

Exercise:___ Details:_____

Medication:___ Details:_____

Other:___ Details:_____

Type of vehicle you were in- Year:_____ Make:_____ Model:_____
What was the damage to the vehicle? Mild:_____ Moderate:_____ Extensive:_____ Totaled:_____
Other vehicle involved- Year:_____ Make:_____ Model:_____
You were- Driver:___ Passenger:___ Pedestrian:___
If you were the *passenger*, your seat was-
Front (right):___ , Rear (right):___ , Rear (middle):___ , Rear (left):___
Where was the point of impact?
Front End (right): ____, Front End (left):___, Driver Side (front):____, Passenger side (front):____, Right Side (middle):___ Left Side (middle):___, Back (right):____ , Back (left):____, Rear End (right):____, Rear End (left):___
Road conditions at the time- Wet:___ Dry:___ Icy:___ Snowy:___ Other:_____
Were you braced for impact? No:___ Yes:___ If yes, *how*? _____
Were you wearing a seatbelt? Yes:___ No:___ **Did airbags deploy during the accident?** Yes:___ No:___
Did your body strike anything inside the vehicle? No:___ Yes:___ If yes, *what*? _____
Did you experience a flash of light or a feeling of explosion in your head? Yes:___ No:___
Immediately after the accident, did you become: Confused:___ Disoriented:___ Dizzy:___ Light Headed:___
Nauseous:___ Blurred Vision:___ Ears Ringing:___ Other:_____
How long did the symptom(s) last? _____
Did you lose consciousness? Yes:___ No:___ **Was your head injured?** Yes:___ No:___
What was the position of your head at the time of the accident?_____
Immediately after the accident, did you experience:
Headache:___ Neck Pain:___ Low Back Pain:___ Other:_____
Did you go to a hospital after the accident? No:___ Yes:___ If yes, *name?* _____
How did you get to the hospital? _____
Treatment received at the hospital:_____
Were any of the following tests performed at the hospital? X-Ray:___ MRI:___ CT Scan:___ Lab Work:___
Have you had any of the following symptoms since your injury?

___Headache	___Hip Pain (R/L)	___Shortness of Breath	___Concentration Difficulty
___Neck Pain	___Leg Pain (R/L)	___Fatigue	___Memory Difficulty
___Neck Stiffness	___Knee Pain (R/L)	___Depression	___Intolerance to Cold
___Mid-back Pain	___Ankle Pain (R/L)	___Lights Bother Eyes	___Sexul Disfunction
___Low-back Pain	___Foot Pain (R/L)	___Face Flushed	___Personality Changes
___Chest Pain	___Shoulder Pain (R/L)	___Difficulty Swallowing	___Pins and Needles in Arm
___Jaw Pain	___Arm Pain (R/L)	___Intolerance to Alcohol	___Pins and Needles in Leg
___Jaw Clicking	___Elbow Pain (R/L)	___Numbness in Fingers	___Personality Changes
___Ears RIng	___Wrist Pain (R/L)	___Numbness in Toes	___Relationship Difficulty
___Restlessness	___Hand Pain (R/L)	___Irritable	___No longe care about things
___Anxiety	___Difficulty Sleeping	___Difficulty Thinking	___Heavy Head
___Vomiting	___Forget ATM/Phone #s	___Writing Problems	___Chest Pain
___Fluid in Ears	___Loss of Attention	___Dizziness	___Blurred Vision
___Diarrhea	___Cold Hands/Feet	___Sciatica	___Reading Problems
___Regional Swelling	___Uncoordinated	___Loss of Balance	___Urinary Difficulties
___Fainting	___Loss of Smell	___Loss of Taste	___Constipation
___Emotional Difficulty	___Intolerence to Heat	___Upset Stomach	___(Other:_____

When did the symptoms first appear?_____
Which of the symptoms were present and active within one year prior to the accident? ____
_____
Have you ever received a concussion prior to the accident? Yes:___ No:___
Any previous motor vehicle accidents? No:___ Yes:___ If yes please, *when/describe*:_____
_____

Please list any medication or supplements you are currently taking (please include dosage):

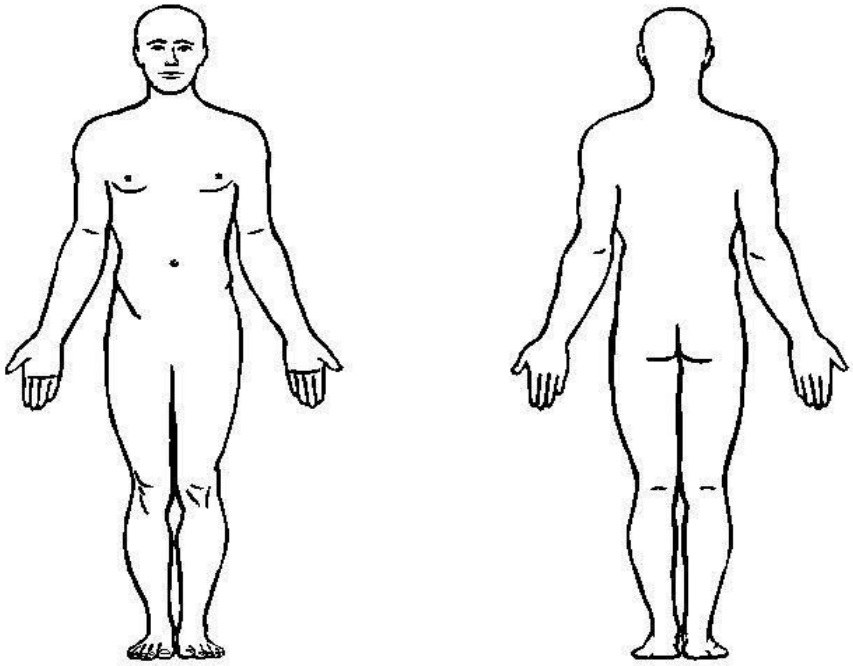
_____

_____

_____

Please indicate on the body diagram where you are experiencing symptoms:

X= Sore N= Numbness B= Burning S= Sharp Pain T= Tingling D= Dull Ache



Please describe anything else you would like to discuss:

_____

_____

_____

I hereby attest that the above information is true and correct to the best of my knowledge.

_____ _____

Signature of Patient or Legal Guardian Date

_____ _____

Print Patient Name & Legal Guardian (if applicable) Relationship to Patient

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Motor Vehicle Accident Financial Policy

This Motor Vehicle Accident (MVA) Financial Policy outlines financial terms and conditions specifically related to payment for the treatment of your MVA related injury. All other terms and conditions of our general Financial Policy (to follow) will apply.

- We will bill your motor vehicle insurance carrier. You must provide us with the information needed in order to bill by completing the attached Intake Form.
- In the event that your claims are denied by your motor vehicle insurance carrier, the personal injury protection benefits are exhausted or you receive a settlement, any balance on your account becomes due in full within 30 days.
- In the event that your claims are denied by your motor vehicle insurance carrier or the personal injury protection benefits are exhausted, we ***may*** be able to file your claim with your personal health insurance carrier. Though we may attempt to bill your personal health insurance carrier, there is no guarantee that they will pay the claim.
- We will not accept an attorney's 'letter of protection' for claims being disputed or in litigation and payment will be collected at the time of service in these cases.
- Missed appointment fees cannot be billed to your motor vehicle insurance carrier. You will be personally responsible for paying these fees. Please see general Financial Policy for full details.
- Not all services can be billed to your motor vehicle insurance carrier. If services cannot be billed to your MVA insurance carrier, you are responsible for the payment of these services.

Regardless of the outcome of your Motor Vehicle Accident claim against an insurance company or litigation you might pursue related to your MVA claim, you are ultimately personally responsible for payment of any services provided by Salem Naturopathic Clinic, PC. Please see our general Financial Policy for payment terms.

I have read and understand the Motor Vehicle Accident Financial Policy and agree to abide by its guidelines:

_____ _____
Signature of Patient or Legal Guardian Date

_____ _____
Print Patient Name & Legal Guardian (if applicable) Relationship to Patient

Revised 2/2020

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Financial Policy

Thank you for choosing us as your healthcare provider. We are committed to providing you with quality care. We are sure you understand that payment for this service is your responsibility. This policy outlines your financial responsibilities related to payment for professional services. Please read it and ask us any questions you may have. When completed, please sign in the space provided. A copy will be provided to you upon request.

Insurance. We can bill most insurance plans, however are not a contracted Medicare provider and we may not be in-network with your insurance company. We will bill your primary insurance and, if applicable, a secondary insurance. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

1. **Proof of insurance.** All patients must complete our patient information form before seeing the doctor. We will obtain a copy of your photo I.D. and valid insurance card. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the charges. If you do not have your insurance card with you, payment in full for each visit is required until we can verify your coverage.

2. **Co-payments and deductibles.** All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

3. **Non-covered services.** Please be aware that some – and perhaps all – of the services you receive may not be covered. You must pay for these services in full at the time of visit or after your insurance has denied them.

4. **Claims submission.** We will submit your claims to assist with payment. Please be aware that your insurance company may need you to supply certain information directly to them. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether your insurance company pays your claim or not. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

5. **Claim Payment.** If your insurance company does not pay within a reasonable time period of 90 days, you may be billed. If we later receive payment from your insurer, we will refund any overpayment to you.

6. **Coverage changes.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. Failure to provide new insurance information at the time of your appointment may result in payment responsibility to fall to you.

Non-Insurance/Self-Pay. If you do not have insurance or have insurance that does not provide payment for our services, you will be considered a self-pay patient and payment in full is expected at each visit.

Lab Services. We can obtain and process a specimen here in our office and send it to our third-party laboratory for analysis for your convenience. If you wish to go elsewhere, we can provide you with a lab order to take to a lab better covered by your insurance or more convenient for you.

Supplements. Many supplements are available for purchase at Salem Naturopathic Clinic. We do not bill insurance for supplements. Payment for supplements must be made in full at the time of purchase.

Non-Sufficient Funds. If you present a check for payment to Salem Naturopathic Clinic and it is not honored by your bank, a $25 Non-Sufficient Funds charge will be added to your account per occurrence.

Medical Record Copies. Salem Naturopathic Clinic charges $25 per request to copy your medical records for you. (This fee does not apply to records requests from other providers). You must complete a Medical Records Request Form and pay the copying fee prior to our releasing records to you.

Cancellation and Missed Appointment Policy. As a courtesy, we request that you provide us with 24 hours notice if you must cancel or reschedule an appointment. After the second consecutive cancelled or rescheduled appointment with less than 24 hours notice, a $50 late cancellation fee will be added to your account. Payment of the late cancellation fee must be made prior to scheduling your next visit. After a third missed appointment without advanced notice, you may be dismissed from the practice. Please help us to serve you better by keeping your regularly scheduled appointment or providing at least 24 hours notice in the event you must cancel or reschedule.

Nonpayment. If you are a self-pay patient and your account is over 90 days past due OR if you are billing insurance and your account is over 120 days past due, you will receive a letter stating that you have 30 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated with our billing service. Please be aware that if a balance remains unpaid, we will refer your account to a collection agency and you and your immediate family members will be discharged from this practice. In addition, if your bill is dismissed by a court as part of your bankruptcy, you and your immediate family members will be discharged from this practice. If you are dismissed from this practice, you will be notified by certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician(s) will only be able to treat you on an emergency basis.

Thank you for understanding our Payment Policy. Please let us know if you have any questions.

I have read and understand the Payment Policy and agree to abide by its guidelines:

_____	_____
Signature of Patient or Legal Guardian	Date
_____	_____
Print Patient Name & Legal Guardian (if applicable)	Relationship to Patient

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I have been given the opportunity to read and review a copy of Salem Naturopathic Clinic, P.C. 's Privacy Practices. I have had all questions regarding these procedures answered to my satisfaction. These policies are in accordance with the most current HIPAA guidelines in my State.

Signed by:

_____ _____
Signature of Patient or Legal Guardian Relationship to Patient

_____ _____
Print Patient's Name Date

_____
Print Name of Legal Guardian (if applicable)

Revised 2/2020

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Informed Consent to Naturopathic Medical Care

I hereby request and consent to the performance of evaluation and management services as well as other procedures by my doctor at the Salem Naturopathic Clinic, PC. I understand that I have the right to ask questions and discuss to my satisfaction with Dr. _____ the nature and purpose of naturopathic medical evaluation and treatment and other procedures which my naturopathic physician may administer.

I understand and am informed that:

1. Naturopathic Medicine is the science, philosophy and art of identifying and treating diseases, dysfunctions, disorders and imbalances of normal human physiologic function. There has been no promise implied or otherwise, of a cure for any symptom, disease or condition as a result of treatment in this clinic.

2. As with any practice of medicine, it is not an exact science, but relies upon information related by the patient, information gathered during examination, and the doctor's interpretation thereof, as well as the doctor's judgment and expertise in working with like cases.

3. I understand that my physician may administer manual therapy using his/her hands. I understand that my physician may use manipulation of joints, tendons, muscles and connective tissue in the body to restore motion / mobility. He or she will use his hands or a mechanical device upon my body to adjust a joint which may cause an audible "pop" or "click."

4. It is not reasonable to expect my physician to be able to anticipate, or explain, all possible risks and complications of a given procedure on any particular visit and I wish to rely on the doctor to exercise professional judgment during the course of any procedures, which he feels at the time to be in my best interest.

5. An undesirable result, or side effect, does not necessarily indicate an error in judgment or an improper treatment. I agree to communicate any such information to my physician in a timely manner so that changes in my treatment plan, if any, can be made.

6. As with any healthcare procedure, there are certain complications which may arise during any given medical procedure. Those complications from manipulation include sprains/strains, dislocations, fractures, disc injuries, or cerebral-vascular accidents. Complications from injections may include pain at site of injection/infusion, allergy to injectant resulting in anaphylaxis, which may be fatal; light-headedness and weakness after injection. These complications are extremely rare occurrences.

I have read the above consent, or had it read to me, have had the opportunity to ask questions and receive answers, am comfortable with the information provided and consent to naturopathic medical evaluation, treatment and management on that basis.

Signed by:

_____ _____
Signature of Patient or Legal Guardian Relationship to Patient

_____ _____
Print Patient's Name & Legal Guardian (if applicable) Date

Revised 2/2020